IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED HEALTHCARE SERVICES, INC.; UNITEDHEALTHCARE INSURANCE COMPANY; and UMR, INC., Plaintiffs, v. HOSPITAL PHYSICIAN SERVICES SOUTHEAST, P.C.; INPHYNET PRIMARY CARE PHYSICIANS SOUTHEAST, P.C.; and REDMOND ANESTHESIA & PAIN TREATMENT, P.C., Defendants.	Case No. 1:23-cv-05221-JPB

DEFENDANTS' MOTION TO DISMISS
FOR LACK OF SUBJECT-MATTER JURISDICTION

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PRELIMINARY STATEMENT

The Court should dismiss this action because it lacks subject-matter jurisdiction. As explained in detail below, United[1] cannot demonstrate an actual controversy between itself and the Georgia Medical Groups[2] based on United's own narrowly construed set of medical claims (the "Litigation Medical Claims").[3] Absent an actual controversy, dismissal is mandatory.

The genesis of this matter is a longstanding pattern of predatory conduct perpetrated by United. United and its affiliates are the nation's largest health insurance company. The Georgia Medical Groups are medical practices operating out of hospitals in Georgia. The Georgia Medical Groups are affiliated with "TeamHealth," a group of companies that provide practice management services to medical professionals throughout the United States.

In or around 2019, United began terminating its network provider agreements with TeamHealth-affiliated provider groups nationwide, including two of the

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[1] "United" refers collectively to Plaintiffs United Healthcare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc.

[2] The "Georgia Medical Groups" are Defendants Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C.

[3] The Litigation Medical Claims are claims for: (a) out-of-network emergency services provided to United's members prior to January 1, 2022 in Georgia, and (b) out-of-network non-emergency services provided to United's members at out-of-network facilities on or after January 1, 2022 in Georgia. (Compl. ¶ 47.)

Georgia Medical Groups here, thereby forcing the groups out of United's network. Yet, because the provider groups are comprised primarily of emergency department physicians and/or other hospital-based specialists, they have been compelled by law and circumstances to render out-of-network care to United's members[4] on an ongoing basis. In the absence of a participating-provider agreement to dictate the appropriate rates of payment, United systematically has reimbursed the resulting claims at amounts well below the reasonable value of the medical services rendered. In so doing, United has generated enormous, ill-begotten profits for itself.

In response to United's systematic underpayments, TeamHealth-affiliated practice groups in nine States—but *not* in Georgia—have brought actions against United seeking additional reimbursement under various state law theories. In these disputes, many—but not all—of the underlying claims for reimbursement involve patients holding health coverage under employer-sponsored, self-funded health plans administered by United. The administration of such plans is governed by ERISA, and United consistently has argued that the medical practices' state law claims for fair reimbursement are precluded by ERISA's preemption clause.[5] But

[4] United's "members" are individuals holding health coverage underwritten and/or administered by United.

[5] *See* 29 U.S.C. § 1144(a).

the courts have just as consistently rejected United's preemption defense[6] because "ERISA does not pre-empt state rate regulations…." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 88 (2020). Undeterred, United now brings this action, asking the Court to grant a declaratory judgment providing, in effect, that the multiple other courts to address the issue uniformly erred. The Court should decline that invitation for several related reasons.

First, dismissal is warranted because the Court lacks subject-matter jurisdiction. The Declaratory Judgment Act ("DJA") permits federal courts "to declare the rights and other legal relations" of interested parties only "[i]n a case of actual controversy." 28 U.S.C. § 2201(a). Here, this foundational requirement is unsatisfied because, on the record presented, there is no actual controversy between United and the Georgia Medical Groups. Rather, United's theory is that because *certain* TeamHealth-affiliated practices have sued United, there necessarily exists an active dispute between United and *all* TeamHealth-affiliated practices. That theory should be rejected because the various TeamHealth-affiliated practices are distinct corporate entities, and there are many reasons—rates historically paid, actual payments received, local market conditions, hospital relationships, business considerations etc.—that might motivate TeamHealth affiliates to assert claims

[6] *See, e.g., Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1297-99 (S.D. Fla. 2021).

against United in one State versus another. Indeed, TeamHealth-affiliated practices operate in forty-seven States. Yet, despite TeamHealth's multiyear dispute with United, its affiliated practices have sued United in only nine out of the forty-seven. And, in fact, the record demonstrates that, *contra* United, the Georgia Medical Groups do *not* presently intend to sue for additional reimbursement in court. Accordingly, the Court is without jurisdiction to hear this dispute. (Part I.)

Second, even if jurisdiction existed, the Court still should dismiss this case. The DJA grants federal courts only the *competency* to issue declaratory judgments, not the *obligation* to do so. As such, courts have broad discretion to deny requests for declaratory relief, even where the jurisdictional prerequisites are otherwise satisfied. Here, the Court should deny United's request because not only is there no *present* controversy, there is no reason to think a controversy will arise in the future. The entire basis for United's hypothesized controversy with the Georgia Medical Groups is that other TeamHealth affiliates in other States have sued United over rates of reimbursement. But the plaintiffs in those other lawsuits universally have alleged inadequate reimbursement amounts for out-of-network *emergency* medical services and/or non-emergency anesthesia services delivered at *in-network* hospitals. Yet United here seeks a declaratory judgment that would apply to the Litigation Medical Claims, which are claims for *non-emergency* hospitalist services and/or anesthesia services delivered at *out-of-network* hospitals. Thus, even if it were

somehow proper for United to use this lawsuit as a vehicle to test the general viability of its ERISA preemption theory based on speculation that an actual controversy may materialize later on, such speculation is entirely unmoored from the historical precedents that United relies upon because the claims at issue differ in kind from those that TeamHealth-affiliated entities historically have challenged. (Part II.)

Ultimately, United has not pled—and cannot plead—any facts suggesting the existence of an actual controversy with the Georgia Medical Groups. Its transparent aim in bringing this case is not to avoid threatened injury in Georgia, but to secure an advisory opinion that it can use to gain advantage in its disputes with other TeamHealth-affiliated practices pending before other courts in other States. The Court must reject this blatant abuse of the judicial process and dismiss the Complaint accordingly.

STATEMENT OF FACTS

United and its affiliates are a health insurer and a third-party administrator ("TPA") for self-funded ERISA plans. (Compl. ¶¶ 13-16.) In these roles, United reviews claims for medical services provided to its members and pays reimbursements to the medical providers. (Compl. ¶¶ 5, 16, 32.) The Georgia Medical Groups are medical practices that operate out of hospitals in Georgia. (Compl. ¶¶ 4, 17-21.) They contract with those hospitals to provide emergency and non-emergency medical services to hospital patients. (Compl. ¶ 4.) The Georgia

Medical Groups are affiliated with TeamHealth, a practice management entity with affiliated medical practices in forty-seven States. (Compl. ¶ 21; Ex. 1 ¶ 11.) Since 2019, TeamHealth-affiliated practices have filed lawsuits against United in nine States. (Ex. 1 ¶ 11.)[7] Those suits have asserted that the rates United paid on commercial, out-of-network emergency services and anesthesia claims were unlawfully low. (Compl. ¶¶ 9.) In each of these disputes, United has argued that the TeamHealth-affiliated practices' state law claims are preempted by ERISA to the extent they challenge the rates paid on claims for services delivered to patients holding coverage under self-funded, ERISA-governed health plans.

Unlike the TeamHealth-affiliated practices in those nine other States, the Georgia Medical Groups have not sued United. (Compl. ¶ 59.) They do not presently intend to do so, nor have they told United that they would. (Ex. 1 ¶¶ 8-9.) Nonetheless, United seeks declaratory relief providing that any claims they theoretically could assert under Georgia state law seeking reimbursement amounts greater than those United has calculated are preempted by ERISA. (Compl. ¶ 79.)

LEGAL STANDARD

The DJA provides that "[i]n a ***case of actual controversy*** within its jurisdiction … any court of the United States … may declare the rights and other

[7] *See* Exs. 2 through 11.

legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a) (emphasis added). The term "case of actual controversy" refers to the same "case or controversy" requirement for federal court jurisdiction set forth in Article III, § 2 of the Constitution. *MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 127 (2007); *see also Cambridge Christian Sch., Inc. v. Fla. High Sch. Athletic Ass'n*, 942 F.3d 1215, 1251 (11th Cir. 2019) (explaining that "[t]he Declaratory Judgment Act does not enlarge the jurisdiction of the federal courts, meaning that, at the very least, a controversy under the Act must also be a 'case or controversy' under Article III") (cleaned up). Thus, when a plaintiff brings a claim under the DJA, "the threshold question is whether a justiciable controversy exists[.]" *Atlanta Gas Light Co. v. Aetna Cas. & Sur. Co.*, 68 F.3d 409, 414 (11th Cir. 1995) (cleaned up).

Because the defense that a complaint for declaratory relief does not raise an actual controversy attacks the court's subject-matter jurisdiction, the proper vehicle is a motion pursuant to Federal Rule of Civil Procedure 12(b)(1). *See, e.g., GEICO Gen. Ins. Co. v. Farag*, 597 F. App'x 1053, 1057 (11th Cir. 2015) ("Declaratory Judgment Act's 'actual controversy' requirement is jurisdictional and, thus, a threshold question in an action for declaratory relief must be whether a justiciable controversy exists … [the court] therefore construe[s] the district court's decision as a dismissal of the claim for lack of subject matter jurisdiction under Fed. R. Civ. P.

12(b)(1)"); *FedEx Corp. Servs., Inc. v. Eclipse IP LLC*, 15 F. Supp. 3d 1346, 1348 (N.D. Ga. 2013) (noting that a plaintiff seeking declaratory relief must establish the existence of a case or controversy, and that if "no such controversy exists, the case must be dismissed for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) of the Federal Rules of Civil Procedure").

Motions under Rule 12(b)(1) come in two distinct forms: facial attacks and factual attacks. *Kennedy v. Floridian Hotel, Inc.*, 998 F.3d 1221, 1230 (11th Cir. 2021). "A facial attack challenges whether a plaintiff has sufficiently alleged a basis of subject matter jurisdiction, and the allegations in his complaint are taken as true for purposes of the motion." *Id*. In contrast, a factual attack challenges "the existence of subject matter jurisdiction in fact, irrespective of the pleadings, and matters outside the pleadings, such as testimony and affidavits are considered." *McElmurray v. Consol. Gov't of Augusta-Richmond Cty.*, 501 F.3d 1244, 1251 (11th Cir. 2007). A court addressing a factual attack "needn't accept the plaintiff's facts as true; rather, the district court is free to independently weigh facts and make the necessary findings." *Gardner v. Mutz*, 962 F.3d 1329, 1340 (11th Cir. 2020); *see also United States v. Cuesta*, 69 F. Supp. 3d 1296, 1297–98 (M.D. Fla. 2014) ("In a factual attack, the presumption of truthfulness afforded to a plaintiff under Fed. R. Civ. P. 12(b)(6) does not attach. Because the very power of the Court to hear the

case is at issue in a Rule 12(b)(1) motion, the Court is free to weigh evidence outside the complaint." (internal citations omitted)).

ARGUMENT

The "actual controversy" requirement is satisfied only where a plaintiff can point to an actual, present controversy involving harm already suffered or imminently threatened. This determination is made "on a case-by-case basis," and the alleged controversy "must be more than conjectural." *Atlanta Gas*, 68 F.3d at 414. As the Eleventh Circuit has explained, "[t]he party who invokes a federal court's authority must show, at an irreducible minimum, that ***at the time the complaint was filed***, he has suffered some actual or threatened injury resulting from the defendant's conduct…." *Id.* (quotation marks omitted and emphasis added). The distinction between a "definite and concrete dispute and [a] case not ripe for litigation is one of degree, determined by the totality of the circumstances." *Id.* (citing *BP Chems. Ltd. v. Union Carbide Corp.*, 4 F.3d 975, 977-78 (Fed. Cir. 1993)).

I. THE COURT LACKS JURISDICTION BECAUSE THERE IS NO ACTUAL CONTROVERSY BETWEEN UNITED AND THE GEORGIA MEDICAL GROUPS

The Court lacks subject-matter jurisdiction here because there is no actual controversy between United and the Georgia Medical Groups. The record

presented[8] makes clear that the Georgia Medical Groups do not presently intend to sue United for additional reimbursement pertaining to the Litigation Medical Claims at issue, and they have not suggested otherwise. Rather, the controversy alleged in United's Complaint is purely speculative and based on how the Georgia Medical Groups might behave in the future, given actions by other TeamHealth-affiliated practices in other States. Under well-established law, that is not enough to raise a justiciable case or controversy.

Atlanta Gas is highly instructive. There, the plaintiff was a power utility responsible for environmental contamination at various sites in Florida and Georgia. *Id.* at 411. The company was concerned—based on the general regulatory climate at the time—that environmental regulators would order cleanup operations at the sites, causing the company to incur substantial costs. *Id.* at 412. To address this concern, the company put its excess liability carriers on notice of potential claims and immediately filed a declaratory judgment action to establish the carriers' duties to defend and indemnify the company. *Id.* When the company filed its action, no regulator had yet ordered cleanup of the sites, no third-party suits had been filed against the company, and the only available estimate of the cleanup costs was for an

[8] In this Motion, the Georgia Medical Groups raise a factual challenge to the Court's subject-matter jurisdiction. Accordingly, the Court must consider the record evidence and is not limited to the four corners of United's Complaint. *McElmurray*, 501 F.3d at 1251.

amount well below the total limit of the company's self-insured retention, above which the excess coverage attached. *Id.*

Presented with those facts, the Eleventh Circuit—*sua sponte*—vacated the district court's summary judgment award and ordered the entire action dismissed for lack of subject-matter jurisdiction. *Id.* at 415-16. It reasoned that:

> When AGL sought the court's guidance through a declaratory judgment, the issues it presented were no more than ***conjectural questions based on the fact that other utilities had battled with insurers over MGP cleanup costs*** …. Not only had the insurers not yet received notice, no one knew exactly what had to be cleaned up, who was to undertake the cleanup, or how much the cleanup would cost. While it is not necessary to know each of these factors with certainty in order to seek declaratory relief, when AGL filed its complaint, it was not clear that state and federal environmental agencies would ever require cleanups at any of AGL's former MGP sites.

Id. at 415 (emphasis added).

These principles command dismissal here. As in *Atlanta Gas*, the issues presented in United's Complaint are "conjectural questions." United's sole basis for filing this suit is that *other* TeamHealth affiliates in *States other than Georgia* have sued United in the past. (Compl. ¶¶ 9-10.) In fact, United expressly pleads that "[t]he position of the [Georgia Medical Groups] was crystallized and communicated, in part, in the context of litigation commenced by other TeamHealth-affiliated providers in jurisdictions outside Georgia." (Compl. ¶ 54.) United notes positions that these other medical practices have asserted in lawsuits pending in Arizona and Florida (Compl. ¶ 55), and it cites deposition testimony delivered by TeamHealth

executives in a matter pending in New York (Compl. ¶¶ 56-57). These statements represent the sum total of United's factual averments as to the existence of an actual controversy in Georgia arising out of the Litigation Medical Claims.[9] But missing from these core allegations is any suggestion that the Georgia Medical Groups have themselves ever threatened to sue United or somehow suggested they would. Absent this critical predication, there is no justiciable dispute for the Court to resolve. United's conjecture that the Georgia Medical Groups may perhaps sue it at some point in the future is simply not enough. *See Malowney v. Fed. Collection Deposit Grp.*, 193 F.3d 1342, 1347 (11th Cir. 1999) (noting that actual controversy "may not be conjectural, hypothetical, or contingent; it must be real and immediate, and create a definite, rather than speculative threat of future injury").

In any event, even if United's *allegations* were sufficient to show a controversy with the Georgia Medical Groups, the *evidence* confirms that no such controversy exists. In support of this Motion, the Georgia Medical Groups have

[9] In setting forth the elements of its claim, United recites that "[t]he [Georgia Medical Groups], through their affiliates, have declared that they are entitled under Georgia state law to recover their full billed charges in all instances where United has calculated allowed amounts for out-of-network services to participants in the United Benefit Plans at any amounts less than their full billed charges." (Compl. ¶ 77.) That is an *ipse dixit* conclusion, not an averment of fact. United has pled no facts suggesting that other TeamHealth-affiliated medical practices are authorized to speak on behalf of the Georgia Medical Groups, nor that TeamHealth personnel have ever expressed a view as to what the Georgia Medical Groups are entitled to recover under Georgia state law.

attached the Declaration of Kent Bristow, TeamHealth's Senior Vice President for Revenue Management. (Ex. 1 ¶ 3.) In that role, Mr. Bristow generally is appointed authorized agent for TeamHealth-affiliated medical practices, with oversight authority and decision-making responsibility over matters involving the practices' relationships with health insurers. (Ex. 1 ¶ 4.) Notably, Mr. Bristow has "authority to determine what reimbursement rates are acceptable to TeamHealth and its affiliates, including the Georgia Medical Groups, and whether to take legal action against health insurers and/or [TPAs] such as United regarding inadequate rates of reimbursement."[10] (Ex. 1 ¶ 7.) As he explains, the Georgia Medical Groups have no present intent to take legal action against United regarding the Litigation Medical Claims at issue. (Ex. 1 ¶ 8.) Nor is he aware of any indication the Georgia Medical Groups or TeamHealth might have given to the contrary. (Ex. 1 ¶ 9.)

Moreover, Mr. Bristow notes that TeamHealth-affiliated practices "are selective and deliberate about whether and when to take legal action against Insurers," and "a decision for a TeamHealth-affiliated medical group in a certain geographic market to bring an action against an Insurer is not indicative of an intent for different affiliates in different markets to do the same." (Ex. 1 ¶ 10.) This reality

[10] United's Complaint cites Mr. Bristow's testimony from the New York matter to support its allegations here as to the existence of an actual controversy in Georgia. (Compl. ¶ 57.)

is well-illustrated by the facts of TeamHealth's dispute with United. To date, TeamHealth-affiliated practices have sued United in only nine out of the forty-seven States in which they operate. (Ex. 1 ¶ 11.) Thus, the disputes between United and TeamHealth-affiliated practices in other States do not suggest the existence of an actual controversy between the Georgia Medical Groups and United in Georgia.

Accordingly, any proffered controversy between the Georgia Medical Groups and United is "conjectural" and "hypothetical," rather than "real and immediate." *Malowney*, 193 F.3d at 1347. The Court therefore must dismiss for lack of subject-matter jurisdiction.

II. THE COURT SHOULD EXERCISE ITS DISCRETION TO DENY DECLARATORY RELIEF

Even if the Court somehow were to conclude that it has jurisdiction to proceed, it still should dismiss United's Complaint. Under the DJA, "any court of the United States … ***may*** declare the rights and other legal relations of any interested party seeking such declaration…." 28 U.S.C. § 2201(a) (emphasis added). This permissive language "only gives federal courts competence to make a declaration of rights; it does not impose a duty to do so." *Ameritas Variable Life Ins. Co. v. Roach*, 411 F.3d 1328, 1330 (11th Cir. 2005) (per curiam). As such, "district courts possess discretion in determining whether and when to entertain an action under the [DJA], even when the suit otherwise satisfied subject matter jurisdictional prerequisites." *Wilton v. Seven Falls Co.*, 515 U.S. 277, 282 (1995); *see also Cambridge Christian*

Sch., 942 F.3d at 1251 (noting that federal courts have "broad statutory discretion to decline declaratory relief," that the "remedy is nonobligatory," and that "in the declaratory judgment context, the normal principle that federal courts should adjudicate claims within their jurisdiction yields to considerations of practicality and wise judicial administration" (brackets and quotation marks omitted)). Here, the Court should exercise its discretion to deny United's request for declaratory relief, for at least two independent reasons.

First, jurisdiction, if it exists at all, is particularly tenuous here because United has excluded the precise types of claims at issue in the other United/TeamHealth cases. Specifically, TeamHealth-affiliated entities have to date sued United over inadequate rates of reimbursement in nine States.[11] (Ex. 1 ¶ 11.) In each of those cases, the plaintiff medical groups challenged rates of reimbursement for emergency medical services or non-emergent anesthesia services delivered at in-network hospitals. (Exs. 2 through 11.) Yet, here, United's Complaint specifically excludes those very claims, instead limiting this dispute to claims for *non-emergency* services delivered at *out-of-network* hospitals.[12] (Compl. ¶ 47.) Determining whether the

[11] The nine States are: New York, New Jersey, Pennsylvania, Florida, Texas, Oklahoma, Nevada, Arizona, and Michigan. For the Court's convenience, the Complaints from the cases filed in these States are attached hereto as Exhibits 2 through 11.

[12] This dispute does include emergency claims and claims for non-emergency services delivered at in-network hospitals prior to January 1, 2022. (Compl. ¶ 48.)

Georgia Medical Groups would ever sue United for additional reimbursement on those claims would require a crystal ball. Moreover, even if it were somehow proper for United to use this dispute to secure an advisory opinion that it could employ in disputes with other TeamHealth-affiliated medical practices (it plainly is not), such opinion would be of limited utility because the factual distinctions between the cases are substantial.

Second, there is no need for declaratory relief on the ERISA preemption issue. United attempts to justify its request by claiming that questions about the applicability of ERISA's preemption clause to legal claims challenging inadequate rates of reimbursement on out-of-network medical claims "create substantial uncertainty," which poses "an intolerable burden for United and the employer plan sponsors, participants and beneficiaries it serves…." (Compl. ¶ 60.) Nonsense. There is no "uncertainty" because the issue has been adjudicated time and again since *Rutledge*—often in cases involving United itself—with courts consistently recognizing that such claims are not preempted. *See, e.g., NEMS PLLC v. Harvard Pilgrim Health Care of Conn. Inc.*, 615 F. Supp. 3d 125, 141–42 (D. Conn. 2022) ("Every court confronted with this question has determined that ERISA does not

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But those legacy claims are several years old, presumably have long since been paid, and no new claims in this category will ever accrue. As such, the need for forward-looking declaratory relief with respect to these claims is minimal to non-existent.

preempt a law requiring insurers to reimburse emergency room physicians at a specific, possibly greater, rate.").[13] Thus, to the extent there was ever any question as to whether claims asserted by medical providers challenging rates of reimbursement under state law are preempted, that question has been answered: they are not. United may not *like* that answer, but the courts have addressed this issue

[13] *See also Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, ___ F. Supp. 3d ___, 2023 WL 2257961, at *5 (S.D. Fla. Feb. 28, 2023) (finding no preemption and explaining that the defendant-payer "misses the central holding of *Rutledge*, which is that a state law doesn't 'relate to' an ERISA plan if it merely 'establishes a floor for the cost of the benefits that plans choose to provide'"); *Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *8–9 (no preemption where payer's "asserted liability does not derive from the particular rights and obligations established by any plan … [n]or do Plaintiffs allege a violation of any plan provision"); *Vanguard Plastic Surgery, PLLC v. United Health Grp. Inc.*, 2021 WL 4651504, at *3 (S.D. Fla. Sept. 21, 2021) (no preemption where "Plaintiff's claims are based on its interactions with Defendants independent of the Plan, and Plaintiff brings those claims in its own right and on its own behalf"); *Emergency Servs. of Okla., PC v. Aetna Health, Inc.*, 556 F. Supp. 3d 1259, 1263–65 (W.D. Okla. 2021) (no preemption because "the plans are not the factual basis for Plaintiffs' claims as Plaintiffs are not seeking payment under the plans and have not asserted their claims based upon any terms of any ERISA plan"); *Kang*, 526 F. Supp. 3d at 1297–99 (no preemption because "the common law causes of action under which Plaintiffs bring their claims all have force and operate independently of the existence of any ERISA plans" and "the Supreme Court has stated that law which increase[s] the costs plans incur in one state versus another does not necessarily have an impermissible connection with an ERISA plan"); *ACS Primary Care Physicians Sw., P.A. v. UnitedHealthcare Ins. Co.*, 514 F. Supp. 3d 927, 939–42 (S.D. Tex. 2021) (finding "emergency care statutes equate to cost regulation that does not bear an impermissible connection with or reference to ERISA, and are therefore not preempted"), *rev'd on other grounds*, 60 F.4th 899 (5th Cir. 2023); *United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct. in and for Cty. of Clark*, 2021 WL 2769032, at *1 (Nev. July 1, 2021) (same).

comprehensively and have been remarkably consistent in their conclusions.[14] If United needs to know for its own planning purposes whether such claims are preempted, it should simply follow the guidance of the numerous courts to have addressed the issue in the last several years, rather than burden this Court with a request to weigh in yet again on this well-settled point of law (in a purely hypothetical dispute).

CONCLUSION

For all the foregoing reasons, the Court should grant the Motion and dismiss the Complaint.

Respectfully submitted, this 5th day of January, 2024.

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[14] One court has bucked the trend and ruled that claims asserted by a medical provider challenging rates of reimbursement are preempted. *AMISUB (SFH), Inc. v. Cigna Health & Life Ins. Co.*, ___ F. Supp. 3d ___, 2023 WL 8232887, at *7-9 (W.D. Tenn. July 11, 2023), *appeal docketed*, No. 23-5714 (6th Cir. 2023). But *AMISUB* is an extreme outlier, is poorly reasoned, and is unlikely to survive appellate scrutiny.

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CERTIFICATE OF COMPLIANCE

Pursuant to L.R. 7.1(D), I hereby certify that the foregoing document complies with the font and point selections approved by L.R. 5.1(C). The foregoing document was prepared using Times New Roman font in 14 point.

This 5th day of January, 2024.

/s/ James W. Cobb
James W. Cobb
Georgia Bar No. 420133

Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused a true and correct copy of the foregoing to be filed with the Clerk of Court using the CM/ECF system, which will send a notification of such filing to all counsel of record.

This 5th day of January, 2024.

/s/ James W. Cobb
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Counsel for Defendants

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED HEALTHCARE SERVICES, INC.; UNITEDHEALTHCARE INSURANCE COMPANY; and UMR, INC., Plaintiffs, v. HOSPITAL PHYSICIAN SERVICES SOUTHEAST, P.C.; INPHYNET PRIMARY CARE PHYSICIANS SOUTHEAST, P.C.; and REDMOND ANESTHESIA & PAIN TREATMENT, P.C., Defendants.	Case No. 1:23-cv-05221-JPB

DECLARATION OF KENT BRISTOW
IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS
FOR LACK OF SUBJECT-MATTER JURISDICTION

In accordance with 28 U.S.C. § 1746, I, Kent Bristow, hereby declare as follows:

1. My name is Kent Bristow. I am over eighteen (18) years old, and I have personal knowledge of the matters set forth in this Declaration. If called to testify to the facts stated herein, I could and would do so competently.

2. This Declaration is made in support of Defendants' Motion to Dismiss for Lack of Subject-Matter Jurisdiction (the "Motion").

3. I am the Senior Vice President, Revenue Management for TeamHealth Holdings, Inc., a term commonly used to refer to an affiliated group of companies that provide practice management services to medical professionals ("TeamHealth"). I have held that position for approximately ten years. I have worked with TeamHealth and its affiliates for over 25 years.

4. As Senior Vice President, Revenue Management, my responsibilities include, for example, overseeing managed care contracting and negotiations and overseeing disputes with insurance companies related to billing and reimbursement for TeamHealth-affiliated medical practices. In general, these medical practices also appoint me as authorized agent with power and authority to enter into managed care agreements and to oversee business processes related to managed care relationships on their behalf. The medical practices include the Defendants in this matter: Hospital Physician Services Southeast, P.C., Inphynet Primary Care Physicians Southeast, P.C., and Redmond Anesthesia & Pain Treatment, P.C. (collectively the "Georgia Medical Groups"). The Georgia Medical Groups are distinct corporate entities, with their own corporate governance.

5. In my roles, I am familiar with the relationship between the Georgia Medical Groups and Plaintiffs United HealthCare Services, Inc., UnitedHealthcare Insurance Company, and UMR, Inc. (collectively "United") in Georgia. My knowledge includes the Georgia Medical Groups' and United's course of dealing,

billing and reimbursement issues between the parties, and the facts and circumstances of this lawsuit.

6. I understand that in this lawsuit, United has put at issue the following specific claims for medical services rendered by the Georgia Medical Groups in Georgia: (a) out-of-network emergency services provided by the Georgia Medical Groups to United's members prior to January 1, 2022 in Georgia, and (b) claims for out-of-network non-emergency services provided to United's members at out-of-network facilities on or after January 1, 2022 in Georgia (the "Litigation Medical Claims").

7. In my roles, I have the authority to determine what reimbursement rates are acceptable to TeamHealth and its affiliates, including the Georgia Medical Groups, and whether to take legal action against health insurers and/or third-party administrators (collectively, "Insurers"), such as United, regarding inadequate rates of reimbursement.

8. Presently, the Georgia Medical Groups have no intent to take legal action against United regarding the Litigation Medical Claims.

9. Additionally, I am unaware of any indication that the Georgia Medical Groups or TeamHealth has given United that the Georgia Medical Groups intend to take action regarding the Litigation Medical Claims.

10. TeamHealth-affiliated medical groups are located in forty-seven states. These medical groups are selective and deliberate about whether and when to take legal action against Insurers. Therefore, a decision for a TeamHealth-affiliated medical group in a certain geographic market to bring an action against an Insurer is not indicative of an intent for different affiliates in different markets to do the same.

11. To date, TeamHealth-affiliated medical groups have sued United in only nine out of the forty-seven States in which they operate.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 4th, 2024

Kent Bristow

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No.: 0:20-cv-60757-WPD

FLORIDA EMERGENCY PHYSICIANS KANG & ASSOCIATES, M.D., INC.; INPHYNET CONTRACTING SERVICES, LLC; INPHYNET SOUTH BROWARD, LLC; PARAGON CONTRACTING SERVICES, LLC; PARAGON EMERGENCY SERVICES, LLC; SOUTHWEST FLORIDA EMERGENCY MANAGEMENT, LLC; and EMERGENCY SERVICES OF ZEPHYRHILLS, P.A.,

Plaintiffs,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.
_____/

AMENDED COMPLAINT

Plaintiffs, Florida Emergency Physicians Kang & Associates, M.D., Inc. ("FEP"); InPhyNet Contracting Services, LLC ("ICS"); InPhyNet South Broward, LLC ("ISB"); Paragon Contracting Services, LLC ("PCS"); Paragon Emergency Services, LLC ("PES"); Southwest Florida Emergency Management, LLC ("SFEM"); and Emergency Services of Zephyrhills, P.A. ("ESZ") (collectively, "Plaintiffs" or "Physicians"), by and through undersigned counsel, hereby sue Defendants United Healthcare of Florida, Inc. ("United HMO"); UnitedHealthcare Insurance Co. ("United PPO"); UMR, Inc. ("UMR"); and MultiPlan, Inc. ("MultiPlan") (collectively, "Defendants"). Collectively, "United HMO," "United PPO", and "UMR" are referred to herein as "United." In support of thereof, Plaintiffs allege as follows:

INTRODUCTION

1. Plaintiffs are providers of emergency medical services. Plaintiffs' physicians and advanced practice nurses staff hospital emergency rooms throughout Florida, where they provide lifesaving medical care to patients, regardless of their ability to pay, including those suffering from COVID-19. This action arises out of a fraudulent scheme among Defendants to deprive Plaintiffs of the full payment Plaintiffs are owed for the emergency medical care they have rendered to patients in Florida insured by United or by an employer-funded health plan for which United serves as a third-party administrator.

2. At all times material to this action, Plaintiffs have not had a written contract with United that establishes the rates of reimbursement they are owed for the emergency services Plaintiffs render to United's members (the "Members"). As such, Florida law provides that Plaintiffs are entitled to reimbursement at a rate equivalent to the lesser of their billed charges or the usual and customary charges for the Plaintiffs' services.

3. At all times material hereto, United has failed to reimburse Plaintiffs at either their billed charges or the usual and customary charges for Plaintiffs' services, in violation of Florida law. Instead, United has dramatically underpaid Plaintiffs for their services.

4. Meanwhile, in an attempt to deceive Plaintiffs into acquiescing to the extraordinarily deficient reimbursement rates United has paid Plaintiffs, United has conspired with Defendant MultiPlan, Inc. to corruptly cloak its inadequate reimbursements in a false veneer of objectivity and reasonableness. United claims to reimburse Plaintiffs in accordance with purportedly objective, allegedly fact-based calculations of usual and customary reimbursement rates generated and supplied to it by MultiPlan through MultiPlan's Data iSight "service." In fact, United's payments to Plaintiffs have no such independent and objective basis. The reimbursement

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rates United purports to "receive" from MultiPlan are in fact rates that United has ***directed*** MultiPlan to "suggest" to United. Through this scheme, MultiPlan functions as a willing conduit through which United endeavors to launder its deficient reimbursements in a façade of legitimacy in order to deceive healthcare providers, such as Plaintiffs, into accepting United's out-of-network reimbursements as being reasonable and representative of the usual and customary charges in the market for the services healthcare providers like Physicians render.

5. Through their fraudulent scheme, Defendants have violated the Racketeering Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961, *et seq.*, and MultiPlan has violated the Florida Deceptive and Unfair Trade Practices Act (FDUTPA), Fla. Stat. §§ 501.201, *et seq.*

6. The reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products) for emergency medical services rendered to United's Members, (b) that were adjudicated as covered, and allowed as payable by United, (c) at rates below the billed charges and the usual and customary provider charges for similar services in the community where Plaintiffs rendered such services to United's Members. These claims are collectively referred to herein as the "Claims."

7. Through this action, Plaintiffs seek treble damages arising from United's underpayments to the Physicians of the emergency services provided to United's Members.

8. In addition to their damages, the Physicians also request an order from the Court declaring the rate at which Florida law requires United to pay the Physicians for their emergency services, and a mandatory injunction or declaration compelling United to pay the Physicians at such rates for the out-of-network emergency services the Physicians render to United's Members in the future.

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9. This lawsuit and the claims asserted herein do not relate to or involve the Physicians' right to payment, but rather the applicable rate of payment the Physicians are entitled to receive for their services. This action does not include any claims in which benefits were denied nor does it challenge any coverage determinations under any health plan that may be subject to the Employee Retirement Income Security Act of 1974.

10. This lawsuit further does not include any government-sponsored products, such as Medicare Advantage and managed Medicaid. Those products are not at issue in this litigation, which arises only from claims involving United's commercial plans and products. Without limitation, Physicians specifically exclude from this lawsuit any service provided to patients 65 years of age or older as of the date services were rendered.

PARTIES

11. Plaintiff FEP is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. FEP has not been a participating provider within United's provider network since January 15, 2020.

12. Plaintiff ICS is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. ICS has not been a participating provider within United's provider network since October 15, 2019.

13. Plaintiff ISB is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. ISB has not been a participating provider within United's provider network since October 15, 2019.

14. Plaintiff PCS is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. PCS has not been a participating provider within United's provider network since January 15, 2020.

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15. Plaintiff PES is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. PES has not been a participating provider within United's provider network since October 15, 2019.

16. Plaintiff SFEM is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. SFEM has not been a participating provider within United's provider network since January 15, 2020.

17. Plaintiff ESZ is a professional emergency medicine group practice which staffs emergency departments and provides emergency services at hospitals in Florida. ESZ has not been a participating provider within United's provider network since January 15, 2020.

18. Upon information and belief, Defendant United HMO is a Florida for-profit corporation with its principal place of business in Hillsborough County, Florida. United HMO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a health maintenance organization ("HMO") in Florida under Fla. Stat. § 641.17, et seq.

19. Upon information and belief, Defendant United PPO is a foreign for-profit corporation with its principal place of business in Hartford, Connecticut. As a preferred provider organization, United PPO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a life and health insurer in Florida under Fla. Stat. § 624.01, et seq.

20. Upon information and belief, Defendant UMR is a foreign for-profit corporation with its principal place of business in Wausau, Wisconsin. UMR operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a third-party administrator in Florida under Fla. Stat. § 624.01, et seq.

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21. Upon information and belief, Defendant MultiPlan is a foreign for-profit corporation with its principal place of business in New York, New York. MultiPlan is not a health insurer nor is MultiPlan regulated by the Florida Office of Insurance Regulation.

JURISDICTION AND VENUE

22. This Court has jurisdiction over the federal claims for relief alleged in Counts I, II, and IX pursuant to 18 U.S.C. §§ 1961, 1962, 1964 and/or 28 U.S.C. § 1331.

23. This Court has the authority to grant declaratory relief under 28 U.S.C. §§ 2201 and 2202 because there is an actual controversy between the Physicians and Defendants.

24. This Court has supplemental jurisdiction pursuant to 28 U.S.C. § 1367 and the doctrine of pendent jurisdiction over the state law claims asserted herein.

25. Venue is proper in this District pursuant to 18 U.S.C. § 1965 and 28 U.S.C. § 1391(b)(2) because a substantial part of the events giving rise to the claims asserted herein occurred in this District and because the Defendants conduct business in this District.

FACTS

The Physicians Are Out-of-Network Providers

26. At all times material hereto, the Physicians have not been participating providers with United.

27. All of the Claims at issue in this action are for reimbursement for services the Physicians provided at times when they were non-participating (or "out-of-network") providers with United.

28. Despite their out-of-network status, the Physicians have provided medically necessary, covered services to United's Members.

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29. At all times material to this action, the Physicians have not agreed to accept any form of discounted rate from United or to be bound by United's payment policies or rate schedules with respect to any of the health care services provided by the Physicians to United's Members. Notwithstanding the absence of any such agreement, at all times material, United has unilaterally applied an unlawful discount to its payments to the Physicians for the Physicians' emergency services.

30. At all times material to this action, United has paid for the emergency services the Physicians have rendered to United's Members, but at rates less than the Physicians are entitled to receive by law. United has made unlawful discounted payments to the Physicians for the emergency services the Physicians have rendered to United's Members, and the unlawfully underpaid Claims continue to accrue.

31. Even though the Physicians are out-of-network providers, and, therefore, have not agreed to accept discounted reimbursement rates from United, United has reimbursed the Physicians for emergency services rendered to United's Members at rates that are substantially less than the rates United previously paid, and the Physicians previously accepted, for the same emergency services prior to United's termination of the participating provider agreements between the parties.

United's Failure to Reimburse the Physicians in Accordance with Florida Law

32. Section 641.513(5), Florida Statutes, which is part of Florida's HMO Act, provides that reimbursement for emergency services by providers such as the Physicians "who do[] not have a contract with the [HMO] shall be the lesser of: (a) The provider's charges; (b) The usual and customary provider charges for similar services in the community where the services were

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provided; or (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

33. Section 627.64194, Florida Statutes, requires insurers to reimburse out-of-network health care providers, such as Plaintiffs, for emergency services that such providers render to the insurer's PPO/POS members in accordance with the provisions of Fla. Stat. § 641.513(5). *See* Fla. Stat. § 627.64194(4) ("An insurer must reimburse a nonparticipating provider of services under subsections (2) and (3) as specified in s. 641.513(5), reduced only by insured cost share responsibilities as specified in the health insurance policy, within the applicable timeframe provided in s. 627.6131.").

34. The Physicians have not reached agreement with United regarding any charges within sixty (60) days of the submittal of the Claims at issue in this action.

35. For the Claims at issue in this action, United has underpaid the Physicians by reimbursing the Physicians substantially less than the Physicians' charges and the "usual and customary provider charges for similar services in the community where the services were provided."

36. United's refusal to lawfully pay the Physicians for the emergency services the Physicians have provided to United's Members has caused, and continues to cause, the Physicians to suffer damages, which are ongoing in nature.

37. The Physicians are entitled to interest on the amounts overdue on the underpaid Claims.

38. As a result of United's violations of Florida law, the Physicians have suffered damages.

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The Physicians Have No Recourse for United's Underpayments Except Against United

39. Under Florida law, the Physicians are precluded from seeking payment from patients for the difference between the amounts allowed as reimbursement by United and the lesser of the Physicians' charges or the usual and customary charges in the community for the services provided. *See* Fla. Stat. §§ 641.3154, 627.64194.

40. Indeed, to this end, the remittance advice documents ("RAs") the Physicians receive from United accompanying United's underpayments of the Claims instruct the Physicians not to bill patients for any amounts beyond the amount of the deductible, copay, and coinsurance applied to the service. These documents explain United's payment in pertinent part as follows: "PROVIDER: DON'T BILL THE PATIENT ABOVE THE AMOUNT OF THE DEDUCTIBLE, COPAY, AND COINSURANCE APPLIED TO THIS SERVICE." The RAs United generates and remits to the Physicians further identify the "Patient Responsibility" for the Physicians' services as only encompassing applicable deductibles, copays, or coinsurance amounts. That is, United advises the Physicians that their Members are not liable for the differential between the Physicians' billed charges and the amounts allowed as payable by United.

41. It is extraordinarily inequitable and unjust for United to fail to reimburse the Physicians at the fair value of the emergency services they rendered to United's Members.

42. At all times material, the Physicians billed United for their Claims arising from the treatment of United's Members. The Physicians did so with the expectation of appropriate reimbursement at no less than the Physicians' charges or the usual and customary charges for the Physicians' services, as required by statute, and United's implied agreement to reimburse the Physicians for the emergency medical care rendered at no less than the Physicians' charges or the usual and customary charges for the Physicians' services.

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43. United knew the Physicians expected payment for the emergency medical care they provided. United and the Physicians have demonstrated their mutual agreement and understanding that United would reimburse the Physicians at their billed charges or at a usual and customary rate. By assuming responsibility for paying for the emergency medical care provided to United's Members, United impliedly agreed to reimburse the Physicians at either their charges or the usual and customary provider charges.

44. United consistently (a) adjudicated the Claims as covered and medically necessary and (b) paid the Physicians for the Claims. However, at all times material, United's payments made for services rendered to Members in both fully-funded and employer-funded plans have been below both the Physicians' charges and the usual and customary provider charges for similar services in the community where the services were rendered.

45. United accepted and enjoyed the benefit of the Physicians' valuable services.

46. United's refusal to appropriately pay the Physicians for the emergency medical care provided to United's Members has caused, and continues to cause, the Physicians to suffer damages in an amount equal to the difference between the amounts paid by United and the lesser of the Physicians' charges or the usual and customary provider charges for the emergency services Physicians rendered, plus the loss of use of that money.

47. United's underpayment of the Claims violates the duty they owe to the Physicians.

48. United continues to underpay the Physicians for covered services rendered to their members. The Physicians therefore seek a declaration establishing the appropriate reimbursement rates to be paid going forward, in order to avoid further harm.

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The Relationship Between the Physicians and United

49. In exchange for premiums, fees, and/or other compensation, United assumes responsibility for paying for health care services rendered to members covered by their health plans.

50. In addition, United provides services such as building participating provider networks and negotiating rates with providers who join their networks.

51. United offers a range of health insurance plans. Plans generally fall into one of two categories: Fully Funded plans and Employer Funded plans.

52. "Fully Funded" plans are plans in which United collects premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums. "Employer Funded" plans are plans in which United provides administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

53. United provides coverage for emergency medical services under both types of plans.

54. United is contractually and legally responsible for ensuring that its members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

55. United highlights such coverage in marketing its insurance products, inducing members to purchase their products and rely upon those representations.

56. For example, on the "patient protections" section of the UnitedHealthcare website, uhc.com, United states:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network

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> provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

57. Payors, like United, typically demand a lower payment rate from contracted participating providers.

58. In return, payors offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

59. United bears responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

60. United understands and expressly acknowledges that their members will seek emergency treatment from non-participating providers and that United is obligated to pay for those services.

The Reasonable Rate for Non-Participating Emergency Services is Well Established

61. For many years, United has allowed payment at 75-90% of billed charges for out-of-network emergency services.

62. United has done so largely through the use of "rental networks," including those offered by MultiPlan, which establish a reasonable rate for provider services through arms'-length negotiations between the rental network and providers, on the one hand, and the rental network and health insurance companies, on the other.

63. Rental networks act as "brokers" between non-participating providers and health insurance companies.

64. A rental network will secure a contract with a provider to discount its out-of-network charges.

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65. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

66. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

67. For many years, the Physicians' contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from the Physicians' billed charges for claims adjudicated through the rental network agreement.

68. This longstanding history establishes that a reasonable reimbursement rate for the Physicians' Claims for emergency services is 75-90% of the Physicians' billed charge.

69. Despite this history, since terminating the network agreements with Plaintiffs, United has slashed their reimbursement rate for Claims to less than half the reasonable reimbursement rate.

70. United's drastic payment cuts are entirely inconsistent with the established rate and parties' history.

United's History of Fraudulently Manipulating Out-of-Network Reimbursement Rates

71. United has a history of fraudulently manipulating reimbursement rates for non-participating providers to maximize its own profits at the expense of others, including their own members.

72. In 2009, UnitedHealth Group, Inc., an affiliate of the United Defendants, was investigated by the New York State Attorney General's Office for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

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73. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

74. Andrew Cuomo, then New York Attorney General, explained of United's scheme: "The lack of accuracy, transparency, and independence surrounding United's process for setting a 'reasonable and customary rate' is astounding. United's ownership of Ingenix coupled with the inherent problems with the data it is using clearly demonstrate a broken reimbursement system designed to rip off patients and steer them towards in-network-doctors that cost the insurer less money." *See* "Cuomo Announces Industry-wide Investigation Into Health Insurers; Fraudulent Reimbursement Scheme" (Feb. 13, 2008), *available at* https://ag.ny.gov/press-release/2008/cuomo-announces-industry-wide-investigation-health-insurers-fraudulent.

75. Like Data iSight here, Ingenix "serve[d] as a conduit for rigged data to the largest insurers in the country." *Id.* Of particular concern was the fact that United's "ownership of Ingenix created a clear conflict of interest because their relationship gave Ingenix an incentive to set rates that benefited United and its subsidiaries." *Id.*

76. UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark. Also in 2009, United HealthCare Insurance Co. and affiliates thereof, paid $350 million to settle class action claims alleging that they underpaid non-participating providers for services arising out of the same conduct in *American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

77. In announcing its settlement with United, the New York Attorney General explained, "[f]or the past ten years, American patients have suffered from unfair reimbursements

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for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry." *See* "Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice Of Manipulating Rates To Overcharge Patients By Hundreds Of Millions Of Dollars" (Jan. 13, 2009), *available at* https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-health-insurance-reform-ends.

78. The New York Attorney General declared that the settlement would "end conflicts of interest" in United's determinations of the "usual and customary" rate. *Id.* Or so he thought.

79. Through MultiPlan and Data iSight, United has endeavored to revive the same fraudulent scheme that the New York Attorney General shut down a decade ago.

FAIR Health Affords Payers and Providers a Database of Usual and Customary Rates

80. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers. For example, numerous states recognize FAIR Health's database as an official source for healthcare cost data to determine reimbursement for non-participating providers' emergency services.

81. United purports to use FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website. United represents that where payment for out-of-network services is to be made the usual and customary rate, United "most commonly refer[s] to a schedule of charges created by FAIR Health, Inc. ('FAIR Health') to determine the amount of the payment." *See* "Information on Payment of Out-of-Network Benefits," *available at* https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits.

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82. As United recognizes, a usual and customary rate is "base[d] . . . on what other healthcare professionals in a geographic area charge for their services." *Id.*

83. While United publicly gives the appearance of holding itself to independent benchmarks to set reimbursement rates, in fact, United has shirked its responsibility to reimburse the Physicians at the usual and customary rate by conspiring with MultiPlan to — yet again — manipulate and depress reimbursements for out-of-network services.

RICO Defendants' Fraudulent Scheme to Deprive the Physicians of Reasonable Reimbursement Violated the Racketeer Influenced and Corrupt Organizations Act (RICO)

84. Defendants violated the Racketeering Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961, *et seq.*, and in particular, 18 U.S.C. §§ 1962(c)-(d).

85. The Defendants conducted and participated directly or indirectly in the affairs of an association-in-fact enterprise ("the Enterprise") through a scheme that formed a pattern of racketeering activity.

86. Each of the Defendants agreed to join the Enterprise with knowledge of the Enterprise's unlawful goals and purposes and to commit acts in furtherance of the Enterprise's common purpose.

87. Each of the Defendants committed the various acts in furtherance of the Enterprise's common unlawful purpose that the Defendants are described to have committed herein.

88. As part of this scheme, the Defendants conspired to, and did knowingly and unlawfully, reduce the Physicians' reimbursement rates for the Claims to amounts significantly below the Physicians' charges and the usual and customary charges for services rendered to Defendants' members to the detriment of the Physicians, to the benefit and financial gain of Defendants, and in violation of Florida law.

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89. To carry out the scheme and in furtherance of the conspiracy, Defendants engaged in conduct that violated federal laws, including, *inter alia*, mail fraud in violation of 18 U.S.C. § 1341, and wire fraud in violation of 18 U.S.C. § 1343.

90. As a result of the scheme, RICO Defendants violated 18 U.S.C. §§ 1962(c)-(d).

Defendants' Activities Constitute a Pattern of Unlawful Racketeering Activity

91. Defendants have committed, and continue to commit, related predicate acts of racketeering activity involving mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, such that they have engaged in a "pattern of racketeering activity" under 18 U.S.C. § 1961(5) and pose a continued threat of racketeering activity, as described below.

92. Defendants have knowingly, wrongfully, and unlawfully reduced payment to the Physicians for the emergency services that the Physicians provided to Defendants' Members, to the financial gain of the Defendants.

93. As a direct and proximate result of those activities, the Physicians have suffered more than $28 million in discrete financial losses, through March 31, 2020, which damages continue to accrue.

The Enterprise and Scheme

94. The Enterprise consists of Defendants' development and use of MultiPlan's Data iSight software in connection with reimbursement determinations by United.

95. Defendants agreed to, and do, manipulate reimbursement rates and control allowed payments to the Physicians through acts of the Enterprise.

96. The Enterprise conceals its scheme by hiding behind written agreements and false statements.

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97. Since at least October 15, 2019, the Enterprise has falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates through the use of Data iSight.

98. In reality, United uses Data iSight as a cover-up for United to justify paying reimbursement to the Physicians that is far less than the reasonable payment rate that the Physicians have historically received and are entitled to under the law.

99. This scheme is concealed through the use of false statements on MultiPlan's website, Data iSight's website, and in United's and Data iSight's communications with providers, including the Physicians.

100. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between Defendants.

(1) The Enterprise's False Statements

a. Transparency

101. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers] . . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

102. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

103. This concealment was designed by the Enterprise to, and does, prevent providers such as the Physicians from receiving the appropriate payment for the services they provide.

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104. For claims whose reimbursement is determined by Data iSight, non-participating providers receive an Explanation of Benefit form ("EOB") from United with "IS" in the "Remark/Notes" column.

105. Over the past 8 months, an ever-increasing number of Claims have been processed by Data iSight with drastically reduced payment amounts.

106. United does not state, on the face of the EOBs, or anywhere else, any reason for the dramatic cut.

107. Instead, the EOBs contain a note to call a toll-free number at Data iSight if there are questions about the claim.

108. In June 2019, affiliates of the Physicians contacted Data iSight via the toll-free number to discuss two claims for the same procedure code, performed at the same facility, billed at the same amount of $700, but for which Data iSight allowed different, insufficient reimbursement amounts at 42% and 59% of billed charges ($295.28 and $413.39, respectively).

109. After affiliates of the Physicians left messages at Data iSight's phone number for approximately two weeks, a Data iSight representative, Phina (Last Name Unknown) ("LNU"), finally connected with the Physicians; however, she was unable to explain why the two claims—for the same procedure at the same facility and billed at the same charge—were allowed at different rates.

110. Further, when asked to provide the basis for the dramatic cut in payment for the claims, the representative did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all.

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111. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

112. Instead, the representative simply stated that the rates were developed by Data iSight and United.

113. When affiliates of the Physicians continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that "it is just an amount that is recommended and sent over to United."

114. When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

115. Further attempts to gain transparency into and understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight's executives have also been futile.

116. Defendants know that the rates that Defendants, through Data iSight, have allowed for the Physicians' Claims do not reflect and are not, in fact, based on objective, reliable data designed to arrive at the usual and customary rates for the services in question.

117. Defendants know that the initial reimbursement rates they allow are insufficient because, when a provider challenges the rate of payment, United authorizes Data iSight to revise the allowed amount by increasing it to a fair, usual and customary rate, but only if the provider persists long enough in the process.

118. The process to contest the arbitrary and deficient payments takes the provider weeks to conclude and is impracticable to follow for every claim — precisely by Defendants' design.

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119. For example, and as evidence of this fraudulent practice, affiliates of the Physicians contested the allowed amounts on the two claims discussed above.

120. Eventually, Carol LNU from Data iSight's "Quality Control" team offered to allow payment of both claims at 85% of their respective billed charges.

121. Thus, absent providers taking the time to individually chase every claim, Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the provider's charges and the usual and customary charges for such services.

122. Moreover, the Enterprise's scheme of refusing to reimburse at usual and customary rates unless and until the Physicians challenge its determinations continually harms the Physicians, in that, even if the Physicians eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens the Physicians with excessive administrative time and expense and deprives the Physicians of their right to prompt payment of clean claims under Florida's Prompt Payment Statute.

b. Defensible and Market Tested

123. The Enterprise's claim to "transparency" is not its only fraudulent claim.

124. The Enterprise, through Data iSight, also falsely claims, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

125. EOBs for claims processed purportedly pursuant to Data iSight contain the following or a similar note: "Calculated using Data iSight, which utilizes cost data if available (facilities) or paid data (professionals)."

126. United further advises as follows in EOBs for many of the claims paid purportedly pursuant to Data iSight:

> In order to help save you and the plan money, [United] uses a service called Data iSight to review select out-of-network claims and recommend a reduced payment

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> amount for out-of-network covered services. . . . Based on the Data iSight review, the recommended amount for the covered services provided is shown on your explanation of benefits (EOB). Your provider will be informed of that recommendation.

127. These notes are intended to, and do, lead providers to believe that the reimbursement calculations are tied to external, objective data.

128. Further, in its provider portal, the Data iSight website describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

129. MultiPlan similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and asserts that it has been "[v]alidated by statisticians as effective and fair."

130. These statements are also false.

131. Data iSight's rates are not effective and fair. Instead, they are artificially low and match the rates United has directed MultiPlan to determine using the Data iSight tool. United and MultiPlan know that these rates are not reflective of fair market value.

132. Furthermore, contrary to its portrayal, Data iSight's rates are unfair because, on belief, MultiPlan is financially incentivized to generate rates that are as low as possible through its contracts with United, rather than rates that accurately reflect the usual and customary charges in the community for the services rendered.

133. For example, over a period of four months in 2020, the Physicians submitted claims for three patients under the procedure code 99285, but received reimbursement in very different allowed amounts:

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134. Plaintiff ISB rendered emergency medical care to patient MV on January 3, 2020, and billed United $1,816.00 for procedure code 99285. United, via Data iSight, allowed just 24% of billed charges, or $436.58. Likewise, for patient BT, ISB rendered emergency medical care on January 9, 2020, and billed United $1,816.00 for procedure code 99285. United, via Data iSight, also allowed just 24% of charges, or $436.58.

135. But for patient LU, Plaintiff ISB rendered emergency medical care on January 2, 2020, and billed United $1,816.00 for procedure code 99285. United, via Data iSight, initially allowed only 34% of billed charges, or $611.21. ISB objected to the deficient payment and United subsequently allowed 90% of billed charges, or $1,634.40 as payment.

136. And for patient IP, Plaintiff ISB rendered emergency medical care on February 1, 2020, and billed United $1,816.00 for procedure code 99285. United, via Data iSight, allowed 100% of billed charges as payment.

PATIENT	DATE OF SERVICE	PROCEDURE CODE	BILLED AMOUNT	ALLOWED AMOUNT	ALLOWED AMOUNT (%)
MV	1/3/2020	99285	$1,816.00	$436.58	24%
BT	1/9/2020	99285	$1,816.00	$436.58	24%
LU	1/2/2020	99285	$1,816.00	$1,634.40*	90%
IP	2/1/2020	99285	$1,816.00	$1,816.00	100%

137. From the above examples, it is clear that MultiPlan's Data iSight service does not use any objective, externally-validated methodology to determine the usual and customary reimbursement rate, as its rates are not consistent, defensible, or reasonable.

138. Additionally, it is clear that United and Data iSight know that amounts determined in arm's length transactions and freely negotiated, result in payments of 90-100% of the Physicians' billed charges, rather than the artificially low amount initially offered.

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139. Defendants' false assertions are designed to mislead the Physicians and similar providers into believing that they will receive payment at reasonable rates. This reimbursement is dictated by Defendants, to the financial detriment of the Physicians.

c. Geographic Adjustment

140. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

141. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

142. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

143. Contrary to those statements, however, claims from providers affiliated with Plaintiffs in different geographic locations show that Data iSight does not adjust for geographic differences but, instead, works with United to cut uniformly out-of-network provider payments across geographic locations.

144. For example, patient WY was treated in Wyoming on January 21, 2019 by an affiliate of Plaintiffs. The provider billed a United affiliate $779.00 for procedure code 99284, and the United affiliate, via Data iSight, allowed $413.39.

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145. Four days later, patient NH was treated on the other side of the country in New Hampshire by an affiliate of Plaintiffs. The provider billed a United affiliate $1,047.00 for procedure 99284, and the United affiliate, via Data iSight, again allowed $413.39.

146. On February 8, 2019, patient OK was treated by an affiliate of Plaintiffs in Oklahoma. The provider billed a United affiliate $990.00 for procedure code 99284, and the United affiliate, via Data iSight, allowed $413.39.

147. Two days later, patients KS and NM were by affiliates of Plaintiffs treated in Kansas and New Mexico, respectively. The providers billed a United affiliate $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, United, via Data iSight, allowed exactly $413.39.

148. One month later, patient CA was treated by an affiliate of Plaintiffs in California. The provider billed a United affiliate $937.00 for procedure code 99284. The United affiliate, via Data iSight, yet again allowed exactly $413.39.

149. In May 2019, patient NY was treated by an affiliate of Plaintiffs in New York. The provider billed $806.00 for procedure code 99284. The United affiliate, via Data iSight, again allowed exactly $413.39.

150. And in November 2019, patient FL was treated by Plaintiff ICS in Florida. ICS billed $1,502 for procedure code 99284. United, yet again, allowed exactly $413.39.

PATIENT	LOCATION	DATE OF SERVICE	BILLED AMOUNT	PROCEDURE CODE	ALLOWED AMOUNT
WY	Wyoming	1/21/19	$779.00	99284	$413.39
NH	New Hampshire	1/25/19	$1,047.00	99284	$413.39
OK	Oklahoma	2/8/19	$990.00	99284	$413.39
KS	Kansas	2/10/19	$778.00	99284	$413.39
NM	New Mexico	2/10/19	$895.00	99284	$413.39
CA	California	3/25/19	$937.00	99284	$413.39
NY	New York	5/19/19	$806.00	99284	$413.39

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FL	Florida	11/02/19	$1,502.00	99284	$413.39

151. United falsely claims on its website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

152. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but would also all be substantially greater than the allowed $413.39, examples of which are set forth below:

LOCATION	PROCEDURE CODE	80th PERCENTILE OF FAIR HEALTH BENCHMARK[1]
Florida	99284	$1,422.00
Wyoming	99284	$1,105.00
New Hampshire	99284	$753.00
Oklahoma	99284	$1,076.00
Kansas	99284	$997.00
New Mexico	99284	$1,353.00
California	99284	$795.00
New York	99284	$768.00

(2) The Enterprise's Predicate Acts

153. To perpetuate the scheme and conceal it from the Physicians, in or around 2018, Defendants entered into written agreements with each other that are consistent with MultiPlan's agreements with similar health insurance companies.

154. Under those contracts, MultiPlan, through Data iSight, would handle claims determinations for services rendered to United's members under pre-agreed thresholds set by United.

[1] The benchmark figures listed in this table are the applicable 80th-percentile rates for the relevant geographic market within each state in which the referenced patient received medical treatment. For example, the $1422 rate for the patient from Florida is the FAIR Health benchmark rate for Florida geozip 03.

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155. By no later than 2019, Defendants coordinated and effectuated, via wire communications, the posting of false statements on websites and the communication of false statements to providers, including the Physicians, in furtherance of the scheme.

156. These statements include MultiPlan's using interstate wires to post, on its websites and the website for Data iSight, that it would provide transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment processes for providers.

157. Data iSight communicated to affiliates of the Physicians by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United."

158. Finally, after weeks of pressure, Data iSight informed the Physicians by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

159. The Enterprise communicated, via wire communications, false and misleading information to the Physicians and falsely denied that it had information requested by the Physicians about the basis for the drastically-cut and unreasonable reimbursement rates that Defendants sought to impose.

160. In addition, since at least October 15, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to the Physicians by means of the United States Postal Service and interstate wires at unlawful rates that were far below reasonable rates for the services provided.

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161. For example, United sent the Physicians, via wire communications, EOBs for emergency services provided to patients under multiple procedure codes, including the following EOBs for procedure code 99285:

162. Patient TH was treated by Plaintiff ICS on November 15, 2019, at a billed charge of $2,147.00, for which United, via Data iSight, allowed just $435.20, or 20% of the billed charges. United sent the EOB for this claim via wire communication on February 5, 2020.

163. Patient EH was treated on December 9, 2019 by Plaintiff ISB at a billed charge of $1,816.00, for which United, via Data iSight, allowed just $435.20, or 24% of charges. United sent the EOB for this claim via wire communication on January 15, 2020.

164. Patient KG was treated on November 17, 2019 by Plaintiff PES, at a billed charge of $1,824.00, for which United, via Data iSight, initially allowed just $609.28, or 33% of charges. United sent the EOB for this claim via wire communication on January 23, 2020. After the Plaintiff objected to the deficient payment, United, via Data iSight, subsequently allowed $1,641.60 as payment, or 90% of charges.

PATIENT	DATE OF SERVICE	BILLED AMOUNT	PROCEDURE CODE	ALLOWED AMOUNT	ALLOWED AMOUNT (%)
TH	11/15/19	$2,147.00	99285	$435.20	20%
EH	12/09/19	$1,816.00	99285	$435.20	24%
KG	11/17/19	$1,824.00	99285	$1,641.60	90%

165. Defendants expected that those unreasonable payments would be accepted in full satisfaction of the Physicians' claims.

166. Defendants have received, and continue to receive, financial gains from their scheme to defraud the Physicians.

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167. The purpose and direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse the Physicians at deficient rates, to the harm of the Physicians, and to the benefit of the Enterprise.

168. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

COUNT I
Violation of RICO, 18 U.S.C. § 1962(c)
(as against all Defendants)

169. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

170. The Physicians are each a "person" within the meaning of 18 U.S.C. §§ 1961(3) and 1964(c).

171. Defendants are each a "person" within the meaning of 18 U.S.C. § 1961(3).

172. As set forth above, since at least October 15, 2019, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of 18 U.S.C. § 1961(4), comprised of at least Defendants, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce.

173. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

174. Defendants had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding the Physicians and preventing the Physicians from obtaining payment for the services they provided to Defendants' Members at no less than the Physicians' charges or the usual and customary rate for the Physicians' services.

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175. As set forth above, the Defendants since at least October 15, 2019, have been, and continue to be, engaged in a scheme to defraud the Physicians by committing a series of unlawful acts which constitute predicate racketeering acts under 18 U.S.C. §§ 1961(1)(B) and 1962(c), involving multiple instances of mail fraud in violation of 18 U.S.C. § 1341 and multiple instances of wire fraud in violation of 18 U.S.C. § 1343.

176. Each Defendant provides benefits to insured Members, processes claims for services provided to Members, purports to determine and recommend a reimbursement rate for such services, and/or issues payments for services, and knowingly and willingly participates in the scheme to defraud the Physicians.

177. As a direct and proximate result of Defendants' violations of 18 U.S.C. § 1962(c), the Physicians were injured in their business, suffering financial losses within the meaning of 18 U.S.C. § 1964(c).

COUNT II
Violation of RICO conspiracy, 18 U.S.C. § 1962(d)
(as against all Defendants)

178. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

179. The Physicians are each a "person" within the meaning of 18 U.S.C. §§ 1961(3) and 1964(c).

180. Defendants are each a "person" within the meaning of 18 U.S.C. § 1961(3).

181. As set forth above, since at least October 15, 2019, Defendants have been, and continue to be, part of an association-in-fact enterprise within the meaning of 18 U.S.C. § 1961(4), comprised of at least Defendants, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce.

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182. Defendants were, and continue to be, associated with the Enterprise and knowingly conspired, within the meaning of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting and participating, directly or indirectly, in the conduct and affairs in the Enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. §§ 1961(1)(B) and 1962(c), including multiple instances of mail fraud in violation of 18 U.S.C. § 1341 and multiple instances of wire fraud in violation of 18 U.S.C. § 1343, in order to defraud the Physicians of a reasonable reimbursement for services.

183. As a direct and proximate result of Defendants' violations of 18 U.S.C. § 1962(d), the Physicians were injured in their business, suffering financial losses within the meaning of 18 U.S.C. § 1964(c).

COUNT III
Violation of FDUTPA
(as against MultiPlan)

184. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

185. MultiPlan engages in trade or commerce by advertising, soliciting, providing, offering, or distributing its Data iSight service, which MultiPlan, according to MultiPlan, generates "fair" reimbursement rates for out-of-network services in accordance with objective independent data.

186. The Physicians are consumers of MultiPlan's services. Insofar as United prices a claim utilizing Data iSight, MultiPlan intends for providers to utilize and rely on its recommended reimbursement rates as fair and reasonable reimbursement rates for out-of-network services based on objective data and neutral analyses. The Physicians are thus intended beneficiaries of MultiPlan's out-of-network pricing services. Indeed, Data iSight advertises its services as

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benefiting healthcare providers. For example, in a section of its website titled "Transparency for You, the Provider," MultiPlan describes Data iSight as affording the following benefits to providers: "A key feature of Data iSight is this website, which gives [providers] a better understanding of how these payment amounts are determined. The website makes the process for determining appropriate payment transparent to you so that you may become a more informed healthcare partner, and to assist you with any questions about how this claim was reduced. It also provides the information to the health plan payer and the patient so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

187. Furthermore, the Physicians are consumers of MultiPlan's rental network services through which MultiPlan serves as a broker between non-participating providers, such as the Physicians, and health insurance companies, such as United.

188. MultiPlan's conduct is unfair and deceptive under FDUTPA. The reimbursement rates that MultiPlan, through Data iSight, generates and purportedly recommends to United are not, in fact, fair and reasonable reimbursement rates for out-of-network services reflecting the usual and customary charges for such services in the community. Nor are they based on Data iSight's independent determinations of objective data as to the usual and customary reimbursements. Rather, the reimbursement rates that MultiPlan purports to recommend to United through Data iSight are rates at which United has instructed MultiPlan to price such claims. MultiPlan thereby knowingly functions as a conduit through which United endeavors to launder its deficient reimbursements in a façade of reasonableness, objectivity, and legitimacy in order to deceive healthcare providers, such as the Physicians, into accepting United's out-of-network reimbursements as being reasonable and representative of the usual and customary charges in the

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market for the services healthcare providers like Physicians render. MultiPlan's conduct is likely to mislead a consumer of its services acting reasonably in the circumstances.

189. Furthermore, contrary to its portrayal, MultiPlan's recommended prices are unfair because, on belief, MultiPlan is financially incentivized to generate rates that are as low as possible through its contracts with United, rather than rates that accurately reflect the usual and customary charges in the community for the services rendered.

190. MultiPlan's conduct has caused Physicians to suffer actual damages. As a direct result of MultiPlan's fraudulent scheme, Physicians have received deficient reimbursements from United on all of the Claims at amounts less than Physicians are entitled to receive. Furthermore, MultiPlan's conduct has harmed the Physicians' contractual relationship with MultiPlan in that they have received less in reimbursement for the Claims than they would otherwise receive if those services had been priced pursuant to MultiPlan's rental network rates, which are rates that Physicians have accepted through their agreements with MultiPlan.

191. MultiPlan has therefore violated FDUTPA, Fla. Stat. § 501.204(1).

COUNT IV – Violation of Florida Statute § 641.513
(against United HMO)

192. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

193. At all times material, the Physicians and United HMO have not had a written contract between them governing the rates at which United HMO must reimburse the Physicians for emergency services provided to United HMO's Members.

194. At all times material, the Physicians have not been a participating provider in United HMO's provider network; therefore, the Physicians have been out-of-network providers.

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195. At all times material, the Physicians have rendered emergency services to United HMO's Members. All such services have been medically necessary, covered services.

196. All of the claims at issue in this count are for services rendered to persons who have contracted, or on whose behalf a contract has been entered into, with United HMO for health care services.

197. Section 641.513(5), Florida Statutes, provides that all HMOs, such as United HMO, must reimburse non-participating providers for emergency services in an amount equal to the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services were provided," or "[t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

198. The Physicians have not reached agreement with United HMO regarding any charges within sixty (60) days of the submittal of the claims at issue in this action. Therefore, under Florida law, the Physicians are entitled to reimbursement at the lesser of their charges or (if hypothetically different) the "usual and customary provider charges for similar services in the community where the services were provided."

199. United HMO has reimbursed the Physicians for the emergency services they have rendered to United HMO's Members at all times material at substantially less than the Physicians' charges.

200. United HMO has reimbursed the Physicians for the emergency services they have rendered to United HMO's Members at all times material at substantially less than the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United HMO's Members.

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201. Accordingly, United HMO has failed to reimburse the Physicians for the emergency services the Physicians rendered to United HMO's Members in accordance with Fla. Stat. § 641.513(5). United HMO has therefore violated Fla. Stat. § 641.513(5).

COUNT V – Violation of Florida Statute § 627.64194
(United PPO)

202. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

203. At all times material, the Physicians and United PPO have not had a written contract between them governing the rates at which United PPO must reimburse the Physicians for emergency services provided to United PPO's Members.

204. At all times material, the Physicians have not been a participating provider in United's PPO provider network; therefore, the Physicians have been out-of-network providers.

205. At all times material, the Physicians have rendered emergency services to United PPO's Members. All such services have been medically necessary, covered services.

206. All of the claims at issue in this count are for services rendered to persons who are covered under a health insurance contract delivered or issued for delivery by United PPO in Florida.

207. Section 627.64194(4), Florida Statutes, requires that all insurers, such as United PPO, reimburse nonparticipating providers, such as Plaintiffs, for both non-emergency services and emergency services rendered to the insurer's members according to the methodology set forth in Fla. Stat. § 641.513(5).

208. Pursuant to Fla. Stat. § 641.513(5), nonparticipating providers are entitled to reimbursement for services rendered in an amount equal to the lesser of the provider's charges, the "usual and customary provider charges for similar services in the community where the services

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were provided," or "[t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

209. The Physicians have not reached agreement with United PPO regarding any charges within sixty (60) days of the submittal of the claims at issue in this action. Therefore, under Florida law, the Physicians are entitled to reimbursement at the lesser of their charges or (if hypothetically different) the "usual and customary provider charges for similar services in the community where the services were provided."

210. United PPO has reimbursed the Physicians for the emergency services they have rendered to United PPO's Members at all times material at substantially less than the Physicians' charges.

211. United PPO has reimbursed the Physicians for the emergency services they have rendered to United PPO's Members at all times material at substantially less than the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United PPO's Members.

212. Accordingly, United PPO has failed to reimburse the Physicians for the emergency services the Physicians rendered to United PPO's Members in accordance with Fla. Stat. § 641.513(5). United PPO has therefore violated Fla. Stat. § 627.4194(4).

COUNT VI – Breach of Contract Implied-in-Fact
(against United)

213. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

214. In addition, and/or in the alternative, at all times material, the Physicians and United have not had a written contract between them governing the rates at which United must reimburse the Physicians for their emergency services.

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215. At all times material, the Physicians have not been a participating provider in United's provider network; rather, the Physicians have been out-of-network providers at all times material.

216. United knew that Plaintiffs would provide emergency services to United's Members at all medical facilities at which Plaintiffs' professionals are staffed to provide emergency care and would provide such care to United's Members without seeking or obtaining prior authorization, as prior authorization is not required in connection with the provision of emergency services.

217. The Physicians have rendered emergency services to United's Members.

218. At all times, United was aware that the Physicians were entitled and expected to be paid the fair value of the emergency services they rendered to United's Members.

219. The Physicians understood that United intended to reimburse the Physicians the fair value of the emergency services the Physicians rendered to United's Members in accordance with applicable law.

220. United has acknowledged its responsibility for payment of the Physicians' emergency services rendered to United's Members by regularly and consistently paying the Physicians for such services, albeit at rates lower than what the Physicians are owed under applicable law.

221. United has further acknowledged its responsibility for payment of the Claims at issue in this action, as all such Claims have been processed and adjudicated by United and determined by United to be covered services.

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222. With respect to each of the Claims at issue in this action, the Physicians and United have established a contract implied-in-fact pursuant to which United must reimburse the Physicians no less than the fair value of the services provided in compliance with applicable law.

223. United has breached its implied-in-fact contract with the Physicians by reimbursing the Physicians for the Claims at issue at less than the fair value of the services provided.

224. United's breach of its implied-in-fact contract with the Physicians has caused the Physicians damage in an amount to be determined at trial equal to the difference between the fair value of the services provided by the Physicians and the amounts paid by United to the Physicians for the emergency services the Physicians' professionals have rendered to United's Members.

COUNT VII – Quantum Meruit
(against United)

225. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

226. In addition, and/or in the alternative, at all times material, the Physicians have conferred a direct benefit upon United by providing valuable emergency services to United's Members. In exchange for premiums, United owes United's Members an obligation to pay for the covered medical services they receive. United derives a direct benefit from the Physicians' provision of emergency services to United's Members because it is through the Physicians' provision of those services that United fulfills its obligations to its Members.

227. There is no dispute that the emergency services at issue that the Physicians provided to United's Members were covered services, because United adjudicated them, determined they were covered services, and paid the Physicians for them, except at an amount less than the fair value of the services. When the Physicians provide covered emergency services to United's

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Members, United receives the benefit of having its contractual obligations to its Members discharged.

228. United has knowledge of the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United received, processed, and adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

229. United has voluntarily accepted and retained the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

230. United voluntarily accepted, retained and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred upon it by the Physicians, knowing that the Physicians expected and expect to be paid the fair value for their services. However, United has failed to reimburse the Physicians the fair value of the services the Physicians have rendered to United's Members at all times material.

231. Under the present circumstances, it would be inequitable for United to fail to reimburse the Physicians the fair value of the emergency services they rendered to United's Members, while retaining the benefits the Physicians conferred upon United.

232. United is therefore liable in *quantum meruit* to the Physicians for failing to reimburse the Physicians the fair value of the services the Physicians rendered to United's Members with respect to each of the Claims. United owes as damages the difference between the fair value of the services the Physicians rendered to United's Members and the amounts United paid for those services.

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COUNT VIII – Unjust Enrichment
(against United)

233. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

234. In addition, and/or in the alternative, at all times material, the Physicians have conferred a direct benefit upon United by providing valuable emergency services to United's Members. In exchange for premiums, United owes United's Members an obligation to pay for the covered medical services they receive. United derives a direct benefit from the Physicians' provision of emergency services to United's Members because it is through the Physicians' provision of those services that United fulfills its obligations to its Members.

235. There is no dispute that the emergency services at issue that the Physicians provided to United's Members were covered services, because United adjudicated them, determined they were covered services, and paid the Physicians for them, except at an amount less than the fair value of the services. When the Physicians provide covered emergency services to United's Members, United receives the benefit of having its contractual obligations to its Members discharged.

236. United has knowledge of the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United received, processed, and adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

237. United has voluntarily accepted and retained the benefits the Physicians conferred on United by providing emergency services to United's Members because, *inter alia*, United adjudicated the Physicians' Claims for such services and determined that they were covered services under United's contracts with its Members.

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238. United voluntarily accepted, retained and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred upon it by the Physicians, knowing that the Physicians expected and expect to be paid the fair value for their services in accordance with Florida law. However, United has failed to reimburse the Physicians the fair value of the services the Physicians have rendered to United's Members at all times material.

239. Under the present circumstances, it would be inequitable for United to fail to reimburse the Physicians the fair value of the emergency services they rendered to United's Members, while retaining the benefits the Physicians conferred upon United.

240. United has therefore been unjustly enriched by failing to reimburse the Physicians the fair value of the services the Physicians rendered to United's Members. United owes as damages the difference between the fair value of the services the Physicians rendered to United's Members and the amounts United paid for those services.

COUNT IX – Declaratory Judgment
(against United)

241. The Physicians re-allege and restate paragraphs 1 through 168 above as if they were fully set forth herein.

242. At all times material, the Physicians have been out-of-network providers when they rendered emergency services to United's Members.

243. At all times material, United has reimbursed the Physicians for the emergency services they have rendered to United's Members at substantially less than the Physicians' charges and the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United's Members. Accordingly, United has failed to reimburse the Physicians for the emergency services the Physicians rendered to United's Members

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in accordance with Sections 641.513(5) and 627.64194(4), Florida Statutes. United has therefore violated Sections 641.513(5) and 627.64194(4), Florida Statutes.

244. United continues to reimburse the Physicians for emergency services rendered to United's Members at substantially less than the Physicians' charges and the usual and customary provider charges for similar services in the community where the Physicians rendered such services to United's Members. United has indicated that it intends to continue to reimburse the Physicians for emergency services in such an unlawful manner.

245. United has reimbursed the Physicians for the emergency services it has rendered to United's Members at substantially less than the fair value of the Physicians' services.

246. United continues to reimburse the Physicians for the emergency services they render to United's Members at substantially less than the fair value of the Physicians' services.

247. The Physicians and United intend for the Physicians to continue to provide emergency services to United's Members as out-of-network providers.

248. Based on the foregoing allegations, real and substantial justiciable controversies exist between United and the Physicians concerning whether the rates at which United reimburses the Physicians for emergency services rendered to United's Members violate Sections 641.513(5), and 627.64194(4), Florida Statutes.

249. Based on the foregoing allegations, real and substantial justiciable controversies exist between United and the Physicians concerning the rates of reimbursement to which the Physicians are entitled as out-of-network providers of emergency services to United's Members under the Florida common law doctrines of breach of implied-in-fact contract, *quantum meruit* and unjust enrichment.

250. These are actual, definite, concrete and substantial controversies that require an immediate determination of the Physicians' rights of reimbursement and whether the rates of reimbursement that United has paid to the Physicians comply with Florida law.

251. Declaratory relief is appropriate here because such judgment will serve a useful purpose in clarifying and settling the rates of reimbursement to which the Physicians are entitled from United for the emergency services the Physicians render to United's Members for so long as the Physicians remain out-of-network providers.

252. There is a bona fide, actual, present practical need for a declaration. Declaratory relief will terminate and afford relief from uncertainty, insecurity, and controversy concerning the rates at which United must reimburse the Physicians for the emergency services the Physicians continue to render to United's Members as an out-of-network provider.

253. All antagonistic and adverse interests relating to the declaration sought herein are parties to this action.

254. The relief sought is not merely to seek legal advice of the Court nor do the Physicians seek answers to questions propounded from mere curiosity.

255. The Physicians are consequently entitled to a declaration of their rights pursuant to Section 86.021, Florida Statutes.

JURY DEMAND

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, the Physicians hereby demand a trial by jury of any issue trial of right by a jury.

PRAYER FOR RELIEF

WHEREFORE, the Physicians pray that this Court:

(i) enter judgments against Defendants and in favor of the Physicians pursuant to the Counts I and II, in an amount constituting treble damages resulting from the

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United's underpayments to the Physicians of the emergency services provided to Defendants' members and reasonable attorneys' fees incurred in bringing this action;

(ii) enter judgments against MultiPlan and in favor of the Physicians pursuant to the Counts III, in an amount equal to the amounts the Physicians' Claims were underpaid and reasonable attorneys' fees incurred in bringing this action;

(iii) enter judgment against United and in the Physicians' favor, awarding the Physicians compensatory damages for the emergency services the Physicians have rendered to United's Members through the date of judgment;

(iv) award the Physicians prejudgment and postjudgment interest on the amounts overdue on the underpaid claims;

(v) award the Physicians their costs;

(vi) enter an order declaring the rate(s) at which United must reimburse the Physicians for the emergency services the Physicians render to United's Members as an out-of-network provider;

(vii) issue a mandatory injunction compelling United to reimburse the Physicians no less than the reimbursement rates to which the Court declares the Physicians are entitled from United for the emergency services the Physicians render to United's Members as out-of-network providers; and

(viii) grant the Physicians any and all further relief as more specifically sought in all preceding paragraphs and as the Court deems just and appropriate under the circumstances.

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Respectfully submitted:

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on June 9, 2020, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record via transmission of Notices of Electronic Filing generated by CM/ECF.

/s/ Justin C. Fineberg
Justin C. Fineberg, Esq.

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EXHIBIT 3

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For their Complaint against Defendants UnitedHealth Group, Inc. ("UHG"), UnitedHealthcare Insurance Company ("UHIC"), UnitedHealthCare of New Jersey, Inc. ("UHC-NJ"), and Multiplan, Inc. ("Multiplan"), the above-captioned Plaintiffs allege as follows:

INTRODUCTION

1. This case is brought in the context of a global coronavirus pandemic, which has already infected over 9.2 million people and claimed over 231,000 lives in this country. The pandemic is ongoing, with new infections and deaths being reported every day. New Jersey has been especially hard hit. As of this writing, there have been over 241,000 cases and more than 16,000 confirmed deaths in New Jersey.

2. Plaintiffs are local, hospital-based, emergency medical care providers. As emergency medical care providers, the Plaintiffs are essential workers on the front lines of the pandemic response.

3. Defendant UHG and its more than 1,200 subsidiaries (collectively "United") comprise the largest health insurer in the United States, reporting $6.7 billion in profits for the second quarter of 2020, a 97 percent increase from the same period in 2019.[1] United insures 80 million people and controls a large percentage of the commercial healthcare marketplace.

4. For many years, all of the Plaintiffs were parties to Medical Group Participation Agreements ("Participation Agreements") with defendants UHIC and UHC-NJ, pursuant to which Plaintiffs were contractually obligated to treated patients covered by health insurance plans funded or administered by United ("United Subscribers" or "Subscribers"), and United agreed to pay Plaintiffs agreed-upon rates for the emergency treatment that Plaintiffs provided to United Subscribers.

5. However, in July 2019, United notified each of the Plaintiffs that it was unilaterally terminating the Participation Agreements. These terminations took effect on May 15, 2020.

[1] *U.S.' Largest Health Insurer Reports $6.7B In Profits Amid COVID, As N.Y. Cuts State Rates*, Newsweek, August 14, 2020, https://www.newsweek.com/us-largest-health-insurer-reports-67b-profits-amid-covid-ny-cuts-state-rates-1525210 (last visited October 27, 2020).

6. Although Plaintiffs are no longer in United's network, United Subscribers continue to seek treatment at the hospitals staffed by Plaintiffs' physicians. Consistent with their legal duties as emergency department physicians, Plaintiffs provide treatment to all such patients.

7. Because, *inter alia*, United offers its Subscribers coverage for emergent care and because Plaintiffs remain legally obligated to treat United Subscribers in the hospital emergency departments they staff, United has quasi-contractual obligations to reimburse Plaintiffs for the reasonable value of their services, less amounts for which patients are typically held responsible, such as co-payments, co-insurance, and deductible ("Patient Responsibility").

8. Since forcing Plaintiffs out of its network, however, United has dramatically slashed the reimbursements it has paid Plaintiffs for the emergency treatment that Plaintiffs continued to provide United Subscribers, to well below a reasonable amount.

9. Within just the first 45 days after Plaintiffs were forced out of United's network, Plaintiffs' physicians provided emergency department treatment to 1,520 United Subscribers. Of that number, United reimbursed Plaintiffs correctly for only 305 such patients.

10. For the remaining 1,215 United Subscribers treated by Plaintiffs during that 45-day period, United paid Plaintiffs less than $400,000 on more than $1.6 million in claims.

11. Even when factoring in Patient Responsibility, Plaintiffs were paid less than 32% of their billed charges on those 1,215 claims.

12. Of those 1,215 underpaid claims during the first 45 days after Plaintiffs left United's network, 197 were for treatment of patients who were suffering from COVID-19. For these 197 claims, Plaintiffs received payments totaling only approximately $91,000 of their charges totaling more than $281,000.

13. The underpayments continue to grow on a daily basis because United Subscribers continue to seek treatment in the hospital emergency departments staffed by Plaintiffs' physicians, and United continues to underpay Plaintiffs for that treatment.

14. United's conduct since Plaintiffs were forced out of United's network is in line with United's asserted goal, as expressed to Plaintiffs' representatives in April 2019, of reducing reimbursement payments for the critical emergency treatment that Plaintiffs provide to United Subscribers by 50%.

15. United has partnered with Defendant Multiplan, a so-called "cost management" company, to achieve its goal of dramatically underpaying Plaintiffs.

16. One product that Multiplan offers to United and other commercial payors is "Data iSight." Multiplan represents to the public, healthcare providers, and patients that the Data iSight process is "transparent," "defensible," and "market tested," and results in a "fair price using amounts generally accepted by providers as full payment for services."

17. Citing Data iSight's analysis, United has drastically cut what Plaintiffs customarily received for providing essential medical services.

18. Data iSight's analysis, however, is not what it purports to be. It does not use the local information it purports to, and it exists simply to paper over the naked, unexcused, and illicit greed of United and other commercial payors, whose growth in profit comes at the direct expense of front-line emergency room physicians like Plaintiffs.

19. Through their actions, Defendants have violated multiple common law and statutory obligations to Plaintiffs.

20. As described more fully below, United is liable to Plaintiffs under the doctrine of *Quantum Meruit*, and under New Jersey's statutory prompt pay obligations, based on United's

unabashed failure to reimburse Plaintiffs for anything close to the fair and reasonable value of the service that Plaintiffs have provided to United Subscribers.

21. As also described more fully below, Multiplan is liable to Plaintiffs on their claim for tortious interference with prospective economic advantage, based on Multiplan's false and misleading statements designed to paper over United's failure to pay Plaintiffs for the fair and reasonable value of their services.

22. Moreover, as further described more fully below, all defendants are liable to Plaintiffs under the New Jersey Racketeer Influenced and Corrupt Organizations ("NJ RICO") Act, *N.J.S.A.* 2C:41-2(c) and 2C:41-2(d), based on their conduct of the affairs of a NJ RICO enterprise through a pattern of racketeering activity as defined in *N.J.S.A.* 2C:41-1(d), and their conspiring to do so. This pattern includes multiple acts of racketeering as defined in *N.J.S.A.* 2C:41-1(a)(1), including acts of theft by unlawful taking in violation of *N.J.S.A.* 2C:20-3, theft by deception in violation of *N.J.S.A.* 2C:204, and theft of services in violation of *N.J.S.A.* 2C:20-8. This pattern also includes multiple acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, which are included within the definition of "racketeering activity" under 18 U.S.C. § 1961(1)(B) and are expressly incorporated into NJ RICO's definition of "racketeering activity" under N.*J.S.A.* 2C:41-1(a)(2).

23. By reason of Defendants' conduct, Plaintiffs have been damaged in the amount of at least $1.1 million, representing the amount by which United has underpaid Plaintiffs for the emergency care that Plaintiffs provided to United Subscribers during just the first 45 days after Plaintiffs were forced out of United's insurance network. This amount increases on a daily basis as Plaintiffs continue to treat United Subscribers. Plaintiffs' damages are subject to trebling on Plaintiffs' NJ RICO claim pursuant to *N.J.S.A.* 2C:41-4(c).

PARTIES

A. Plaintiffs

24. Plaintiffs are physician practice groups who staff emergency departments of hospitals across New Jersey. All of the Plaintiffs maintain administrative offices at 307 South Evergreen Avenue, Woodbury, NJ 08096, in Gloucester County.

25. Plaintiff Atlantic ER Physicians Team Pediatric Associates, PA, is a professional emergency medicine group practice that staffs the emergency department at Kennedy University Hospital Washington Township Campus, 435 Hurffville Cross Keys Road, Turnersville, NJ 08012. It conducts business in Gloucester County, New Jersey.

26. Plaintiff Emergency Care Services of NJ, PA, is a professional emergency medicine group practice that staffs the emergency departments at Inspira Medical Center Mullica Hill, located at 700 Mullica Hill Road, Mullica Hill, NJ 08602; and Inspira Medical Center Woodbury, located at 509 North Broad Street, Woodbury, NJ 08096. It conducts business in Gloucester County, New Jersey.

27. Plaintiff Emergency Physician Associates of North Jersey, PC, is a professional emergency medicine group practice that staffs the emergency departments at Chilton Memorial Hospital, 97 West Parkway, Pompton Plains, NJ 07444; Raritan Bay Medical Center, One Hospital Plaza, Old Bridge, NJ 08857; Raritan Bay Medical Center, 530 New Brunswick Avenue, Perth Amboy, NJ 08861; Overlook Medical Center, 99 Beauvoir Avenue at Sylvan Road, Summit, NJ 07901; Riverview Medical Center, 1 Riverview Plaza, Red Bank, NJ 07701; and East Orange General Hospital, East Orange, NJ 07018. It conducts business in the following New Jersey Counties: Essex, Morris, Middlesex, Monmouth, and Union.

28. Plaintiff Emergency Physician Associates of South Jersey, PC, is a professional emergency medicine group practice that staffs the emergency departments at Virtua Willingboro

Hospital, 218 A. Sunset Road, Willingboro, NJ 08046; Jefferson Cherry Hill Hospital, 2201 Chapel Ave and Cooper Landing Road, Cherry Hill, NJ 08002; Jefferson Stratford Hospital, 18 E. Laurel Road, Stratford, NJ 08084; Jefferson Washington Township Hospital, 435 Hurfville-Cross Keys, Turnersville, NJ 08012-2453; Virtua Memorial--Berlin, 100 Townsend Road, Berlin, NJ 08009; Virtua Memorial--Marlton, 90 Brick Road, Marlton, NJ 08053; Virtua Memorial, Camden, 100 Atlantic Avenue, Camden, NJ 08104; Virtua Memorial, Voorhees, 100 Bowman, Voorhees, NJ 08104; Emergency Care Services of New Jersey, P.A., 509 N. Broad Street, Woodbury, NJ 08096. It conducts business in the following New Jersey Counties: Burlington, Camden, and Gloucester.

29. Plaintiff Emergency Physician Services of New Jersey, PA, is a professional emergency medicine group practice that staffs the emergency departments at Holy Name Medical Center, 718 Teaneck Road, Teaneck, NJ 07666; Penn Medicine Princeton Health, 1 Plainsboro Road, Plainsboro, NJ 08536; and Virtua Memorial Hospital, 175 Madison Avenue, Mount Holly, NJ 08060. It conducts business in the following New Jersey Counties: Bergen, Middlesex, and Burlington.

30. Plaintiff Middlesex Emergency Physicians, PA, is a professional emergency medicine group practice that staffs the emergency department at Hackensack JFK Medical Center, 65 James Street, Edison, NJ 08820. It conducts business in Middlesex County, New Jersey.

31. Plaintiff Plainfield Emergency Physicians, PA, is a professional emergency medicine group practice that staffs the emergency departments at Muhlenberg Regional Medical Center, 1200 Park Avenue, Plainfield, NJ 07061. It conducts business in Union County, New Jersey.

B. Defendants and the NJ RICO Enterprises

32. Defendant UHG is a corporation organized under the laws of the State of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343. UHG is the parent of numerous, wholly-owned subsidiaries. These wholly-owned subsidiaries act in concert and under common control to maximize profits for UHG's shareholders.

33. One such subsidiary is Defendant UHIC, a corporation organized under the laws of the State of Connecticut, with its principal place of business located in Hartford, Connecticut.

34. Another such subsidiary is Defendant UHC-NJ, a corporation organized under the laws of the State of New Jersey, with its principal place of business located in Fairfield, New Jersey.

35. Defendant Multiplan is a New York corporation with its principal place of business at 115 Fifth Avenue, New York, NY 10003. Multiplan develops and operates healthcare provider networks and offers related cost management products to insurance companies and other payers of health benefits. As noted above, one such product is Data iSight, which Multiplan offers to United and other payers.

36. United and Multiplan (collectively, "the United-Multiplan Enterprise" or "Enterprise") constitute a NJ RICO "enterprise" within the meaning of *N.J.S.A.* 2C:41-(c). The United-Multiplan enterprise is an ongoing association of legal entities "associated in fact although not a legal entity" under *N.J.S.A.* 2C:41-(c).

37. The United-Multiplan Enterprise is an ongoing informal organization, engaged in and the activities of which affect trade or commerce, with the common purpose of engaging in a course of conduct.

38. The United-Multiplan Enterprise has as a purpose engaging in and attempting to engage in incidents of racketeering activity intended to unlawfully reduce the amounts paid to Plaintiffs and other out of network providers of medical services.

39. There are relationships among the entities that form the Enterprise.

40. Specifically, the United entities have relationships with Multiplan. The United entities have contracts with Multiplan, coordinate their efforts with Multiplan, and share with Multiplan money obtained from Plaintiffs and other victims of the scheme.

41. The relationships between the members of the association-in-fact enterprise known as the United-Multiplan Enterprise are sufficient to permit them to pursue the enterprise's purpose. The United entities cooperate closely with Multiplan to implement the scheme and share the benefits of the scheme with Multiplan. These relationships continue to the present as the United-Multiplan Enterprise continues to pursue its purpose.

42. The Enterprise furnishes the vehicle through which the acts of racketeering activity are committed.

43. The Enterprise functions as a continuing unit.

44. Each of the Defendants participates purposefully and knowingly in the affairs of the United-Multiplan Enterprise by engaging in activities that seek to further, assist or help effectuate the goals of the enterprise.

45. Each of the Defendants agreed to participate in the affairs of the Enterprise with knowledge of the Enterprise's unlawful goals and purposes, including the scheme, to commit acts in furtherance of the Enterprise's common purpose, and to share in monies obtained through the scheme.

46. Each of the Defendants has engaged and continues to engage in incidents of racketeering activity in furtherance of the Enterprise's common unlawful purpose.

47. Defendants agreed to, and do act through the Enterprise to, manipulate reimbursement rates and control allowed payments to the Physicians.

48. As detailed more fully below, each of the named defendants has participated, directly or indirectly, in the affairs of themselves, the other named defendants, and the United-Multiplan Enterprise through a pattern of racketeering as defined in *N.J.S.A.* 2C:41-1(a)(1) and (2). This pattern includes multiple acts of theft by unlawful taking in violation of *N.J.S.A.* 2C:20-3, theft by deception in violation of *N.J.S.A.* 2C:20-4, theft of services in violation of *N.J.S.A.* 2C:20-8, and mail and wire fraud in violation of 18 U.S.C. § 1341 and 1343, which are included among predicate acts of "racketeering activity" under N.*J.S.A.* 2C:41-1(a)(2).

JURISDICTION AND VENUE

49. Venue is proper in this Court pursuant to *R.* 4:3-2(a) because all of the Plaintiffs maintain administrative offices in Gloucester County, and some of the plaintiffs in this action --- including Plaintiff Atlantic ER Physicians Team Pediatric Associates, PA, Plaintiff Emergency Care Services of NJ, PA, and Emergency Physician Associates of South Jersey, PC -- staff the emergency departments of hospitals located within Gloucester County, New Jersey. Thus, all plaintiffs actually do business in Gloucester County and, therefore, are deemed to reside in Gloucester County under *R.* 4:3-2(b).

50. This Court has personal jurisdiction over all of the Defendants in this action because all of the Defendants have sufficient minimum contacts with the State of New Jersey and, as alleged below: (i) the Defendants are found in, have agents in, and/or transact their business and affairs in New Jersey; (ii) a substantial part of the events or omissions giving rise to the claims for

relief occurred in New Jersey; (iii) the ends of justice require that those of the Defendants residing outside New Jersey be brought before the Court to answer for their conduct engaged in and directed toward this State; and (iv) one of the objects of Defendants' conspiracy was to injure Plaintiffs in New Jersey, and all Defendants were aware of this object.

STATEMENT OF FACTS

A. Background

51. Plaintiffs provide life-saving emergency care to thousands of residents throughout the State of New Jersey.

52. The claims at issue in this action are for services Plaintiffs rendered to patients insured by commercial insurance plans sold and/or administered by United, including plans purchased from the healthcare exchanges, since Plaintiffs exited United's network on May 15, 2020.[2]

53. The underpaid claims at issue do not relate to or involve any government sponsored products, such as Medicare Advantage and managed Medicaid.

54. As providers of emergency medical services, Plaintiffs do not and cannot verify a patient's insurance benefits and obtain authorization for treatment from insurance companies prior to rendering treatment.

55. This is due to the practical impossibility of obtaining insurance eligibility information or insurance pre-certification in emergency medical situations and the legal requirements imposed upon emergency medical professionals.

[2] Healthcare Exchanges refers to those exchanges established by the Affordable Care Act ("ACA") and may be operated by either the federal or state government. New Jersey operates its own ACA exchange. *See* https://nj.gov/getcoverednj (last visited October 27, 2020).

56. Healthcare providers are either "in-network" or "out-of-network" with respect to a particular insurance carrier. "In-network" or "participating" providers are those who contract with a health insurer that requires them to accept discounted negotiated rates as payment in full for covered services.

57. "Out-of-network" or "non-participating" providers are those that do not have contracts with an insurance carrier to accept discounted rates and instead set their own fees for services based on a percentage of charges.

58. From November 1, 2008, until May 15, 2020, Plaintiffs were "in-network," or "participating" providers with United. This meant that Plaintiffs were contractually obligated to treat patients covered by health insurance plans funded or administered by United ("United Subscribers" or "Subscribers"), and United agreed to pay Plaintiffs agreed-upon rates for the emergency treatment that Plaintiffs provided to United Subscribers.

59. However, on July 9, 2019, United issued written notices to each of the Plaintiffs informing them that United was unilaterally terminating Plaintiffs' Participation Agreements with UHIC and UHC-NJ.

60. At the time United issued its termination notices, the parties were within an annual renewal term that was not set to expire until May 15, 2020. Yet, in violation of the contractual termination provisions, United's termination notices stated that Plaintiffs' Participation Agreements would terminate effective November 1, 2019, instead of at the conclusion of the contractual renewal term on May 15, 2020.

61. When Plaintiffs brought this clerical mistake to United's attention, United doubled down and insisted that it had the right to terminate Plaintiffs' Participation Agreements on November 1, 2019, rather than at the conclusion of the renewal term on May 15, 2020.

62. Given United's recalcitrance, Plaintiffs were forced to challenge the termination date in arbitration and ultimately prevailed. Accordingly, the Participation Agreements terminated effective May 15, 2020, at which point Plaintiffs became out-of-network with respect to United.

B. United's Pre-Termination Communications with Plaintiffs Signal United's Intention to Dramatically Slash Plaintiffs' Payments for Emergency Services Provided to United Subscribers

63. Pre-termination communications between representatives of Plaintiffs and United explain why United was so anxious to terminate Plaintiffs' Participation Agreements. From late 2017 to 2019, representatives of Plaintiffs attempted to negotiate with United for Plaintiffs to remain contracted, participating, in-network providers with United at sustainable rates, and for other affiliated entities to become contracted, participating, in-network providers with United. These communications occurred over the course of multiple meetings in person, by phone, and by email correspondence. However, United refused to negotiate in good faith.

64. As part of these negotiations, Plaintiffs' agent met with United representatives Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthcare Services, Inc.

65. In or around December 2017, Mr. Rosenthal told Plaintiffs' agent that United intended to implement a new benchmark pricing program to reduce out-of-network reimbursements.

66. United then proposed to Plaintiffs' agent a contractual rate that was roughly half the average reasonable rate at which United had historically reimbursed Plaintiffs, a drastic and unjustified discount from what United had been paying Plaintiffs for years on their non-

participating claims, and an amount materially less than what United was paying other contracted providers in the same geographic market. United's proposed rate was neither reasonable nor fair.

67. Subsequently, in May 2018, Mr. Rosenthal escalated United's threats to Plaintiffs' agent, making clear during a meeting that, if Plaintiffs' agent did not agree to contract for the drastically reduced rates, United would implement benchmark pricing that would reduce all Plaintiffs' non-participating reimbursement by one-third.

68. On or about November 2, 2018, Plaintiffs' representative spoke with John Haben, VP UnitedHealth Network, Greg Dosedel, VP National Ancillary Contracting for UnitedHealth Network, and Chris Parillo, VP Network Management. In this conversation, United's team focused on their intent to lower the amount that was paid to Plaintiffs and to do so through "benchmark" pricing.

69. On or about December 14, 2018, Plaintiffs' representative was able to speak with Mr. Haben. In this conversation, Plaintiffs' representative continued to press the issue of appropriate payment rates. During this conversation, Mr. Haben did little more than reiterate that United would utilize benchmark pricing software to achieve lower rates. United did exactly that. As Mr. Haben told Plaintiffs' representative during this meeting, it was not his problem to determine appropriate market rates of payment; instead, it was his problem to stop Multiplan from paying 90% of Plaintiffs' billed charges.

70. Despite having announced their intent to slash reimbursement rates to Plaintiffs' agent, and even stating the amount by which rates would be reduced, United and Multiplan continue to represent to Plaintiffs, other providers, and the public that the reimbursement rates paid for out-of-network emergency services reflect the rates paid by similar payers in the same geographic region. As set forth in detail in the following sections, these representations were false.

71. On or about April 18, 2019, Plaintiffs' representative spoke with Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare and other senior management from United. United's team responded that payments would continue to decrease and would be paid at 250% of Medicare rates beginning in 2020. When asked why United was forcing such dramatic cuts on out-of-network reimbursements, Mr. Schumacher said it was simply "because we can."

72. Continuing the scheme, on July 7, 2019, Mr. Schumacher advised in a phone call to Plaintiffs' agent that United over three years planned to cut every Plaintiffs' rates to just 42% of the average and reasonable rate of reimbursement that Plaintiffs had received in 2018.

73. Mr. Schumacher additionally advised that United leadership was aware of and supported the drastic cuts, while providing no objective basis for them.

74. The next day, July 8, 2019, United's representative Angie Nierman, a Vice President of Networks at Defendant UnitedHealth Group, Inc., sent via interstate wires a written proposal to Plaintiffs' agent reflecting Mr. Schumacher's stated cuts.

75. In addition to denying Plaintiffs what is owed to them for the claims at issue in this litigation, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

76. This scheme is consistent with statements made to Plaintiffs' representative by Multiplan executives Bruce Singleton, SVP Network and Development Strategy, and Michael McEttrick, VP Healthcare Economics, in a discussion on July 11, 2019, just two days after United notified Plaintiffs that it was terminating Plaintiffs' Participation Agreements. Plaintiffs' representative was told that Data iSight looks at "a lot" of claims to derive a median accepted charge amount. They would not provide any further transparency or specifics into how the amount

was determined. Neither Singleton nor McEttrick would state what data sources were used to derive the payment amounts.

77. Singleton and McEttrick acknowledged that payers such as United could affect pricing and then quickly backtracked, asserting the supposed independence of the Data iSight product. Overall, the conversation clearly pointed to the conspiracy between United and Multiplan to "fix" pricing outcomes and underpay out-of-network emergency providers such as Plaintiffs.

C. Since United Terminated Plaintiffs' Participation Agreements, United Subscribers Have Continued to Seek and Obtain Emergency Medical Treatment from Plaintiffs' Physicians

78. As noted above, United's termination of Plaintiffs' Participation Agreements took effect on May 15, 2020. Since then, Plaintiffs have been out-of-network with United.

79. Although Plaintiffs are now out-of-network with respect to United, United Subscribers continue to receive treatment from Plaintiffs' physicians at the hospital emergency departments they staff. Importantly, federal and New Jersey law obligate Plaintiffs, as emergency medical providers, to provide treatment to all patients who present at emergency departments. 42 U.S.C. § 1395dd; *N.J.S.A.* 26:2H-18.64.

80. Among other things, the federal Emergency Medical Treatment and Labor Act ("EMTALA"), and similar provisions of New Jersey laws and regulations, mandate that hospitals and the physicians that staff hospital emergency departments have a duty to provide an appropriate medical screening examination to all individuals who come to an emergency department with what they believe to be an emergent or urgent condition. 42 U.S.C. § 1395dd(a); *N.J.S.A.* 26:2H-18.64; *N.J.A.C.* 8:43G-12.7(c).

81. If it is determined that an emergency medical condition exists, the patient must be evaluated by a physician and, with certain limited exceptions, provided such medical treatment as

is necessary to assure that the condition has been stabilized. 42 U.S.C. § 1395dd(b), (c); *N.J.A.C.* 8:43G-12.7(d), (e).

82. If it is determined that an emergency does not exist, the patient shall either be treated in the emergency department or referred to an appropriate health care provider, and be given appropriate discharge instructions. *N.J.A.C.* 8:43G-12.7(f), (n).

83. Importantly, New Jersey regulations make clear that no patient who comes to a hospital emergency department shall be discharged to home or another facility without being seen and evaluated by qualified medical personnel, which must occur within four hours of the patient's coming to the emergency department. *N.J.A.C.* 8:43G-12.7(g).

84. EMTALA and New Jersey law subject emergency department physicians to civil liability for violations. For example, "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital" who negligently violates EMTALA is subject to civil monetary penalties of up to $50,000 per violation. 42 U.S.C. § 1395dd(d)(1)(B).

85. There are no exceptions to the emergency medicine providers' legal obligation to render services based on a patient's ability to pay or the presence of health insurance. Notably, *N.J.S.A.* 26:2H-18.64 provides that "[n]o hospital shall deny any admission or appropriate services to a patient on the basis of that patient's ability to pay or source of payment." A patient's ability to pay in no way affects or impedes the delivery of emergency care by Plaintiffs or the hospitals they staff.

D. With Plaintiffs' Duty to Treat United Subscribers Comes United's Concomitant Duty to Pay Plaintiffs a Reasonable Rate for Out-of-Network Emergency Services

86. Because emergency medical providers have no discretion to turn patients away, and must treat all patients, regardless of ability to pay, they depend on commercial insurance

companies to meet their legal responsibility and timely and properly pay a reasonable rate to providers such as Plaintiffs who are not "in-network" and are not "participating" providers.

87. The duty of healthcare insurers to pay a reasonable rate to out-of-network providers for the treatment they are required to provide to those insurers' subscribers derives not only from principles of fundamental fairness and equity, but also from multiple sources of state and federal law.

1. New Jersey's Prompt Payment Requirements

88. For example, in processing United's claims, United is governed by the prompt payment requirements of the New Jersey Health Claims Authorization, Processing and Payment Act ("HCAPPA").

89. HCAPPA's requirements are codified in various sections of the New Jersey Statutes, including, as applicable to United, *N.J.S.A.* 17B:26-9.1 (applicable to health insurance other than group and blanket insurance), *N.J.S.A.*17B:27-44.2 (applicable to group health and blanket insurance), and *N.J.S.A.* 26:2J-8.1(d)(9) (applicable to health maintenance organizations). Regardless of the nature of the payor and type of insurance, however, HCAPPA's prompt payment requirements are the same.

90. Under HCAPPA, the insurance carrier must acknowledge receipt of all claims, both emergent and non-emergent, within two working days. *See N.J.S.A.* 17B:26-9.1(d)(5); *N.J.S.A.* 17B:27-44.2(d)(5) and *N.J.S.A.* 26:2J-8.1(d)(5).

91. HCAPPA further requires insurance carriers to pay claims within 30 days after the insurance carrier receives the claim when submitted electronically, or 40 days if received non-electronically, provided the following conditions apply:

(a) the healthcare provider is eligible at the date of service;

(b) the person who receives the healthcare service is covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that is distributed in advance to the healthcare provider or covered person in accordance with the provisions of section 4 of P.L.2005, c. 352 (C.17B:30-51); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

N.J.S.A. 17B:26-9.1(d)(1), 17B:27-44.2(d)(1) and *N.J.S.A.* 26:2J-8.1(d)(1).

92. In addition, HCAPPA requires that, if all or a portion of the claim is not paid within the statutory timeframe for one or more statutorily enumerated reasons, the payer shall notify the health care provider and covered person in writing within 30 days of receipt of an electronic claim, or within 40 days of receipt of a claim submitted by other than electronic means, that: (i) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim; (ii) the claim contains incorrect information with a statement as to what information must be corrected for the adjudication of the claim; (iii) the payer disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or (iv) the payer finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor. *N.J.S.A.* 17B:26-9.1(d)(2); *N.J.S.A.* 17B:27-44.2(d)(2).

93. Moreover, under HCAPPA, an insurance carrier's dispute of a portion of the claim does not excuse the carrier from payment of the entire claim: "Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance

with the time limit established in paragraph (1) of this subsection." *N.J.S.A.* 17B:26-9.1(d)(4), *N.J.S.A.* 17B:27-44.2(d)(4) and *N.J.S.A.* 26:2J-8.1(d)(4).

2. New Jersey's Emergency Coverage Mandates

94. New Jersey regulations also mandate that insurance carriers determine coverage promptly and pay promptly to ensure patient access to emergency care regardless of the patient's type of insurance coverage. Under this regulatory regime, New Jersey law requires healthcare insurers to notify their subscribers that they are entitled to have "access" and "payment of appropriate benefits" for emergency conditions on a "24 hours a day," "seven days a week" basis. *N.J.A.C.* 11:24A-2.5(b)(2).

95. Further, under New Jersey law prior to August 30, 2018, for the emergency/urgent treatment provided by Plaintiffs to United Subscribers, insurers who provided coverage for emergency/urgent care and receive a claim for emergency/urgent care provided by an out-of-network hospital were required to pay an amount sufficient to protect the patient/insured from being balance billed. To meet this obligation, insurers could (a) pay the full amount of the charges, (b) negotiate a settlement of the claim with the provider, or (c) negotiate an in-network agreement with the provider. *Aetna Health, Inc. v. Srinivasan*, 2016 N.J. Super. Unpub. LEXIS 1515 (App. Div., June 29, 2016).

3. The OON Act Modifies New Jersey's Emergency Coverage Mandate, but Retains the Obligation for Insurers to Pay a Reasonable Rate

96. The New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act ("OON Act"), codified at *N.J.S.A.* 26:2SS-1 to -20, modified HCAPPA's prompt payment requirements for inadvertent or emergency claims upon taking effect on August 30, 2018. The OON Act applies to all health insurance plans in New Jersey other than

self-funded plans governed by the federal Employee Retirement Income Security Act that have not opted into the law's coverage.

97. Specifically, under the OON Act, for inadvertent or emergency out-of-network payments, the insurer must make a determination within 20 days from the date of receipt of a claim for services whether it considers the claim to be excessive. *N.J.S.A.* 26:2SS-9(c). If not, the insurer must promptly pay the claim. If the insurer considers the claim to be excessive, it must notify the provider of this determination within 20 days of receipt of the claim. If the insurer provides this notification, the insurer and the provider have 30 days from the date of notification to negotiate a settlement. The insurer may attempt to negotiate a final reimbursement amount with the out-of-network healthcare provider, which differs from the amount paid by the insurer pursuant to the requirements under *N.J.S.A.* 26:2SS-9.

98. If no settlement is reached after 30 days, the insurer must pay the provider the insurer's final offer for the services. If the insurer and provider cannot agree on the final offer as a reimbursement rate for these services, the insurer, provider, or patient beneficiary, as applicable, may initiate binding arbitration within 30 days of the final offer, pursuant to *N.J.S.A.* 26:2SS-10.

99. Binding arbitration under the OON Act is permissive, not mandatory, for claims subject to the OON Act. *N.J.S.A.* 26:2SS-7 ("If a covered person receives medically necessary services at an out-of-network health care facility on an emergency or urgent basis as defined by [EMTALA and *N.J.S.A.* 26:2H-18.64)], and the carrier and facility cannot agree on the final offer as a reimbursement rate for these services pursuant to section 9 of this act, the carrier, health care facility, or covered person, as applicable, *may* initiate binding arbitration pursuant to section 10 or 11 of this act") (emphasis added).

100. The OON Act does not dispense with the requirement that insurers pay providers a reasonable amount for the services covered under the OON Act. It just impacts who determines the reasonable rate. For claims subject to the OON Act that are arbitrated, the arbitrator determines the appropriate amount payable. *N.J.S.A.* 26:2SS-10. For claims that are not subject to the OON Act (such as claims where the United Subscriber is covered by a self-funded ERISA Plan), or claims for which arbitration has not been requested, healthcare providers may seek to enforce common law remedies to recover the reasonable value of their services from insurers. *See The Plastic Surgery Center, P.A. v. Aetna Life Ins. Co.*, No. 18-3381, 18-3356, 2020 WL 4033125 (3d Cir. July 17, 2020) (holding that plaintiff out-of-network health care provider could pursue state common law claims for breach of contract and promissory estoppel claims independent of ERISA, as they sought to enforce obligations independent of an ERISA plan); *Srinivasan*, 2016 N.J. Super. Unpub. LEXIS 1515 (App. Div., June 29, 2016) (upholding $2.1 million judgment in favor of out-of-network provider against health insurer on unjust enrichment claim).

101. New Jersey law also provides interest as a penalty against insurers such as United for overdue payments in the amount of 12% per annum, *N.J.S.A.* 17B:26-9.1(d)(9), *N.J.S.A.* 17B:27-44.2(d)(9) and *N.J.S.A.* 26:2J-8.1(d)(9), except during the pendency of arbitration under the OON Act, to the extent that the OON Act applies, *see N.J.S.A.* 26:2SS-10(c)(2). The interest must be paid to the healthcare provider at the time the overdue payment is made. *N.J.S.A.* 17B:27-44.2(d)(9) and *N.J.S.A.* 26:2J-8.1(d)(9).

4. Federal Coverage and Payment Mandates

102. The duty of health insurers such as United to pay out-of-network providers a reasonable rate for emergency care is also embodied in federal coverage and payment mandates. For example, the Patient Protection and Affordable Care Act ("ACA") requires health insurers

such as United to reimburse out-of-network providers for emergency services at a sufficiently high level to ensure that their Subscribers' cost-sharing does not exceed what the Subscribers' cost-sharing would have been had they obtained the emergency services at an in-network facility. 42 U.S.C. § 300gg-19a(b)(1). For out-of-network emergent claims, United must ensure that it pays at least the greatest of three amounts specified in 29 C.F.R. § 2590.715- 2719A(b)(3)(i)(A)-(C). One of these is the amount for the emergency service calculated using the method the plan generally uses to determine payments for out-of-network services (such as usual, customary and reasonable charges), but substituting in-network cost-sharing provisions. (*See id.*).

103. Moreover, the Families First Coronavirus Response Act ("FFCRA") was enacted on March 18, 2020. Pub. L. No. 116-127 (2020). Section 6001 of the FFCRA generally requires group health plans and health insurers such as United that offer group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection and diagnosis of COVID-19, when those items or services are furnished on or after March 18, 2020, and during the applicable period of the federal COVID-19 public health emergency declaration.[3] Under the FFCRA, plans and health insurers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

104. Additionally, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was enacted on March 27, 2020. Pub. L. No. 116-136 (2020). Section 3201 of the CARES Act amended Section 6001 of the FFCRA to include a broader range of diagnostic

[3] The Secretary of Health and Human Services has recently extended the public health emergency period under the FFCRA through January 31, 2021. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx (last visited October 27, 2020).

items and services that plans and health insurers such as United must cover without any cost-sharing requirements or prior authorization or other medical management requirements. Additionally, Section 3202 of the CARES Act generally requires plans and health insurers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the provider's published billed charges.

105. United's own website purports to comply with the FFCRA and CARES Act mandates by stating, "[t]o help you access the COVID-19 treatment you need, UnitedHealthcare is extending cost-share waivers for our Individual, Fully-Insured Group Market and Medicare Advantage health plans, as noted below," and that for individually and fully-insured group health plans, "[y]ou will have $0 cost-share (copay, coinsurance and deductible) for network visits, including a telehealth visit, for COVID-19 treatment through Dec. 31, 2020. Out-of-network cost-share waivers will end Oct. 22, 2020."[4]

E. Instead of Paying Out-of-Network Providers Reasonable Rates, United Conspires with Multiplan to Fabricate Artificially Low Rates

106. Instead of paying out-of-network health care providers reasonable rates, United has conspired with Multiplan to fabricate artificially low rates.

1. Background: The Ingenix Precursor

107. The enterprise formed between United and Multiplan seeks to reproduce a scheme involving a fraudulent database created and operated by a wholly-owned United subsidiary formerly known as "Ingenix." (Ingenix is now called "Optum.")

108. The Ingenix scheme led United to pay $400 million in settlements in 2009.

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[4] *See* https://www.uhc.com/health-and-wellness/health-topics/covid-19/coverage-and-resources (last visited October 27, 2020).

109. Similarly, with regard to the claims mentioned in this filing, instead of using their own fraudulent databases as was done with Ingenix, United has employed Multiplan and Data iSight to play the role of Ingenix and in so doing has created a NJ RICO enterprise.

110. An investigation into Ingenix by then New York Attorney General Andrew Cuomo "uncovered a fraudulent and conflict-of-interest ridden payment system affecting millions of patients and their families and costing Americans hundreds of millions of dollars in unexpected and unjust medical costs."[5]

111. In 2009, United paid $400 million to settle cases arising from this misconduct. Three hundred fifty million dollars was paid to settle a class action against those entities. Another fifty million was paid for the establishment of the FAIR Health database and website. The settlement agreement dictated that "United shall use [FAIR Health] as the basis for determining Allowed Amounts for Covered Out-Of-Network Services or Supplies." The Settlement Agreement stated the standard "usual, customary, and reasonable" ("UCR") reimbursement rates were equivalent to "reasonable and customary," "average," or "prevailing" *charges* submitted by healthcare providers.

112. Also in 2009, the Office of the Attorney General for the State of New York announced the results of its investigation into Ingenix in a landmark agreement entitled "Assurance of Discontinuance Under Executive Law § 63(15)" ("Assurance Order"). According to the Assurance Order, the payment rates compiled by Ingenix were based on a "conflict of interest." The attorney general concluded that the system "meant to reimburse consumers fairly as a

[5] *Attorney General Cuomo Announces Historic Nationwide Reform Of Consumer Reimbursement System For Out-Of-Network Health Care Charges*, NY AG Press Release, October 27, 2009. https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-reform-consumer (last visited October 27, 2020).

reflection of the market is instead wholly owned and operated by the [insurance] industry" who have an "incentive to manipulate the data they submit to Ingenix so as to depress payment rates they determine using the Ingenix schedules, given their own payment obligations toward consumers."

113. The prices generated by Ingenix were inadequate because: 1) Ingenix did not audit the data provided by insurers to make sure that the charges properly reflect what providers actually charged in the marketplace; 2) Ingenix used statistically invalid "edits" to exclude a disproportionate amount of high charges from its UCR calculations; and 3) Ingenix "lumped" charges for the same service together regardless of whether the service was provided by a certified specialist with many years of experience or a less experienced provider such that the aggregate UCR rate calculated by the database was artificially low.

114. Although this matter did not ultimately go to a jury, the allegations clearly show that this conduct was fraudulent.

115. The fraud alleged in this case is even worse because the data that Multiplan uses here to price the claims of out of network providers is even further removed from true UCR rates than it was in Ingenix.

116. The Assurance Order required the insurance industry cease using the Ingenix database and create a "new, independent database, not controlled by any insurer, to be used for determining fair and accurate reimbursement rates." The Assurance Order also established a "Healthcare Information Transparency Website" to inform and educate the public about reimbursement rates.

117. This "new" database was funded by UnitedHealth Group ($50 million), Aetna ($20 million), Wellpoint ($10 million), CIGNA ($10 million), MVP Health Care Inc. ($535,000),

Independent Health ($475,000), and HealthNow ($212,500). Out of this settlement, the independent not-for-profit entity "FAIR Health, Inc." (which stands for "Fair and Independent Research") was created.

118. When the settlement was announced, Thomas L. Strickland, then the Executive Vice President and Chief Legal Officer of UnitedHealth Group, stated: "We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy…We are pleased that a not-for-profit entity will play this important role for the marketplace."[6] United's subsequent conduct belies this statement.

119. As a result of the bad press surrounding the Ingenix name, United changed Ingenix's name to "Optum" in 2010.

120. Unfortunately for healthcare providers, United's legal obligations under the Assurance Agreement to utilize FAIR Health and pay out-of-network claims at a fair rate predicated upon UCR terminated five years after the creation of FAIR Health, in or about 2015.

121. Not long after the termination of its obligations under the Assurance Agreement, free from its terms and without a court order requiring it pay out-of-network healthcare providers using a UCR rate, United sought out the services of a third party, Multiplan, to repeat the same fraud.

[6] *Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice Of Manipulating Rates To Overcharge Patients By Hundreds Of Millions Of Dollars*, NY OAG Press Release January 13, 2009, https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-health-insurance-reform-ends (last visited October 27, 2020).

2. The Defendants form the United-Multiplan Enterprise to Fraudulently Avoid Paying "Reasonable" Payments

122. Defendants, United and Multiplan have formed an ongoing informal organization, with the common purpose of engaging in a course of conduct that includes the development and implementation of a scheme to fraudulently underpay out-of-network emergency medical services.

123. Defendants associated with one another to assert a false and fraudulent methodology applied to a fraudulently manipulated database as an excuse for under-reimbursing Plaintiffs for services provided, to the Defendants' financial benefit.

124. An association does not stop becoming an association because the relationship between its insureds are documented in a contract, nor does anything in the definition of enterprise insulate from liability those whose common purpose may include some legal activity. NJ RICO's definition of enterprise expressly "includes illicit as well as licit enterprises." *N.J.S.A.* 2C:41-1(c).

125. The enterprise formed by United and Multiplan is the vehicle for the illegal, racketeering activity of theft by unlawful taking, theft by deception, theft of services, and mail and wire fraud, as discussed more fully below.

126. The Defendants share a common purpose in performing these activities, which includes financial gain as the direct result of the fraudulent scheme.

127. The Defendants worked together to develop the false and fraudulent reimbursement rates that were provided to Plaintiffs and other emergency medical providers.

128. This is clearly set forth in "Whitepapers" described in the following sections. The Whitepapers provided the roadmap that United and Multiplan jointly developed to achieve specific, fraudulent payment rates.

129. United exercised control over the Enterprise by setting "target prices" for Multiplan to beat, and by determining the method and "routing" that would be used by Multiplan to arrive at

the underpayment amount. United also sent the eventual payment to the provider along with written misrepresentations regarding the payment.

130. Multiplan exercised control over the Enterprise by designing and implementing Data iSight to achieve the low payment rates under the target price determined by United, without regard to UCR rates using purposefully faulty data that Multiplan had purchased.

131. For all of the claims, United compensates Multiplan based on the underpayment of claims.

132. Plaintiffs and providers have a property interest in their accounts receivable related to the payment of claims for their professional services.

133. Underpayment of the claims through fraudulent means deprives Plaintiffs and providers of their property. United and Multiplan both profit from this fraud.

134. United profits by fraudulently retaining money that properly belongs to Plaintiffs for the services that Plaintiffs' physicians provided to United Subscribers..

135. Multiplan profits when United shares with it the money obtained by implementing the fraudulent Data iSight process.

136. Multiplan's implementation of Data iSight to further the fraudulent scheme and further the purpose of the enterprise shows Multiplan's management over and participation in the enterprise.

137. Further, there are relationships among the entities associated with the enterprise.

138. United contracts with Multiplan to create the false impression of legitimacy to their activities.

139. United and Multiplan coordinate their efforts in undertaking the racketeering activities.

140. United and Multiplan share the money obtained from Plaintiffs and other victims of the scheme.

141. The relationships between United and Multiplan are sufficient to permit them to pursue the enterprise's purpose.

142. These relationships continue to the present time and the enterprise continues to pursue its purpose. The enterprise functions as a continuing unit.

3. The FAIR Health Database

143. The creation of the FAIR Health database was intended to provide a reasonable methodology for determining reimbursements to out-of-network health care providers, including Plaintiffs. Indeed, then New York Attorney General Andrew Cuomo stated that he believed that the FAIR Health database would solve the inherent conflicts of interest that plagued the Ingenix databases.

144. The FAIR Health database claims "to provide reliable information about healthcare costs because each year health insurers around the country send [it] over a billion healthcare bills, which are added to FAIR Health's database of more than 31 billion claims," and that FAIR Health uses "information from those claims to estimate what providers charge, and what insurers pay, for providing healthcare to patients."[7] No providers submit pricing information; only insurers do so. Many states use the FAIR Health database as a guidepost for healthcare consumer protection.

145. Moreover, Maximus, the arbitration contractor engaged by the New Jersey Department of Banking and Insurance to decide payor-provider arbitrations under the OON Act,

[7] FAIR Health Consumer, "About FAIR Health," accessed at https://www.fairhealthconsumer.org/#about (last visited October 27, 2020).

considers FAIR Health the "usual, customary and reasonable" ("UCR") benchmarks in deciding arbitrations.

146. The purpose and intent behind the establishment of the FAIR Health Database is to prevent insurers from using skewed methodologies to calculate payments, as was done using Ingenix.

147. United utilized the Ingenix databases to significantly underpay valid claims.

148. In past litigation, United has asserted to courts that FAIR Health "analyzes and groups medical procedures by codes, the geographical area where the procedures were performed, and the amount charged by the providers. This database is often used by private health insurers to calculate the UCR amount for specific procedures and inform the amounts that they will be willing to pay to out-of-network providers." *UnitedHealthcare Servs., Inc. v. Asprinio*, 16 N.Y.S.3d 139, 145 (N.Y. Sup. Ct. 2015).

149. United was required to use FAIR Health or a database with identical parameters to calculate "reasonable" charges until 2015, when the settlement agreement with the New York Attorney General expired.[8]

150. When the FAIR Health requirement expired, United began planning to resurrect their fraudulent payment scheme by forming an enterprise with Multiplan wherein Multiplan assumed the functions previously performed by Ingenix by having the Data iSight methodology stand in for the Ingenix databases.

[8] United Health Ingenix Settlement Agreement Term 4.4 pp. 14 accessed at https://www.mssny.org/App_Themes/MSSNY/pdf/Practice_Resources_Class_Action_Settlements_United_Healthcare-Ingenix_United_Healthcare-Ingenix_Settlementpdf.pdf (last visited October 27, 2020).

151. As part of this iteration of the scheme, United attempts to make the general public and its victims believe that FAIR Health is still the basis for its payment decisions for out-of-network services.

152. United represents that where payment for out-of-network services is to be made at the usual and customary rate, United "most commonly refer[s] to a schedule of charges created by FAIR Health, Inc. ('FAIR Health') to determine the amount of the payment." *See* "Information on payment of out-of-network benefits."[9]

153. As described more fully in the following sections, this statement is demonstrably false.

4. United's Circumvention of Fair Health and Use of Data iSight

154. Instead of paying fair and reasonable rates, United deployed a scheme to underpay out-of-network providers of emergency services, including Plaintiffs.

155. This scheme injured not only Plaintiffs but many other out-of-network providers of emergency services.

156. The goals of United's scheme are to pocket the difference between the fair and reasonable price of healthcare and the underpaid amount; for United and its subsidiaries and affiliates to retain premium amounts that healthcare consumers believed were applied towards healthcare services; to eliminate competition between contracting and non-contracting providers; to push non-contracting providers into unfavorable contracts with United; and to avoid liability for the scheme (the "underpayment scheme"). United conspired with Multiplan to perpetrate the underpayment scheme.

[9] https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits (last visited October 27, 2020).

157. Multiplan promotes itself across the health insurance industry as an unregulated cost management company. Multiplan offers a menu of services for "cost control." Some of the above services are legitimate while others some are fraudulent.

158. Specifically, Multiplan makes available Data iSight, billed as "[t]he most effective, defensible way to value a medical claim when an agreed reduction isn't available."[10] Multiplan describes Data iSight as a "last resort" pricing option. Multiplan also represents, in its marketing material, that its services are "completely transparent."

159. In fact, Data iSight's calculations are not completely or even partially transparent; rather, they are deliberately opaque. Data iSight is a complex product implemented by a software engine that is designed to cull the lowest possible number from a flawed, proprietary database of healthcare claims data that is wholly unrepresentative of amounts actually charged by or paid to similar medical providers in Plaintiffs' surrounding area.

160. Multiplan, as payment for use of the Data iSight, receives a percentage of the difference between a target rate[11] of payment set by United, and the artificially low number Data iSight delivers as a rate of payment. The artificially low Data iSight number is based solely on a manipulated rate that has no basis in objectively gathered and analyzed data.

[10] https://www.multiplan.com/payers/resourcecenter/salescenter/pdfs/MKT5105_Data_iSight.pdf (last visited October 27, 2020).

[11] The "Target Rate" is an initial amount provided by United to be passed with the claim as it goes through FRED and subsequent processes that the final payment amount should be less than in pricing terms.

5. The Mechanics of the Data iSight Process

(a) Overview

161. United conspired with Multiplan to utilize Data iSight to generate and pay artificially depressed payment rates with no resemblance to the methodology United claimed to have used in mailed and electronic correspondence and in published media.

162. Instead of looking at the actual insurance benefits or the law to determine how much to pay for a claim, and despite having billions of lines of claim data and years of claims history to reference, a database of payment information it paid to create, and its own in-house data analytics company, United enlisted the help of Multiplan.

163. United knows that most of its plans required it to pay health care providers fairly for out-of-network emergency services at rates equivalent to amounts charged for similar services by similar providers in the providers' geographic areas. United also knows that federal and state law impose similar obligations on United to pay health care providers fairly for out-of-network emergency services.

164. Instead of using the FAIR Health Database or its own internal data, United used Multiplan to determine payment rates. The lower the rate that Multiplan produced, the more money Multiplan was paid.

165. Multiplan literally has the FAIR Health data at their fingertips, built into their computer systems, but chooses not use it.

166. Multiplan offered a menu of pricing tools that it knew would be used to derive different payment rates for the same quoted insurance term, *i.e.* "amounts charged for services by similar providers in a similar geographic area."

167. Multiplan offered three general categories of services to United: 1) United could rent access to Multiplan's contracts with providers through "rental-network" agreements; 2) United could have Multiplan negotiate individual claims on behalf of United for individual agreements with providers for payment; or 3) United and Multiplan could use Data iSight to calculate payment rates.

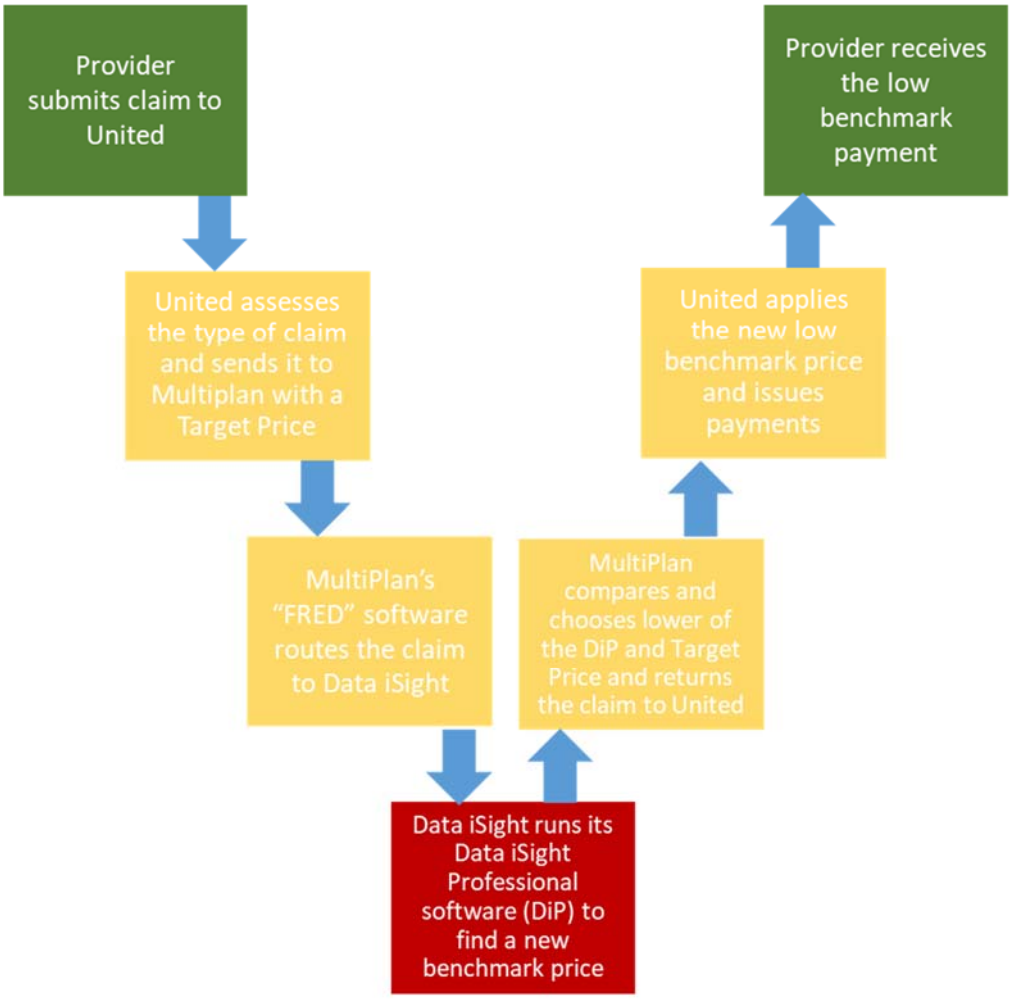
168. For the underpaid claims described in Part F, *infra*, United and Multiplan agreed to use Data iSight instead of Multiplan's negotiations or rental network services.

169. United deliberately avoided using Multiplan's other "legitimate" products because those services priced claims at higher rates than United wanted to pay. United chose to use Data iSight pricing because it knew, based on Multiplan's marketing and on meetings between United and Data iSight, that payment rates would be artificially low.

170. Multiplan Inc. offers a host of mechanisms for "cost-containment." Multiplan has an internal "Claims Savings" search engine, known within the company as "FRED."

171. FRED takes inputs from the claims United forwards it, and routes them to the respective repricing tool, runs the respective tool, and produces an output.

172. Data iSight can be generally summarized by the following flowchart:



173. In general, Data iSight derives a rate, then compares the rate to the "benchmark" or Target Price selected by United, where United sends one. If the Data iSight rate is lower than the Target Price and the provider's billed charges, then the Data iSight rate is used to pay claims.

174. The pricing process starts with United forwarding a claim to Multiplan. At its sole discretion, United chooses which claims to price internally, which claims to send for one of Multiplan's other pricing products, and which claims to price through Data iSight.

175. United sends claim information to Multiplan electronically via a software "electronic data interchange" program (hereinafter "EDI"). The EDI process allows United to communicate several critical inputs to Multiplan: (A) Claims Information (Policy Type, Charge

Amount, Billing Codes); (B) Routing to Designated Repricing Tool (*i.e.*, whether to route the claim to Data iSight or to other Multiplan pricing products such as "Negotiations" or "Rental Networks"; (C) the Benchmark "Target Price" for the claim (*i.e.*, the benchmark price that determined Multiplan's compensation); or (D) the percentile of Data iSight's proprietary database to use to set a benchmark rate.

176. Once Multiplan receives information from United, it routes the information through its "FRED" search engine, which in turn routes the claim to Data iSight.

177. The most commonly used and pernicious repricing method utilized by Data iSight, "DiP," is discussed below.

178. Significantly, the FRED system has FAIR Health usual and customary data loaded into it, available at the click of a mouse, but Multiplan and United consciously choose not to use it.

(b) DiP: The Data iSight Software Engine

179. Upon receipt of the data, Data iSight deploys its proprietary claims repricing method. The method first classifies and sorts claims information based on type of care. For hospital or facility services, the claims are then sent to the next step in the Data iSight process that is used cost to determine payment.

180. Professional claims, like those billed by the Plaintiffs in this action, are distinct from hospital or facility claims. Professional claims are for the treatment provided directly by physicians, like Plaintiffs in this case. Professional claims were priced by a specific Data iSight process known internally at Multiplan as "DiP", internal shorthand for "Data iSight Professional."

181. DiP is a computer program that takes the codes transmitted by United and applies a convoluted algorithm to "edit" and recalculate claims payment rates.

(c) Claims Editing

182. Data iSight's first step in processing claims is to apply "edits." "Editing" claims modifies the billing codes on Providers' billing forms to reduce the payment rates that the engine generates.

183. United and Multiplan each oversee different aspects of the claims editing, further demonstrating their joint management and control of the enterprise.

184. Three technical variables fuel the rates the Data iSight engine produces: Conversion Factors, Relative Value Units, and Geographic Practice Cost Indices. Data iSight borrowed these terms and their application from the Medicare Program.

(d) Medicare Inputs

185. The DiP software applies cost adjustments from Medicare in calculating physician payments. DiP adjusts the payment amounts based on "Conversion Factors" (hereinafter "CFs"), "Relative Value Units" (hereinafter "RVUs") and "Geographic Practice Cost Index" (hereinafter GPCI) inputs.

(e) Conversion Factors

186. The application of Medicare billing mechanics is incompatible with calculation of "reasonable" or "usual, customary, and reasonable" ("UCR") payment rates. Medicare reimbursement rates are not established based on the charges of similar providers in the same geographic area and are not subject to state regulation.

187. To generate a "reasonable" or UCR payment rate, the Data iSight product applies a "conversion factor" or "CF" to the Medicare payment rate.

188. This hidden transformation lie at heart of the underpayment scheme.

189. Medicare does not have a unique payment rate for the professional services of emergency room physicians.

190. Data iSight has created its own CF for the professional services of emergency room physicians.

191. The CF Data iSight applies is derived from a database created by Intercontinental Medical Statistics ("IMS"), a company that purchases data from pharmacies, insurers, and electronic medical record software, anonymizes it, and sells the data back, primarily to drug companies.

192. While Multiplan represents that the IMS database contains billions of claims, it actually only contains tens of millions of claims. In terms of scale, the FAIR Health dataset contains approximately 100 data points for every one contained within the IMS dataset.

193. IMS is now known as IQVIA. The database is not public, is not vetted, is not comprehensive, and is designed to sell itself. Multiplan paid hundreds of thousands of dollars a year to access the information IMS compiled. Multiplan chose this database despite already having access to the FAIR Health Database discussed *infra*.

194. By using the IQVIA data set, the payment rate that is ultimately calculated through Data iSight is even further removed from the usual and customary rate than was the Ingenix rate. The deeply flawed Ingenix data set contained commercial charge data, albeit heavily manipulated.

195. Despite IQVIA costing substantially more to utilize than FAIR Health data, which is available to United and Multiplan for a nominal fee, the added expense for IQVIA is well worth it to United and Multiplan because of its opaque nature and ready susceptibility of its data to manipulation. Further, IQVIA is not accessible to the general public, preventing any independent verification or accountability of its contents and use.

196. Multiplan chose this database because it knew that the IMS/IQVIA data could be readily manipulated using the Data iSight product, producing the artificially lower payments rates that Multiplan and United desired.

197. The IMS/IQVIA database more readily lends itself to the "reverse engineering" accomplished by Data iSight, whereby the payment rate was predetermined.

198. The IMS database that Data iSight used to power its calculations was secret, proprietary, and unvetted. In other words, the IMS database fulfilled the same purpose as the Ingenix database. Both were manipulated to produce fraudulently low underpayment rates.

199. The rates DiP creates are untethered to services actually provided. Instead, they are based on a formula whose base value stems from a methodology with no clear relationship to the amounts charged by other providers for the services provided.

200. DiP used the IMS database on an undifferentiated nationwide basis, meaning that geography is not taken into consideration when calculating the CF. Instead of using the prevailing UCR rates in a local area, DiP applied Medicare's location-based GPCI cost adjustment factor discussed below.

(f) RVUs and GPCIs

201. RVUs[12] and GPCIs[13] are components that are used to calculate the amount that Medicare will pay for a claim. They are not based on usual and customary rates; instead, the

[12] An RVU is a Relative Value Unit. It is a measure of value used in Medicare's reimbursement formula. Medicare's reimbursement formula is based on the resources that it takes to provide a service, not the usual and customary charges. RVUs are based on Medicare's determination of the value of the resources used to provide a service divided into three separate RVU values: one for physician work, one for practice expense, and one for malpractice insurance expense.

[13] A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for

Medicare formula is based on the resources that Medicare believes go into providing a specific service.

202. Data iSight uses the Medicare RVUs and GPCIs to derive the payment amount. The problems in doing so are at least two-fold. RVUs and GPCIs are all based on Medicare's assessment of how resources are used in providing specific services, not the charges of similar providers in the same geographic areas.

203. Further, these factors do not account for or correct the intentionally skewed data that is inputted and to which the methodology is then applied. The truism learned by generations of statisticians, "GIGO: garbage in, garbage out," applies.

(g) Target Pricing: Meet or Beat

204. Once the engine yields the DiP, United and Data iSight engaged the second phase of the underpayment scheme: the "meet or beat."

205. In most instances, DiP was compared to a target payment, or benchmark, amount. Within Multiplan this was known as the "meet or beat" price.

206. The target payment is an initial amount provided by United to be passed with the claim as it goes through FRED and subsequent processes that the final payment amount should be less than in pricing terms.

207. In all cases, United had complete control over the Target Price and Multiplan had complete control over its implementation over Data iSight.

208. The Data iSight engine's objective was to beat United's target payment.

209. Multiplan was paid based on how much it undershot the target payment.

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work, practice expense, and malpractice). The GPCI has 112 different geographic areas. By contrast, there are 1,471 geographic zip codes. The GPCI is intended to account for the varying cost of resources by geographic area, not the varying cost of billed services.

210. Typically, Multiplan was paid a fee equal to a percentage of the "margin" or "savings" amount, i.e. the difference between the target amount sent over by United with the claim, and the amount of the new, low payment that Multiplan's Data iSight calculated.

211. The dollar amount that United ultimately paid for the claims in this case was the lowest of three numbers: Target Price, Billed Amount, or DiP. In every case, the compensation structure agreed upon between Multiplan and United incentivized artificially low payments.

212. United would represent, among other things, that Data iSight derived payment was comparable to, and based on, what similar providers in Plaintiffs' geographic area charged for the same or similar services. In fact, the purpose of the scheme was to produce a rate that was far lower than any reasonable or customary rate, and indeed, was not based on charges at all.

6. Marketing the Conspiracy

213. Multiplan markets Data iSight to United and other insurers as a product capable of underpaying claims discreetly and with minimal complaints from health care providers. Multiplan explained to United that its Data iSight tool could be deployed in the ER provider context to drastically reduce United's payments to non-participating ER providers.

214. Multiplan and United developed and implemented a scheme to underpay ER physicians without facing pushback from their insureds, precisely because patient responsibility is limited by statute.

215. United believes that use of the "independent" Data iSight product will shield it from liability.

216. United also misrepresents to insureds and insurance plans how much it pays out in claims by claiming certain amounts of "savings."

217. Neither healthcare providers nor insureds agree to the "savings" as implemented by United and Multiplan.

218. This enterprise has allowed United and Multiplan to make billions of dollars at the expense of numerous out-of-network providers, including Plaintiffs.

(a) Multiplan's Secret Annual Events: Meetings of the Enterprise

219. Multiplan and United worked out the details of their enterprise through frequent in-person meetings and electronic and wire communications and through the exchange of internal non-public documents called Whitepapers.

220. Multiplan secretly discussed the Data iSight Professional ("DiP") methodology and other proprietary discounting schemes with United at annual events hosted by the Client Advisory Board of Multiplan ("CAB"). The "CAB" consists of the senior marketing individuals at Multiplan including Susan Mohler, Multiplan's Vice President of Marketing, and Dale White, the Executive Vice President of Sales, Bruce Singleton, Senior Vice President of Network Strategy Network and Michael McEttrick, the Vice President Healthcare Economics.

221. At these events, United and Multiplan and Multiplan's other customers would come together, at various discrete locations around the country, to discuss, among other topics, the DiP repricing scheme and how to make more money off it.

222. These secret meetings established a forum for United to form an Enterprise with Multiplan to suppress the rates paid to healthcare providers.

223. During these events, Multiplan presents slide shows outlining the profits and "savings" that could be made using DiP methodology and related discounting schemes.

224. The DiP methodology is specifically designed to be adapted and customized based on input and direction from the insurer and these events and the Road Shows described below

allow United and its competitors to discuss the customizations they want in the claim pricing directly with Multiplan.

225. Both United and Multiplan have management and oversight of the RICO enterprise that they formed to use the DiP methodology in their racketeering activities.

226. The CAB emphasizes that Multiplan's healthcare repricing tools are unregulated.

227. The absence of regulation allows United and Multiplan, unfettered, to develop jointly the underpayment scheme.

228. United partners with Multiplan to use the DiP methodology so that the "Paid Claims" rate produced through DiP's methodology can be presented as "independent" and "defensible," permitting United and other insurers to avoid their responsibility for the derived rates. All of this is a smokescreen meant to hide the fraud.

229. Multiplan emphasizes to United and other at these meetings that if they are ever subject to pushback or scrutiny about their reasonable or UCR rates, they need only to point to the unregulated DiP methodology and assert that they relied on DiP's use of mysterious "objective" and "data-backed" pricing methodology, the true details of which are never revealed to the provider.

230. At the annual meetings, United and Multiplan discuss situations where dissatisfied patients and/or providers push back or challenged underpaid amounts. In such situations, the DiP methodology and rate are deceitfully presented to patients as a "fair" and "transparent" justification for the underpayment.

231. In fact, Multiplan employs several teams trained to handle any pushback from patients and/or providers. Its so-called "appeal managers," "negotiators," and the like are trained

to avoid any comparison between Multiplan's rates and a usual, customary, and reasonable charge. Multiplan and United depend on keeping the actual terms and methodology of DiP secret.

(b) Multiplan's Secret Road Shows: Further Meetings of the Enterprise

232. Multiplan's CAB, including representatives Susan Mohler of Multiplan and Dale White, Multiplan's Executive Vice President of Sales, also brought secret "Road Shows" or client status updates mixed with sales pitches directly to United and presented PowerPoint slideshows detailing the profits that could be realized by insurers using the DiP pricing methodology.

233. During the Road Shows and in subsequent interactions, The CAB produces detailed descriptions of DiP's methodology through internal non-public "Whitepapers" with input from United on how it would like its claims routed through the myriad of Multiplan payment engines, including DiP, to maximize the enterprise's profits.

234. At these Road Shows, representatives of United and Multiplan discuss in detail the DiP pricing methodology and other methodologies that Multiplan uses to unlawfully lower the prices paid for healthcare services to patients with United administered insurance.

235. In particular, representatives such as Rebecca Paradise, the Vice President of Out of Network Payment Strategies at United, are involved in these talks.

236. The text of the underpayment methodology is described in Whitepapers, which are essentially user-manuals for the implementation of the scheme and formation of the enterprise between United and Multiplan to carry out their racketeering and other illegal activities.

237. The Whitepapers are developed over the course of the collaboration between United and Multiplan.

(c) The Secret Internal Whitepapers

238. Multiplan's marketing and sales departments, including Jaqueline Kienzle, Vice President of Sales and Account Management at Multiplan, and manager of United's account, Susan Mohler, and Dale White, exchange with United these internal non-public Whitepapers. The Whitepapers are created by the Multiplan marketing department in concert with Multiplan's data engineers.

239. Whitepapers are secret internal documents that explain, in detail, exactly how the DiP methodology can be implemented to derive any payment price United or any other payer wants.

240. Executives from United, including Rebecca Paradise, the Vice President of Out of Network Payment Strategies, review, comment, and provide feedback on Multiplan's Whitepapers in order to structure United's relationship with Multiplan and implement the DiP methodology.

241. United's representatives provide direction to Multiplan such that Multiplan revises its Whitepapers to ensure that the DiP methodology will yield the lowest payment possible.

242. The Whitepapers explain that United sets performance standards which are defined by target prices. Multiplan uses DiP to derive a price below the target price, and United pays Multiplan a percentage of the "savings" generated by use of the DiP methodology.

243. Thus, these jointly developed Whitepapers provide a partial blueprint of the vehicle that is being used to carry out racketeering acts that directly damage Plaintiffs through underpayment of valid, medically necessary claims.

(d) The Network Access Agreement

244. The National Network Access Agreement ("Agreement") is a written contract between United and Multiplan that sets out how United and Multiplan profit from the proceeds of the DiP-generated underpayments.

245. Exhibits and Amendments to this Agreement detail the fee and incentive structure between the parties and how United compensates Multiplan for access to the DiP methodology. It also discusses how Multiplan receives a percentage of the margin between the target rate and the artificially low number Data iSight delivers as a rate of payment.

246. Although on its face it may appear to be a benign legal contract between businesses, the Agreement actually is intended to provide cover and a vehicle for the parties to share the ill-gotten gains of the DiP pricing methodology.

7. Misrepresentations in Furtherance of the Conspiracy

247. In furtherance of the conspiracy between United and Multiplan to artificially reduce payments using Data iSight, both entities have engaged in numerous false and misleading statements through the mails and wires, described more fully above and in the following discussion.

(a) Provider Remittance Advice forms and Explanations of Benefits

248. Every time a claim is processed by United, United's claim handling system sends to the healthcare provider an alleged explanation of how and why the claim was processed in a specific way. That document, called a "Provider Remittance Advice" (hereinafter "PRA"), is generally transmitted to the treated patient and the treating provider via the United States Postal Service.

249. Additionally, every time a claim is processed by United, United's claim handling system sends out an explanation of how and why a claim was processed in a specific way. That document, called an "Explanation of Benefits" (hereinafter "EOB"), is generally transmitted to the treated patient and the treating provider via the United States Postal Service or electronically over the wires.

250. PRAs and EOBs for claims processed by Data iSight contain the notation "IS" and the following remark:

> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF- NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835-4022 OR VISIT DATAISIGHT.COM, THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT, WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

251. As detailed below, for emergency treatment that Plaintiffs provided United Subscribers during the period May 15, 2020, to June 30, 2020, United sent over the mails and wires numerous PRAs and EOBs containing this or a substantially similar notation.

252. This notation is substantially similar to the hundreds of thousands, if not millions, of PRAs and EOBs that United sends to other out-of-network emergency health care providers for claims that have been processed using Data iSight.

253. The PRAs and EOBs that United sent in this action are false and were created with the intent to deceive the documents' recipients -- including Plaintiffs, patients, and the plans that United administers -- into believing that the Data iSight process is transparent, defensible, and

market-tested, and results in a fair price using amounts generally accepted by providers as full payment for services. In fact, as set forth above and in Part F below, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable payment rate. Its rates are not defensible or reasonable.

254. The Defendants know that the rates that Data iSight has allowed are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

255. They know this because when a provider challenges the payment, Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the provider persists long enough in the process.

256. This process to contest the unreasonable payment takes weeks to conclude for the provider and is impracticable to follow for every claim – a fact that United is aware of.

257. Thus, absent providers taking the time to chase every claim, Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

258. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until Plaintiffs challenge its determinations continually harms Plaintiffs, in that, even if Plaintiffs eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens Plaintiffs with excessive administrative time and expense and deprives Plaintiffs of their right to prompt payment of clean claims under New Jersey's HCAPPA statute and related regulation.

(b) Website misrepresentations

259. Multiplan's and United's websites contain additional misrepresentations relating to the process by which Data iSight calculates health care reimbursements.

260. In its healthcare provider portal, Data iSight describes its methodology for payment determinations as being "calculated using paid claims data from millions of claims…The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

261. Multiplan's website further describes Data iSight's process as using "cost- and reimbursement-based methodologies" and represents that it has been "[v]alidated by statisticians as effective and fair."

262. These statements on Multiplan's website are demonstrably false. Again, as set forth above and in Part F, below, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable payment rate. Its rates are not defensible or reasonable.

263. Moreover, Defendants furthered the scheme by using false representations to providers promising geographic adjustments to allowed rates. Indeed, on its online provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

264. Multiplan further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] [the Centers for Medicare and Medicaid Services ("CMS")] Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly- available database of paid claims.

265. Contrary to those statements, however, and as described above and in Part F below, Data iSight's pricing is not based on "amounts generally accepted by providers as full payment for services." Nor does Data iSight adjust for geographic differences. Instead, it works with United to cut uniformly out-of-network provider payments across geographic locations.

266. Additionally, United falsely claims on their website that they "frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals."[14]

267. Contrary to this misrepresentation, none of the claims at issue in this litigation were paid at the 80th percentile of the FAIR Health benchmark despite both United and Multiplan having access to it. The 80th percentile of FAIR Health Benchmark databases clearly shows that payment for the above non-participating provider charges, when based on a geographically adjusted basis, would not only vary widely, but also be much higher than the amounts that United "allowed" on Plaintiffs' claims, as described in Part F, below.

268. As noted above, Multiplan has FAIR Health data built into its FRED system, but it has consciously chosen not to use it.

269. Defendant Data iSight's website further claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

270. Contrary to these claims, Data iSight uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate payment."

[14] https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits (last visited October 27, 2020).

271. This concealment was designed to, and does, prevent providers such as Plaintiffs from discovering that the payment they receive is anything but "appropriate." However, Plaintiffs were able to discover that United's payments were anything but "appropriate."

F. Since Plaintiffs Have Left United's Network, United Has Used Data iSight to Underpay Plaintiffs

1. Plaintiffs Have Continued to Treat and Timely Bill United for the Services Their Physicians Provide to United Subscribers

272. As noted above, since Plaintiffs have left United's network, Plaintiffs have continued to provided emergency treatment to United Subscribers, as they are required to do by law.

273. In just the first 45 days after Plaintiffs were forced out of United's network, Plaintiffs' physicians provided emergency department treatment to 1,520 United Subscribers.

274. For the healthcare claims at issue here, the hospital where the emergency services were provided was responsible for obtaining and did obtain the patient's insurance information and demographics.

275. The emergency healthcare billing process operated as follows: patients were admitted to Emergency Departments ("EDs") of hospitals where they were screened and stabilized without inquiry into their ability to pay.

276. The screening and stabilizing providers recorded the services they provided in medical record "charts."

277. If patients were insured, they provided their insurance information and patient demographics to the hospital's billing department.

278. The hospital's billing department then sent the patient's demographics, medical records, and insurance information to the Plaintiffs.

279. This is the standard practice for hospitals that contract with outside groups to provide emergency services.

280. The Plaintiffs' billing departments transcribed patients' medical charts into standardized billing codes, created invoices with standard charges, medical coding, patient demographics, and submitted the invoices electronically to United.

281. Regardless of the specific United subsidiary or entity responsible for administering the patient's plan, all invoices were submitted through a common United portal.

282. Every claim at issue was approved for payment by United.

283. The invoices were all submitted using standardized claims forms called HCFA-1500 forms. Every claim at issue in this case was submitted directly to United or its subsidiaries.

284. In billing United for the emergency department services that Plaintiffs' physicians provide to United Subscribers, Plaintiffs follow the industry-standard Current Procedural Technology ("CPT") coding system established by the American Medical Association ("AMA") and routinely accepted by United and other private and governmental payors.

285. The most commonly used CPT codes billed by Plaintiffs' emergency department physicians are CPT Codes 99284, 99285, and 99291.

286. According to United's "Emergency Department (ED) Facility Evaluation and Management (E&M) Coding Policy," (hereinafter "United Emergency Department Policy"),[15] CPT Code 99284 applies to the following:

> Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies

[15] *See* https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Emergency-Department-Facility-Evaluation-Mgmt-Policy.pdf (last visited October 27, 2020).

> are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

287. According to the same United Emergency Department Policy, CPT Code 99285 applies to the following:

> Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

288. According to the same United Emergency Department Policy, CPT Code 99291 applies to the following: "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes." Additional units of 30 minutes of critical care are billed to CPT Code 99292.

289. For emergency department treatment of lesser severity provided by Plaintiffs' physicians, Plaintiffs bill United using CPT Codes 99281, 99282, and 99283.

290. Plaintiffs also occasionally provide routine electrocardiogram services for which they bill United using CPT Code 93010, denoting, "Electrocardiogram, routine ECG with at least 12 leads."

291. After receiving the claims, they were processed, approved for payment, the payment amount was determined, and the claims were paid to the hospital and providers with accompanying notes about how much the patient owed and United's explanation for the amount it paid.

2. United Has Processed Plaintiffs' Claims Through Data iSight and Dramatically Underpaid Plaintiffs' Claims

292. However, instead of paying a "reasonable" rate to Plaintiffs, since Plaintiffs have left United's network, Defendants have used Data iSight to generate a fraudulent "reasonable" rate as justification for underpaying most of Plaintiffs claims.

293. For the healthcare claims at issue, the Plaintiffs were reimbursed at a rate that was far below the rates that United had paid Plaintiffs under their agreements with UHIC and UHC-NJ for many years, and far below what would be considered reasonable by any standard.

294. Specifically, of the 1,520 United Subscribers that Plaintiffs' emergency physicians treated in just the first 45 days after Plaintiffs left United's network, upon information and belief, United processed at least 1,215 of these claims through Data iSight.

295. In doing so, United drastically underpaid Plaintiffs by more than $1.1 million on these 1,215 claims, even after taking into account Patient Responsibility, broken down as follows:

a. Atlantic ER Physicians Team Pediatric Associates, PA: total United underpayments of $2,843 on 3 patient visits;

b. Emergency Care Services of NJ, PA: total United underpayments of $52,913 on 54 patient visits;

c. Emergency Physician Associates of North Jersey, PC: total United underpayments of $460,260 on 456 patient visits;

d. Emergency Physician Associates of South Jersey, PC: total United underpayments of $269,025 on 263 patient visits;

e. Emergency Physician Services of New Jersey, PA: total United underpayments of $187,497 on 296 patient visits;

f. Middlesex Emergency Physicians, PA: total United underpayments of $138,348 on 129 patient visits;

g. Plainfield Emergency Physicians, PA: total United underpayments of $10,414 on 14 patient visits.

296. Of these 1,215 claims that United processed through Data iSight for services rendered between May 15 and June 30, 2020, 197 were for treatment provided to COVID-19 patients, for which United underpaid Plaintiffs by $190,786.65 on $281,845.33 in claims, paying Plaintiffs just 32% of Plaintiffs' billed charges.

297. The underpayments are not isolated to a particular type of service provided or billing code Plaintiffs used. Rather, they span all of the services and CPT codes or combination of codes Plaintiffs' emergency department physicians have used.

298. Of the 1,215 of Plaintiffs' claims that United processed through Data iSight for services provided between May 15 - June 30, 2020, 1,018 were for non-COVID-19 patients. As the following table indicates, regardless of the CPT code or combination of codes Plaintiffs billed United, United's average reimbursement was just a fraction of Plaintiffs' billed charges where the claim was processed through Data iSight:

NON-COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS' EMERGENCY DEPARTMENT PHYSICIANS:

MAY 15 - JUNE 30, 2020 (claims processed through Data iSight)

CPT CODE	Total # of Claims	Average Billed Charge Per Claim	Average Allowed by United Per Claim (Average % of Billed Charges)	Average Underpayment per Claim	Total Underpayment
93010	5	$96.80	$24.36 (25.17%)	$72.44	$362.18
99281	2	$221.00	$106.68 (48.27%)	$112.33	$224.65
99281 combined with another code	1	216.00	$57.13 (26.45%)	$158.87	$158.87
99282	16	$453.75	$125.81 (27.73%)	$327.94	$5,347.04
99282 combined with another code	12	$448.58	$133.77 (29.82%)	$314.81	$3,777.71
99283	103	$709.21	$188.55 (26.59%)	$520.34	$53,594.53
99283 combined with another code	103	$931.81	$259.37 (27.84%)	$672.44	$69,260.97
99284	179	$1,086.88	$324.24 (29.83%)	$761.64	$136,333.25
99284 combined with another code	125	$1,370.14	$398.62 (29.09%)	$971.28	$121,410.14
99285	269	$1,576.00	$478.85 (30.38%)	$1,097.65	$295,267.38
99285 combined with another code	167	$1,682.37	$469.47 (27.90%)	$1,212.62	$202,506.80
99291	21	$1,785.00	$732.08 (41.01%)	$1,052.92	$22,111.35
99291 combined with another code	15	$2,050.93	$657.59 (32.06%)	$1,350.58	$20,258.72
TOTAL	1018	$1,298.54	$383.56 (29.54%)	$914.06	$930,513.59

299. United's pattern of underpaying Plaintiffs' out-of-network claims through Data iSight applied equally to COVID-19 patients, despite the global pandemic and United's special coverage obligations under the FFCRA and the CARES Act. Specifically, United processed 197 of Plaintiffs' claims for services provided between May 15 - June 30, 2020, for COVID-19 patients. As the following table indicates, again, for each of the specific CPT codes Plaintiffs billed to United for COVID-19 patients, United's average reimbursement remained just a fraction of Plaintiffs' billed charges where the claim was processed through Data iSight:

COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS' EMERGENCY DEPARTMENT PHYSICIANS:

MAY 15 - JUNE 30, 2020 (claims processed through Data iSight)

CPT CODE	Total # of Claims	Average Billed Charge Per Claim	Average Allowed by United Per Claim (Average % of Billed Charges)	Average Underpayment per Claim	Total Underpayment
99283	17	$574.43	$183.10 (31.88%)	$381.76	$6,489.89
99284	9	$985.78	$277.53 (28.15%)	$708.25	$6,374.27
99285	151	$1,497.64	$469.68 (31.36%)	$1,024.77	$154,740.15
99291	20	$1,853.15	$693.02 (37.40%)	$1,159.12	$23,182.34
TOTAL	197	$1,430.69	$458.95 (32.08%)	$968.46	$190,786.65

300. The Defendants know that the rates that Data iSight have allowed for Plaintiffs' claims since May 15, 2020, as depicted above, are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate. Notably, these average allowed rates are substantially lower than the rates that United has allowed for the 305 of Plaintiffs' claims not processed through Data iSight between May 15 - June 30, 2020.

301. Specifically, as the following table indicates, for non-COVID-19 claims for services between May 15 - June 30, 2020, where, upon information and belief, United did not process the claims through Data iSight, United's average allowed payments were close to Plaintiffs' billed charges:

NON-COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS' EMERGENCY DEPARTMENT PHYSICIANS:

MAY 15 - JUNE 30, 2020 (claims not processed through Data iSight)

CPT CODE	Total # of Claims	Average Billed Charge Per Claim	Average Allowed by United Per Claim (Average % of Billed Charges)	Average Underpayment per Claim	Total Underpayment
93010	1	$102.00	$91.80 (90.00%)	$10.20	$10.20
99281	4	$109.75	$100.25 (91.34%)	$9.50	$38.00
99281 combined with another code	2	$111.50	$106.20 (95.25%)	$5.30	$10.60
99282	13	$491.08	$468.00 (95.30%)	$23.08	$300.00
99282 combined with another code	2	$237.00	$213.30 (90.00%)	$23.70	$47.40
99283	34	$705.62	$664.94 (94.19%)	$40.68	$1,383.00
99283 combined with another code	24	$993.59	$905.89 (91.17%)	$93.26	$2,518.10
99284	43	$1,041.63	$975.73 (93.67%)	$65.90	$2,833.50
99284 combined with another code	21	$1,293.71	$1,181.71 (91.34%)	$112.00	$2,352.10
99285	72	$1,606.96	$1,505.31 (93.67%)	$101.65	$7,318.68
99285 combined with another code	43	$1,682.14	$1,532.37 (91.10%)	$149.77	$6,439.98
99291	1	$1,860.00	$1,674.00 (90.00%)	$186.00	$186.00
99291 combined with another code	1	$5,572.00	$4,340.00 (77.89%)	$1,232.00	$1,232.00
TOTAL	264	$1,234.33	$1,140.88 (92.43%)	$93.45	$24,669.56

302. And as the following table indicates, for COVID-19 claims for services between May 15 - June 30, 2020, where United did not process the claims through Data iSight, United's average allowed payments were again close to Plaintiffs' billed charges

COVID-19 UNITED SUBSCRIBERS TREATED BY PLAINTIFFS' EMERGENCY DEPARTMENT PHYSICIANS:

MAY 15 - JUNE 30, 2020 (claims not processed through Data iSight)

CPT CODE	Total # of Claims	Average Billed Charge Per Claim	Average Allowed by United Per Claim (Average % of Billed Charges)	Average Underpayment per Claim	Total Underpayment
99283	3	$472.00	$447.40 (94.79%)	$24.60	$73.80
99284	5	$1,144.60	$1,012.96 (88.50%)	$131.64	$658.20
99285	32	$1,519.78	$1,393.09 (91.66%)	$126.69	$4,054.20
99291	1	$1,906.00	$1,618.20 (84.90%)	$287.80	$287.80
TOTAL	41	$1,406.78	$1,283.02 (91.20%)	$123.76	$5,074.00

303. As further evidence that the Data iSight rates are wholly inconsistent with what would be considered "reasonable" reimbursement rates by any standard, with the exception of Code 99281, the average Data iSight rates are substantially lower than the rates to which United agreed under its own recent terminated Participation Agreements with Plaintiffs. In fact, most of the rates Data iSight came up with were lower than the rates in place under those contracts in 2008, as the following table indicates:

Average Data iSight Rates for Plaintiffs Claims (May 15 - June 30, 2020) versus United Contracted Rates

CPT CODE	Data iSight Allowed Rate for non-COVID-19 claims (May 15-June 30, 2020)	Data iSight Allowed Rate for COVID-19 claims (May 15-June 30, 2020)	Contracted Rates (May 15, 2016-May 14, 2020)	Contracted Rates with Plaintiffs (June 18, 2008 - June 17, 2009)
99281	$106.68	--	$85.22	$73.27
99282	$125.81	--	$145.96	$121.74
99283	$188.55	$183.10	$327.77	$273.36
99284	$324.46	$277.53	$511.24	$426.41
99285	$478.85	$469.68	$800.13	$667.36
99291	$732.08	$693.02	$1,199.27	$1,000.27

304. As the foregoing examples make clear, United and Multiplan have used Data iSight to produce fraudulent data in an effort to deceive healthcare providers and deprive them of the reimbursements to which they are entitled by law.

305. Defendants use the claims processing function as a means of enriching themselves by drastically under-paying out-of-network emergency department physicians such as Plaintiffs while retaining for themselves the balance of the funds they have drawn down from the health insurance plans United administers. United advances these goals through numerous uses of the mails and wires in furtherance of its schemes to defraud.

306. Plaintiffs have been harmed in their businesses and property by Defendants' conduct. They were deprived of the fair value of their services and lied to by the Defendants who told them that their reimbursements were consistent with an objective calculation of reasonable rates and comparable with rates charged by their local competitors.

307. Unfortunately, the severe economic harm Plaintiffs have suffered is not the only fallout from Defendants' conduct. In addition to profit, Defendants and the United-Multiplan Enterprise have the effect of eliminating competition between contracting and non-contracting providers; pushing non-contracting providers into unfavorable contracts with United; and attempting to avoid liability for their conduct.

308. Worst of all, there is no end in sight. The use of Data iSight has become the Defendants' and the Enterprise's regular way of doing business. As noted above, United Subscribers continue to receive treatment in the emergency departments of hospitals staffed by Plaintiffs' physicians, and Plaintiffs are legally required to treat these patients. Unless and until the Courts or law enforcement officials compel an end to United's and Multiplan's claims administration schemes, United will continue to illegally and aggressively underpay Plaintiffs --

and numerous other out-of-network emergency physicians around the country -- every day, aided by the fraudulent Data iSight methodology administered by Multiplan.

309. Unless stopped, Defendants' conduct will ultimately force Plaintiffs and other out-of-network emergency department physicians to accept unreasonably low in-network contracts that do not cover their operating costs, or more likely drive them out of business.

CAUSES OF ACTION

COUNT ONE

Quantum Meruit--

Against UnitedHealth Group, Inc. UnitedHealthcare Insurance Company, and UnitedHealthCare of New Jersey, Inc.

310. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

311. Under New Jersey law, a cause of action for *Quantum Meruit* requires (1) the performance of services in good faith, (2) the acceptance of the services by the person to whom they are rendered, (3) an expectation of compensation therefor, and (4) the reasonable value of the services.

312. Since leaving United's network on May 15, 2020, to comply with their ethical and legal obligations under federal and New Jersey law, Plaintiffs have continued to provide emergency medical treatment and services to United Subscribers in good faith.

313. United could not lawfully prevent their members from seeking emergency medical care from the Physicians. Thus, the parties were, in effect, compelled to do business with each other.

314. Given the nature of these relationships, an equitable obligation arises to account for the value of the services Plaintiffs provided to United Subscribers.

315. United Subscribers accepted the treatment and services that Plaintiffs provided to them.

316. At the time Plaintiffs treated United Subscribers, Plaintiffs reasonably expected to be compensated for the medical treatment and services that Plaintiffs provided to United Subscribers and, accordingly, submitted claims to United for payment for this treatment and services, listed on Exhibits A and B.

317. The reasonableness of Plaintiffs' expectation is underscored by the state and federal laws described more fully above requiring United to reimburse Plaintiffs promptly and fairly.

318. Thus, Defendants are obligated to reimburse the Plaintiffs for the reasonable value of the services they provided.

319. By providing treatment and services to United Subscribers, Plaintiffs have also directly benefitted United. Specifically, for each claim for reimbursement that Plaintiffs submitted to United, United has drawn down from the trust funds of the health insurance plans the full charge amount of Plaintiffs' claims and impermissibly retained those funds for their own purpose.

320. The reasonable value of the treatment and services that Plaintiffs rendered to United Subscribers is the full amount of their billed charges.

321. As set out more fully above, United has drastically underpaid Plaintiffs and, therefore, has not reimbursed Plaintiffs for the reasonable value of the treatment and services that Plaintiffs rendered to United Subscribers.

322. Accordingly, under the doctrine of *Quantum Meruit*, United is liable to Plaintiffs for the full amount of Plaintiffs' billed charges since Plaintiffs have left United's network on May 15, 2020, less any amounts actually paid by United and any applicable Patient Responsibility Amounts.

COUNT TWO

Violation of New Jersey Health Claims Authorization, Processing and Payment Act ("HCAPPA")

Against UnitedHealth Group, Inc. UnitedHealthcare Insurance Company, and UnitedHealthCare of New Jersey, Inc.

323. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

324. HCAPPA requires health insurers such as United to pay health care providers' claims promptly, provided that the claims meet the criteria for payment set forth in *N.J.S.A.* 17B:26-9.1(d)(1), *N.J.S.A.* 17B:27-44.2(d)(1) and *N.J.S.A.* 26:2J-8.1(d)(1).

325. Specifically, for out-of-network emergency claims governed by the OON Act post August 30, 2018 -- such as the claims for the emergency treatment Plaintiffs' physicians have provided to United Subscribers since May 15, 2020 -- New Jersey law requires that such claims be paid in full no more than 50 days after electronic submission, except to the extent disputed in accordance with the procedures of the OON Act. *See N.J.S.A.* 26:2SS-9.

326. Plaintiffs' claims for the emergency treatment they provided to United Subscribers since May 15, 2020, meet all the criteria for payment under HCAPPA, *N.J.S.A.* 17B:26-9.1(d)(1), *N.J.S.A.* 17B:27-44.2(d)(1) and *N.J.S.A.* 26:2J-8.1(d)(1). As described more fully above, on the dates the services were provided, the United covered the out-of-network emergency services Plaintiffs' physicians provided to United Subscribers, and Plaintiffs' agents submitted the claims to United on the appropriate claim forms.

327. However, as described more fully above, United failed to remit full reimbursement of Plaintiffs' charges for healthcare services, or provide a written explanation for the failure to pay

all or a portion of such claims, within the statutorily proscribed time frames under HCAPPA or the OON Act.

328. Moreover, as described more fully above, United failed to provide written notice specifying that that Plaintiffs' out-of-network emergency claims were incomplete or contained incorrect information, that United disputed the amounts claimed in whole or in part, or that there was strong evidence of fraud, as HCAPPA requires of any carrier that fails to timely pay a claim for reimbursement. *N.J.S.A.* 17B:26-9.1(d)(2), *N.J.S.A.*17B:27-44.2(d)(2), or *N.J.S.A.* 26:2J-8.1(d)(2)). Nor did United seek to dispute any of Plaintiffs' out-of-network claims in accordance with the OON Act.

329. Instead, as described more fully above, for the vast majority of claims that Plaintiffs submitted to United since exiting United's network on May 15, 2020, notified Plaintiffs and United Subscribers on PRA and EOB forms that United had processed the claims through Data iSight.

330. United's failure to timely pay the full amounts due to Plaintiffs for their out-of-network emergency claims for services provided since Plaintiffs left United's network has resulted overdue payments under HCAPPA.

331. By reason of the foregoing, Plaintiffs are entitled to recover from United the full underpaid and unpaid amounts on all of Plaintiffs' out-of-network emergency claims for services since May 15, 2020, together with statutory interest in the amount of 12% per annum, *N.J.S.A.* 17B:26-9.1(d)(9), *N.J.S.A.* 17B:27-44.2(d)(9) and *N.J.S.A.* 26:2J-8.1(d)(9).

COUNT THREE

Tortious Interference with Prospective Economic Advantage -- Against Multiplan, Inc.

332. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

333. Plaintiffs have had an existing and reasonable expectation of an economic benefit from United in the form of reasonable reimbursement from United for the medically necessary emergency service Plaintiffs provided to United Subscribers.

334. As detailed more fully above, Multiplan had full knowledge of Plaintiffs' reasonable expectations.

335. Multiplan's actions set forth above in deploying the Data iSight methodology to paper over United's underpayments to Plaintiffs have interfered with Plaintiffs' reasonable expectations.

336. Multiplan's actions have been malicious in that Multiplan had no legal justification to interfere with Plaintiffs' expectation of a reasonable reimbursement from United. Importantly, Multiplan has sought to paper over United's underpayments through false and misleading statements and other conduct, described more fully above.

337. But for Multiplan's interference, Plaintiffs had a reasonable probability of continuing to receive reasonable reimbursement for the medically necessary emergency service Plaintiffs provided to United Subscribers.

338. As a direct and proximate result of Multiplan's conduct, Plaintiffs have suffered and will continue to suffer irreparable harm and monetary damages.

COUNT FOUR

NJ RICO-- Violation of *N.J.S.A.* 2C:41-2(c)
Against All Defendants

339. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

340. Each of the Plaintiffs is a "person" within the meaning of *N.J.S.A.* 2C:41-1(b).

341. Each of the Defendants is a "person" within the meaning of *N.J.S.A.* 2C:41-1(b).

342. The United-Multiplan Enterprise is an "enterprise" within the meaning of *N.J.S.A.* 2C:41-1(c).

343. The United-Multiplan Enterprise is engaged in activities which affect trade or commerce for purposes of *N.J.S.A.* 2C:41-2(c).

344. Each of the Defendants is associated with the United-Multiplan Enterprise. Moreover, each of the Defendants has conducted or participated, directly or indirectly, in the conduct of the affairs of the United-Multiplan Enterprise through a pattern of racketeering activity within the meaning of *N.J.S.A.* 2C:41-1(a) and (d).

345. The pattern of racketeering activity under *N.J.S.A.* 2C:41-1(a) and (d), described more fully above, includes multiple and repeated acts of theft by unlawful taking in violation of *N.J.S.A.* 2C:20-3. Under this statute, a person is guilty of theft if he or she unlawfully takes, or exercises unlawful control over, moveable property with purpose to deprive him or her thereof, or unlawfully transfers any interest in immovable property of another with purpose to benefit himself or herself or another not entitled thereto. *N.J.S.A.* 2C:20-3(a), (b).

346. In violation of *N.J.S.A.* 2C:20-3(a), Defendants unlawfully took and exercised unlawful control of money rightfully belonging to Plaintiffs -- specifically, reimbursements to which Plaintiffs were entitled for the out-of-network emergency services that Plaintiffs' physicians provided to United Subscribers. This money constitutes moveable property within the meaning of *N.J.S.A.* 2C:20-3(a). Defendants knew that they had no right to take or exercise control of these funds, yet took and/or controlled them anyway, with the purpose of depriving Plaintiffs of them.

347. Moreover, in violation of *N.J.S.A.* 2C:20-3(b), Defendants unlawfully transferred Plaintiffs' rights and interests in being paid reasonable amounts for the out-of-network emergency services they provided to United Subscribers. These rights and interests constitute immovable

property within the meaning of *N.J.S.A.* 2C:20-3(b). Defendants knew that they had no right to transfer Plaintiffs rights and interests in being paid reasonable amounts for their services away from Plaintiffs, yet they did so anyway, with the purpose of benefitting themselves and others not entitled to benefit from Plaintiffs' out-of-network emergency services.

348. The pattern of racketeering activity under *N.J.S.A.* 2C:41-1(a) and (d), described more fully above, also includes multiple and repeated acts of theft by deception in violation of *N.J.S.A.* 2C:20-4. Under this statute, a person is guilty of theft by deception if he or she purposely obtains the property of another by deception, which is defined to include situations in which a person, *inter alia*, "[c]reates or reinforces a false impression, including false impressions as to law, value, intention or other state of mind," "[p]revents another from acquiring information which would affect his judgment of a transaction," or "[f]ails to correct a false impression which the deceiver previously created or reinforced…." *N.J.S.A.* 2C:20-4(a)-(c).

349. In violation of *N.J.S.A.* 2C:20-4(a)-(c), Defendants repeatedly obtained money that rightfully belonged to Plaintiffs through repeated acts of deception within the meaning of this statute, described more fully above. These acts of deception included, but were not limited to, misrepresentations as to the validity of the Data iSight methodology and the validity of United's reimbursements to Plaintiffs pursuant to that methodology.

350. The pattern of racketeering activity also includes multiple and repeated acts of theft of services in violation of *N.J.S.A.* 2C:20-8. Under this statute, a person commits theft of services if, *inter alia*, he or she purposely obtains professional services by deception or threat, or by other means, to avoid payment for the service. *N.J.S.A.* 2C:20-8(a).

351. In violation of *N.J.S.A.* 2C:20-8(a), Defendants repeatedly obtained for United Subscribers hospital emergency treatment provided by Plaintiffs that Defendants knew were

available only for compensation at reasonable rates. Defendants did so using deception and other means designed to avoid full payment for the services, described more fully above, including Defendants' deployment of the Data iSight methodology, their misrepresentations as to the validity of the Data iSight methodology and the validity of United's reimbursements to Plaintiffs pursuant to that methodology, and other deceptive conduct, described more fully above.

352. The pattern of racketeering also includes multiple acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, which are included within the definition of "racketeering activity" under 18 U.S.C. § 1961(1)(B) and are expressly incorporated into NJ RICO's definition of "racketeering activity" under N.*J.S.A.* 2C:41-1(a)(2). Specifically, Defendants repeatedly and continuously used the mails and wires in furtherance of a scheme to defraud Plaintiffs, United Subscribers, and members of the public into believing that the Data iSight methodology is "transparent," "defensible," and "market tested," and results in a "fair price using amount generally accepted by providers a full payment for services." Defendants made numerous statements over the mails and wires in furtherance of this scheme and with the specific intent to deceive. The express purpose of Defendants' scheme to defraud is to deprive Plaintiffs and other hospital emergency physicians of fair and reasonable reimbursements for the services they render to United Subscribers.

353. Each Defendant has engaged in at least two incidents of racketeering activity that have the same or similar purposes, results, participants, victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.

354. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has the same or similar purposes, in that they sought to, and did, unlawfully avoid reimbursing Plaintiffs as required by law.

355. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has similar results, in that they sought to, and did, unlawfully avoid reimbursing Plaintiffs as required by law.

356. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has the same or similar participants, including but not limited to Defendants.

357. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that has the same or similar victims, consisting of the Plaintiffs and other out-of-network providers, whom Defendants have schemed to under reimburse based upon false and fraudulent data.

358. The incidents of racketeering activity engaged in by the Defendants embrace criminal conduct that is not isolated, rather those incidents are part of the Defendants regular way of doing business and are regularly and systematically engaged in by them to deny out-of-network providers, including Plaintiffs, appropriate reimbursement.

359. The last incident of racketeering activity engaged in by Defendants occurred within ten years after a prior incident.

360. The incidents of racketeering activity involve under-reimbursement for services provided to different persons, on different dates, at different locations, by different physicians employed by different providers.

361. Defendants' conduct poses a continuing threat of racketeering activity, as described below.

362. Defendants have engaged in thousands of incidents of racketeering activity directed at Plaintiffs and other providers.

363. Defendants have engaged in these incidents of racketeering activity and criminal activity on a continuing basis.

364. The incidents of racketeering activity engaged in by Defendants have been and continue to be part of the Defendants' regular way of doing business.

365. The incidents of racketeering activity are extremely lucrative for Defendants. Defendants will continue to engage in similar incidents of racketeering activity indefinitely, unless forced to cease by judicial intervention.

366. As a direct result of United's violations of *N.J.S.A.* 2C:41-2(c), Plaintiffs have suffered substantial and direct injury to their businesses or property within the meaning of *N.J.S.A.* 2C:41-4(c), including, but not limited to: (i) lost revenue from United's intentional underpayment of claims submitted for reimbursement for emergent medically necessary treatment of United Subscribers; (ii) lost revenue from Defendants' intentional diversion of healthcare reimbursements that are otherwise due and payable to Plaintiffs; (iii) lost revenue from patients being dissuaded from seeking healthcare from Plaintiffs; and (iv) the costs in time, person-hours, and other administrative expense incurred because of Defendants' unlawful conduct.

COUNT FIVE

NJ RICO-- Violation of *N.J.S.A.* 2C:41-2(d)
by conspiring to violation of *N.J.S.A.* 2C:41-2(c)
Against All Defendants

367. Plaintiffs re-allege and incorporate by reference the allegations of the foregoing paragraphs as if fully set forth herein.

368. Each of the Plaintiffs is a "person" within the meaning of *N.J.S.A.* 2C:41-1(b).

369. Each of the Defendants is a "person" within the meaning of *N.J.S.A.* 2C:41-1(b).

370. The United-Multiplan Enterprise is an "enterprise" within the meaning of *N.J.S.A.* 2C:41-1(c).

371. The United-Multiplan Enterprise is engaged in activities which affect trade or commerce for purposes of *N.J.S.A.* 2C:41-2(c).

372. Defendants conspired with each other, within the meaning of *N.J.S.A.* 2C:41-2(d), to violate the provisions of *N.J.S.A.* 2C:41-2(c).

373. Specifically, United and Multiplan each agreed and intended, or adopted the goal of furthering or facilitating, the following endeavor: to conduct or participate, directly or indirectly, in the management and operation of the affairs of the United-Multiplan enterprise, through a pattern of racketeering activity in violation of *N.J.S.A.* 2C:41-2(c).

374. As set forth above, Defendants have been and continue to be part of an association-in-fact enterprise within the meaning of N.J. Stat. Ann. § 2C:41-1(c).

375. Defendants have agreed to a conspiracy that has as its objective a substantive violation of the RICO Act.

376. Each Defendant has agreed to participate directly or indirectly in the conduct of the affairs of the Enterprise by agreeing to commit, or aid other members of the conspiracy to commit, at least two predicate acts.

377. The Defendants acted knowingly and purposely with knowledge of the unlawful objective of the conspiracy and with the intent to further its unlawful objective.

378. As a direct and proximate result of Defendants' violations of N.J. Stat. Ann. § 2C:41-2(d), the Plaintiffs have been injured in their businesses and property, suffering financial losses.

379. The pattern of racketeering activity under *N.J.S.A.* 2C:41-1(a) and (d), described more fully above, includes multiple and repeated acts of theft by unlawful taking in violation of *N.J.S.A.* 2C:20-3(a) and (b), theft by deception in violation of *N.J.S.A.* 2C:20-4, theft of services in violation of *N.J.S.A.* 2C:20-8, and multiple acts of mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, which are included within the definition of "racketeering activity" under 18 U.S.C. § 1961(1)(B) and are expressly incorporated into NJ RICO's definition of "racketeering activity" under N.*J.S.A.* 2C:41-1(a)(2).

380. For example, as set forth more fully above, United has conspired with Multiplan to engage in acts of theft by unlawful taking, theft by deception, theft of services, and schemes to defraud Plaintiffs, United Subscribers, and members of the public into believing that the Data iSight methodology is "transparent," "defensible," and "market tested," and results in a "fair price using amount generally accepted by providers a full payment for services, rather than what it really is -- an effort to paper over patently unreasonable and unlawful health care reimbursement payments.

381. In addition, as described more fully above, Defendants have used the wires and mails in furtherance of their schemes to defraud, and they have conspired to engage in these schemes for the express purpose of depriving Plaintiffs of money and other property.

382. As a direct result of United's violations of *N.J.S.A.* 2C:41-2(d) by conspiring to violate *N.J.S.A.* 2C:41-2(c), Plaintiffs have suffered substantial and direct injury to their businesses or property within the meaning of *N.J.S.A.* 2C:41-4(c), including, but not limited to: (i) lost revenue from United's intentional underpayment of claims submitted for reimbursement for emergent medically necessary treatment of United Subscribers; (ii) lost revenue from Defendants' intentional diversion of healthcare reimbursements that are otherwise due and payable to Plaintiffs;

(iii) lost revenue from patients being dissuaded from seeking healthcare from Plaintiffs; and (iv) the costs in time, person-hours, and other administrative expense incurred because of Defendants' unlawful conduct.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for relief and judgment against all Defendants, jointly and severally, as follows:

1. Payment for the reasonable value of services rendered by Plaintiffs to United Subscribers on Plaintiffs' *Quantum Meruit* claim;

2. Compensatory and consequential damages against Multiplan resulting from its tortious interference with Plaintiffs' prospective economic advantage, as set forth above and to be further established at trial;

3. Treble damages against all Defendants as to Plaintiffs' NJ RICO claims pursuant to *N.J.S.A.* 2C:41-4(c);

4. Statutory interest in the amount of 12% per annum under HCAPPA;

5. The costs of this suit (including reasonable attorneys' fees) and pre-judgment and post-judgment interest;

6. The imposition of reasonable restrictions on the future activities of the Defendants, including but not limited to prohibiting them from engaging in the same type of endeavor as the enterprise alleged herein;

7. Ordering the dissolution of the United-Multiplan Enterprise;

8. Entering a cease and desist order which specifies the acts or conduct which is to be discontinued;

9. Order the restitution monies and property unlawfully obtained or retained by the Defendants;

10. Exemplary and/or punitive damages under the New Jersey Punitive Damages Act, *N.J.S.A.* 2A:15-5.9 to -5.12 for Defendants' intentional, willful, wanton, outrageous or malicious misconduct, characterized by their evil or rancorous motive, ill will and intent to injure Plaintiffs; or Defendants' gross recklessness or gross negligence evincing a conscious disregard for Plaintiffs' rights.

11. Such other and further relief as the Court deems just and proper.

JURY DEMAND

Plaintiffs hereby demand a trial by jury for each and every one of the foregoing claims so triable.

DEMAND FOR PUNITIVE DAMAGES

Pursuant to *N.J.S.A.* 2A:15-5.11, Plaintiffs hereby demand punitive damages on all of their claims against Defendants for which punitive damages are available.

DESIGNATION OF TRIAL COUNSEL

Plaintiffs designate Anthony P. La Rocco, Esq., as trial counsel in this matter.

Respectfully submitted,

K&L GATES LLP

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By: */s/ Anthony P. La Rocco, Esq.* _____
Anthony P. La Rocco, Esq.

Dated: November 2, 2020

R. 1:38-7(c) CERTIFICATION

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with Rule 1:38-7(b).

Respectfully submitted,

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Attorneys for Plaintiffs

By: */s/ Anthony P. La Rocco, Esq.* _____
Anthony P. La Rocco, Esq.

Dated: November 2, 2020

***R.* 4:5-1 CERTIFICATION**

I certify that the matter in controversy is not the subject matter of any other action pending in any court or of any pending arbitration or administrative proceeding. I further certify that no other non-party should be joined in this action pursuant to R. 4:28, and no other non-party is subject to joinder pursuant to R. 4:29-1(b).

Respectfully submitted,

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By: */s/ Anthony P. La Rocco, Esq.* _____
Anthony P. La Rocco, Esq.

Dated: November 2, 2020

EXHIBIT 4

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

EMERGENCY DEPARTMENT PHYSICIAN, P.C. AND EMERGENCY PROFESSIONALS OF MICHIGAN, P.C., Plaintiffs, v. UNITEDHEALTHCARE, INC., UNITEDHEALTHCARE INSURANCE COMPANY AND UNITED HEALTHCARE SERVICES, INC., Defendants.	Case No. 19-cv-12052 Hon. Stephen J. Murphy, III Mag. Mona K. Majzoub Civil Action

FIRST AMENDED COMPLAINT

Plaintiffs Emergency Department Physicians, P.C. and Emergency Professionals of Michigan, P.C. ("Plaintiffs" or the "Emergency Physicians"), by and through their counsel, Miller, Canfield, Paddock and Stone, P.L.C., state as follows for their First Amended Complaint against Defendants UnitedHealthcare, Inc., UnitedHealthcare Insurance Company and United HealthCare Services, Inc. ("Defendants" or the "Insurance Companies"):

INTRODUCTION

1. The Emergency Physicians are groups of hospital-based physicians who provide life-saving emergency care to thousands of citizens of Michigan, but have not been properly reimbursed for providing these services. Unlike most other physicians, these emergency department physicians have no ability to choose the patients that they treat. By necessity and under compulsion of federal law, the Emergency Physicians are obligated to treat all patients who require emergency services. Given the critical need for these services, health insurers are required to compensate emergency medicine physicians at fair market value, irrespective of whether the doctors are part of the insurers' preferred provider networks. Reasonable compensation is essential to permit the Emergency Physicians to continue to provide high-quality emergency services, and to attract and retain physicians who are willing to work long hours under great stress in order to perform life-saving medical services in otherwise underserved areas of Michigan.

2. The Insurance Companies have historically compensated the Emergency Physicians at more reasonable rates. In recent years, however, the Insurance Companies have slashed the rates at which they pay the Emergency Physicians for the emergency services they must provide. More specifically, the Insurance Companies are paying some of the Emergency Physicians' claims at rates that are substantially below what they historically paid for the same services,

and significantly below the rates at which the Insurance Companies continue to pay other similar claims.

3. There is no legitimate basis for the drastic price cut the Insurance Companies have recently imposed. Instead, on information and belief, the Insurance Companies' underpayment of the Emergency Physicians' reimbursement claims is part of a deliberate, systematic, and ongoing scheme to save the Insurance Companies money and increase profits at the expense of the Emergency Physicians and their patients. This tactic will ultimately have the unfortunate effect of depriving communities like Detroit of Emergency Physicians who are willing to provide all residents with adequate emergency medical care, regardless of their ability to pay.

4. This action does not involve a dispute over the Emergency Physicians' right to payment for the services they provided to patients covered under the commercial health plans operated by the Insurance Companies (the "Health Plans"). Nor does this action seek payment for claims arising out of the denial of benefits under any of the Insurance Companies' Health Plans, or the denial of coverage for any services performed for patients. Indeed, the Insurance Companies have already determined that these services are "covered services" and agreed to pay the claims at issue in this action. Thus, the claims are "clean" under the meaning of MCL 500.2006(14)(a) ("Clean Claims").

5. Instead, the issue in this matter is that the Insurance Companies are woefully underpaying these claims for covered services at an amount that is patently below the required reasonable value of the services provided by the Emergency Physicians.

6. Furthermore, all the claims at issue in this action involve services that the Emergency Physicians provided to Patients[1] as nonparticipating providers – i.e., as providers who are not under contract with the Insurance Companies. Thus, because the Emergency Physicians are not receiving the certainty that comes from a contractual relationship, they have not agreed to accept from the Insurance Companies any reduced reimbursement for emergency medicine services. Nor have they agreed to be bound by the Insurance Companies' unilaterally -set reimbursement policies or rate schedules.

7. As such, the only reimbursement claims within the scope of this action are those non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products) that were adjudicated as covered and allowed as payable by the Insurance Companies for services rendered on or after January 1, 2016, and were reimbursed at rates below the reasonable

[1] Throughout this Complaint, the term "Patients" is intended to refer to those beneficiaries who are covered under Health Plans and were treated by the Emergency Physicians for covered services for which the Emergency Physicians were not properly reimbursed.

value of the services rendered as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to as the "Non-Participating Claims."[2]

8. For the Non-Participating Claims, the Insurance Companies have unilaterally and arbitrarily set the reimbursement rates paid to the Emergency Physicians for their services at levels that are significantly below the Emergency Physicians' billed charges and below fair market value for the services rendered.

9. As a result of their policy and practices, the Insurance Companies have failed to properly reimburse the Emergency Physicians for the critical services they have provided to Patients. In particular, the Insurance Companies have failed to properly reimburse Emergency Professionals of Michigan, P.C. for services performed on or after January 1, 2016, and they have failed to properly reimburse Emergency Department Physicians, P.C. for services performed on or after October 15, 2017. At least $2.9 million is presently due and owing to the Emergency Physicians for services already performed, and this amount is growing

[2] Neither Medicare Advantage nor managed Medicaid products are at issue in this action. This lawsuit and the claims asserted herein do not relate to or involve the Emergency Physicians' right to payment, but rather the applicable rate of payment the Emergency Physicians are entitled to receive for their services. This action does not include any claims in which benefits were denied nor does it challenge any coverage determinations under any health plan that may be subject to the Employee Retirement Income Security Act of 1974. Nor does this lawsuit involve any claim by the Emergency Physicians for benefits under a health plan based on an assignment of benefits from any member of the Insurance Companies.

with each passing day as the Emergency Physicians continue to provide much-needed emergency care for patients in Southeastern Michigan, including Wayne County and the City of Detroit.

PARTIES

10. Plaintiff Emergency Department Physicians, P.C. is a Michigan professional services corporation that provides emergency medicine services to patients at various hospitals in southeastern Michigan, including Wayne County.

11. Plaintiff Emergency Professionals of Michigan, P.C. is a Michigan professional services corporation that provides emergency medicine services to patients at various hospitals in southeastern Michigan, including Wayne County.

12. Defendant UnitedHealthcare, Inc. is a Delaware Corporation with its principal place of business in Edina, Minnesota. UnitedHealthcare, Inc. is responsible for paying for certain of the emergency medical services at issue in this action. On information and belief, UnitedHealthcare, Inc. is a health insurance company doing business in Michigan.

13. Defendant UnitedHealthcare Insurance Company is a Connecticut corporation with its principal place of business in Hartford, Connecticut. UnitedHealthcare Insurance Company is responsible for paying for certain of the emergency medical services at issue in this action. On information and belief,

UnitedHealthcare Insurance Company is a health insurance company doing business in Michigan.

14. Defendant United HealthCare Services, Inc. is a Minnesota corporation with its principal place of business in Minnetonka, Minnesota. United HealthCare Services, Inc. is responsible for paying for certain of the emergency medical services at issue in this lawsuit. On information and belief, United HealthCare Services, Inc. is a health insurance company doing business in Michigan.

JURISDICTION AND VENUE

15. The amount in controversy exceeds $25,000, exclusive of interest, costs, and attorney fees.

16. In addition to seeking damages, the Emergency Physicians seek equitable and declaratory relief over which the Court has subject matter jurisdiction.

17. Jurisdiction and venue are proper pursuant to MCL 600.711, MCL 600.715, and MCL 600.16211.

18. An actual controversy exists between the parties and requires a declaratory judgment to determine the parties' respective rights and legal relations. Therefore declaratory judgment jurisdiction is proper in this Court pursuant to MCR 2.605.

19. This case meets the statutory requirements for a business dispute as defined in MCL 600.8031 and should, therefore, be assigned to the Business Court.

FACTS

The Emergency Physicians Provide Necessary Emergency Care

20. The Emergency Physicians are emergency medicine physicians who staff emergency departments 24 hours a day, 7 days a week. The Emergency Physicians provide emergency department coverage for at least 10 different hospitals throughout the St. John (recently renamed "Ascension") and Oakwood (recently renamed "Beaumont") Health Systems, which have sites in Wayne County.

21. By deciding to enter the field of emergency medicine, the Emergency Physicians have committed to providing emergency medical care to all patients, regardless of insurance coverage or ability to pay, including patients with insurance coverage that is issued or underwritten by the Insurance Companies.

22. Under the federal Emergency Medical Treatment Act ("EMTALA"), all emergency room physicians must evaluate, stabilize, and treat all patients, regardless of their insurance status or ability to pay. *See* EMTALA, 42 U.S.C. § 1395dd. Hospitals are subject to civil liability for a violation of EMTALA's mandates. *See id*. § 1395dd(d)(2)(A), and "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital"

and negligently violates EMTALA is subject to civil monetary penalties of up to $50,000.00 per violation. *Id*. § 1395dd(d)(1)(B).

23. EMTALA is one of the central sources of patient protection in the United States healthcare system. But, EMTALA does not imply that emergency medicine physicians must provide services for free. Rather, given the mandate that emergency medicine physicians must perform these services, there is a corresponding and implied mandate that whenever (and wherever) possible, these physicians must be paid the reasonable value of the services they have rendered. On average, given the fact that not all patients are insured, an emergency medicine physician provides almost $140,000 of charity care every year, and a third of emergency physicians provide more than 30 hours of charity care each week. Almost 1 in 5 emergency patients has no ability to pay. This is all the more reason why insurers who have actually agreed to provide coverage for emergency room services are required to pay for the reasonable value of the services rendered by a group of physicians who have no choice but to provide emergency medical services to any person who needs them.

24. Specifically, for the Non-Participating Claims, the Michigan Prompt Pay Act, MCL 500.2006, requires the Insurance Companies to promptly pay the Emergency Physicians' Clean Claims in full within forty-five (45) days of receipt.

25. Michigan common law additionally requires the Insurance Companies to reimburse the Emergency Physicians for the Non-Participating Claims at rates, at a minimum, equivalent to the fair market value of the Emergency Physicians' services.

26. These guarantees are vital to keeping trained emergency medicine specialists in the field, and ensuring that high-quality emergency medicine services are available to Michigan residents, including those in Detroit and other parts of Wayne County. These guarantees ensure that emergency medicine physicians are properly educated and receive continued training. They incentivize emergency medicine physicians to move to underserved areas in order to provide emergency medical services across the state.

27. Because there is no contract between the Insurance Companies and any of the Emergency Physicians for the Non-Participating Claims, the Emergency Physicians are designated as "non-participating" or "out-of-network" providers. The Emergency Physicians have not agreed to accept any form of discounted rate from the Insurance Companies, or to be bound by the Insurance Companies' payment policies or rate schedules with respect to the emergency medical care provided to Patients.

28. The Non-Participating Claims seek reimbursement for services that the Emergency Physicians provided to thousands of Patients when the Patients were in dire need.

29. The Emergency Physicians have rendered a wide array of emergency - in some instances, life-saving - services to Patients enrolled in the Insurance Companies' Health Plans, treating conditions such as cardiac arrest, gunshot wounds, broken limbs, life-threatening allergic reactions, and obstetrical distress.

The Insurance Companies Underpaid the Emergency Physicians for Emergency Medicine Services

30. The Insurance Companies are national managed care organizations that underwrite, operate and administer Health Plans, including HMOs, in Michigan.

31. In exchange for premiums and/or fees or other compensation, the Insurance Companies pay for health care services rendered to their members, including the emergency medical services the Emergency Physicians have provided and continue to provide to Patients. The Insurance Companies are responsible for ensuring that their members receive emergency medical services at any time of the day without the need to obtain those services from participating providers. Satisfying this core obligation for Patients is a linchpin of the health benefits that Insurance Companies provide to Patients. Indeed, on information and belief, the Insurance Companies market their insurance products as providing for

such coverage, inducing members to purchase their products and rely on their representations.

32. In spite of the essential role emergency medicine physicians like the Emergency Physicians play in the United States healthcare system, the Insurance Companies have refused to offer sustainable provider contracts to the Emergency Physicians.

33. In recent years, the Insurance Companies have continuously and arbitrarily decreased their reimbursements to the Emergency Physicians for valuable and necessary emergency services provided to Patients. While the Insurance Companies underpaid only 5% of the Emergency Physicians' Clean Claims in 2016, the number of underpaid Clean Claims jumped to almost 25% in 2017. Beginning in 2019, the Insurance Companies were systematically underpaying close to 75% of the Emergency Physicians' Clean Claims.

34. The Insurance Companies' reimbursements to the Emergency Physicians have been materially below (1) the Emergency Physicians' billed charges; (2) the rates other third-party payors have agreed to pay the Emergency Physicians for emergency medicine services; (3) the rates the Insurance Companies historically paid the Emergency Physicians for providing emergency medicine services to Patients; and (4) the rates the Insurance Companies pay to other emergency physicians for providing the same services in the same geographic area.

35. For example, in at least one instance, the Insurance Companies have arbitrarily reimbursed the Emergency Physicians for emergency services with the current procedural terminology ("CPT") codes 99283 and 99284 using a Medicare reimbursement rate that was nearly half of what they used to reimburse a different group of emergency physicians who provided identically-coded services in the same geographic area in the same calendar year.

36. This disparity in payments is due, in part, to the fact that the Insurance Companies are reimbursing Emergency Physicians for services provided to members of their fully-underwritten plans at significantly lower rates than they are for services provided to members of employer-funded plans (for which the Insurance Companies only provide administrative services). Put more succinctly, when their own money is at stake, the Insurance Companies pay a substantially lower reimbursement rate.

37. The Emergency Physicians have not agreed to accept payment from the Insurance Companies for the emergency medicine services provided to Patients at a rate below their billed charges for Clean Claims, or to be bound by the Insurance Companies' reimbursement policies or rate schedules with respect to any of the Non-Participating Claims.

38. All of the Non-Participating Claims at issue in this lawsuit have been adjudicated by the Insurance Companies and determined to be medically

necessary, covered services for which the Insurance Companies are obligated to pay on behalf of the Emergency Physicians.

39. The Insurance Companies have refused to negotiate with the Emergency Physicians to reach a mutually agreeable rate of payment for the Emergency Physicians' services, and are therefore obligated to pay the Emergency Physicians' Clean Claims in full pursuant to MCL 500.2006.

40. By assuming responsibility for paying for the emergency medical services provided to Patients, the Insurance Companies are obligated to reimburse the Emergency Physicians in accordance with the standards established by Michigan law – including the standard requiring the Insurance Companies to reimburse the Emergency Physicians for the reasonable or fair market value of their services.

41. If the Emergency Physicians are not paid sufficient compensation to staff emergency rooms, local communities will ultimately suffer from not having enough providers to keep emergency departments in operation.

42. The Emergency Physicians bring this action to collect damages due for reimbursement amounts that the Insurance Companies have arbitrarily withheld from the Emergency Physicians on the Non-Participating Claims, as well as a declaration that the Insurance Companies must prospectively pay the Emergency

Physicians for the reasonable value of their services at a going-forward rate to be determined by the trier of fact.

COUNT I
Violation of Michigan Prompt Pay Act (MCL 500.2006)

43. Plaintiffs re-allege and restate paragraphs 1 through 42 above as if they were fully set forth herein.

44. From January 1, 2016 to the present, and continuing, the Emergency Physicians have undertaken to provide emergency medicine services to Patients, and the Insurance Companies have undertaken to pay for such services provided to Patients.

45. The Emergency Physicians have submitted to the Insurance Companies Non-Participating Claims seeking payment for emergency medicine services provided to Patients from January 1, 2016-present, and continuing.

46. Each of the Emergency Physicians' Non-Participating Claims (i) identifies both the health facility where the services where provided and the health professional who provided them, including identifying numbers, sufficiently to verify affiliation status; (ii) sufficiently identifies the patient and health plan subscriber; (iii) lists the date and place of service; (iv) is a claim for covered services provided to a Patient; (v) substantiates the medical necessity and appropriateness of the service provided; (vi) identifies the service rendered using a

generally accepted system of procedure or service coding; and (vii) includes all documentation necessary for Defendant to adjudicate the claim.

47. The Insurance Companies did not notify the Emergency Physicians of any reasons that prevented the Non-Participating Claims from being Clean Claims. The Emergency Physicians' Non-Participating Claims are therefore Clean Claims.

48. The Insurance Companies failed to timely pay the Emergency Physicians' charges on the submitted Clean Claims in full and within forty-five (45) days of receipt of the Clean Claims. Instead, the Insurance Companies unilaterally and arbitrarily paid the Emergency Physicians amounts far below the amounts billed, leaving a substantial balance due on each of the Clean Claims submitted for services rendered on or after January 1, 2016, long after that timely payment deadline, in violation of MCL 500.2006(8)(a).

49. The Insurance Companies have communicated to the Emergency Physicians their intent to continue paying the Emergency Physicians less than their billed charges, and thus to continue violating MCL 500.2006(8)(a) by failing to pay the Emergency Physicians' Clean Claims within forty-five (45) days of receipt.

50. As a result of the Insurance Companies' continual violations of MCL 500.2006(8)(a), the Emergency Physicians are entitled to an award of damages in

the amount of their billed charges for all Clean Claims, less amounts paid, plus simple interest at the statutory rate of 12% per annum.

COUNT II
Breach of Implied-in-Fact Contract

51. Plaintiffs re-allege and restate paragraphs 1 through 50 above as if they were fully set forth herein.

52. From January 1, 2016 to the present, and continuing, the Emergency Physicians have undertaken to provide emergency medicine services to Patients, and the Insurance Companies have undertaken to pay for such services provided to Patients.

53. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided to Patients, the parties implicitly agreed, and the Emergency Physicians had a reasonable expectation and understanding, that the Insurance Companies would reimburse the Emergency Physicians for Non-Participating Claims at a rate reflecting the reasonable value of the Emergency Physicians' services in the marketplace. This expectation is underscored by the fact that the Insurance Companies have previously paid (and in some cases are still paying) the Emergency Physicians for Non-Participating Claims at a rate that reflects the reasonable value of the services in the marketplace.

54. The Insurance Companies breached their agreement with the Emergency Physicians by failing to pay the fair market value of the emergency medicine services the Emergency Physicians have provided, and continue to provide, to Patients for services rendered on or after January 1, 2016.

55. At all material times, the Insurance Companies knew that the Emergency Physicians had not agreed to accept payment for their emergency medicine services at a rate below the reasonable value of the Plaintiffs' services in the marketplace, nor had the Emergency Physicians agreed to be bound by the Insurance Companies' reimbursement policies or rate schedules.

56. The Emergency Physicians have performed all obligations under their implied contract with the Insurance Companies concerning emergency medicine services to be performed for Patients.

57. At all material times, all conditions precedent have occurred that were necessary for the Insurance Companies to perform their obligation to pay the Emergency Physicians on the Non-Participating Claims at the reasonable value of the Emergency Physicians' emergency medicine services provided to Patients.

58. As a result of the Insurance Companies' breach of the implied contract to pay the Emergency Physicians on the Non-Participating Claims at the reasonable value for the Emergency Physicians' services in the marketplace, the

Emergency Physicians have suffered injury and they are entitled to monetary damages from the Insurance Companies to compensate for that injury.

59. The Emergency Physicians seek an award of damages, in an amount that will continue to accrue through the date of trial as a result of the Insurance Companies' continuing breach of contract, equal to the difference between the reasonable value of the services the Emergency Physicians have provided, and continue to provide, to Patients and the amount the Insurance Companies actually paid for those services, plus interest, as well as the time-value of the money that the Insurance Companies arbitrarily withheld from the Emergency Physicians.

COUNT III
Unjust Enrichment/Breach of Implied-in-Law Contract

60. Plaintiffs re-allege and restate paragraphs 1 through 59 above as if they were fully set forth herein.

61. The Insurance Companies have agreed to make available emergency medicine services to their members, including Patients. The Emergency Physicians conferred a benefit upon the Insurance Companies by meeting the Companies' obligation to their Patients and providing valuable emergency medicine services to Patients, all while understanding that the Insurance Companies committed to the Emergency Physicians that they would pay for those services at fair market value. The Insurance Companies derive a benefit from the

Emergency Physicians' provision of these services because they are relieved of the obligation to make emergency medicine services available to their members.

62. There is no dispute that the emergency medicine services provided by the Emergency Physicians in this case were covered services because the Insurance Companies adjudicated and paid for those services as covered, albeit at an amount less than the reasonable value of the services. The Insurance Companies have led both Patients and the Emergency Physicians to believe that they would pay for the services rendered by the Emergency Physicians to Patients.

63. The Insurance Companies voluntarily accepted, retained, and enjoyed, and continue to accept, retain, and enjoy, the benefits conferred upon them by the Emergency Physicians, knowing that the Emergency Physicians expect to be paid the reasonable value of their services.

64. The Insurance Companies have failed to pay the reasonable value of the benefit conferred upon them by the Emergency Physicians' performance of the emergency medicine services that the Insurance Companies agree to make available to the Patients and/or that underlie the Non-Participating Claims.

65. By underpaying the Emergency Physicians on the Non-Participating Claims, the Insurance Companies have been unjustly and inequitably enriched at the Emergency Physicians' expense, and are unjustly retaining the difference between the reasonable value of the services rendered to Patients and the arbitrary

reimbursement amount paid to the Emergency Physicians. It is unjust for the Insurance Companies to retain the benefit they received without paying the full amount of the value of that benefit – i.e., without paying the Emergency Physicians quantum meruit or the reasonable value of the emergency medicine services the Emergency Physicians provided to Patients.

66. The Emergency Physicians seek damages, in an amount that will continue to accrue through the date of trial, equal to the difference between the reasonable value in the marketplace of the emergency medicine services the Emergency Physicians provided to Patients and the amount the Insurance Companies paid for those services, plus interest, as well as the time-value of the money that the Insurance Companies arbitrarily withheld from the Emergency Physicians.

COUNT IV
Declaratory Relief Pursuant to MCR 2.605

67. Plaintiffs re-allege and restate paragraphs 1 through 66 above as if they were fully set forth herein.

68. The Emergency Physicians seek a declaratory judgment pursuant to MCR 2.605.

69. There is an actual controversy between the parties concerning the amount the Insurance Companies must pay to the Emergency Physicians to compensate them for emergency medicine services provided to Patients. A

declaratory judgment is necessary to resolve that controversy and avoid further ongoing and future harm to the Emergency Physicians.

70. All interested parties are presently before the Court.

71. A judicial declaration is necessary and appropriate to clarify the parties' respective rights and obligations.

72. The Emergency Physicians are entitled to a declaration that the Insurance Companies are obligated to pay the Emergency Physicians' charges in full, and within forty-five days from the submission of all Clean Claims covering those services provided to Patients, pursuant to MCL 500.2006.

73. Alternatively, the Emergency Physicians are entitled to a declaration that the Insurance Companies are obligated to pay the Emergency Physicians the reasonable value of the emergency medicine services provided to Patients (including the Non-Participating Claims already submitted to the Insurance Companies for payment), as well as the time-value of the money that the Insurance Companies have arbitrarily withheld from the Emergency Physicians.

74. The Emergency Physicians are also entitled to a declaration that the Insurance Companies must pay the Emergency Physicians prospectively for Non-Participating Claims in an amount that represents the reasonable value of the services the Emergency Physicians provide.

WHEREFORE, the Emergency Physicians pray that this Honorable Court:

A. Enter judgment against the Insurance Companies and for the Emergency Physicians on Count I in amounts representing the difference between the full amounts of Clean Claims submitted to the Insurance Companies for emergency medicine services the Emergency Physicians provided to Patients for services rendered on or after January 1, 2016, and the amounts arbitrarily and unilaterally paid by the Insurance Companies on those Clean Claims;

B. Alternatively, enter judgment against the Insurance Companies and for the Emergency Physicians on Counts II and III in amounts representing the difference between the amounts the Insurance Companies arbitrarily and unilaterally paid to the Emergency Physicians for emergency medicine services provided to Patients on or after January 1, 2016, and the reasonable value of those services in the market, as well as the time-value of the money that the Insurance Companies arbitrarily withheld from the Emergency Physicians, as determined at trial;

C. Decree that the Insurance Companies must pay the Emergency Physicians for all Clean Claims submitted for emergency medicine services to be provided to Patients in full and timely consistent with MCL 500.2006;

D. Alternatively, decree that the Insurance Companies must pay the Emergency Physicians prospectively for the emergency medical services that the

Insurance Companies render to the Insurance Companies' members in an amount that represents the reasonable value of the Emergency Physicians' services;

E. Award the Emergency Physicians statutory interest of 12% per annum on all amounts found due under Count I, or, alternatively, at the applicable prejudgment and post-judgment interest rates established by Michigan law on all amounts found due under Counts II and III;

F. Award the Emergency Physicians their costs associated with this litigation; and

G. Award any such further relief as this Court deems just and proper.

Respectfully Submitted,

By: /s/ *Sonal Hope Mithani*
Sonal Hope Mithani (P51984)
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Attorneys for Plaintiffs

Dated: June 5, 2020

JURY DEMAND

Plaintiffs demand a trial by jury of all issues so triable.

Respectfully Submitted,

By: /s/ *Sonal Hope Mithani*
Sonal Hope Mithani (P51984)
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Attorneys for Plaintiffs

Dated: June 5, 2020

CERTIFICATE OF SERVICE

I hereby certify that on June 5, 2020, I electronically filed the foregoing papers with the Clerk of the Court using the ECF system which will send notification of such filing to all ECF filers of record.

By: /s/ *Sonal Hope Mithani*

Dated: June 5, 2020

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EXHIBIT 5

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

EMERGENCY CARE SERVICES OF PENNSYLVANIA, P.C. AND EMERGENCY PHYSICIAN ASSOCIATES OF PENNSYLVANIA, P.C.,

Plaintiffs,

Case No.

v.

UNITEDHEALTH GROUP, INC.,
UNITED HEALTHCARE SERVICES, INC.,
UNITEDHEALTHCARE, INC.
UNITEDHEALTH NETWORKS, INC.
UNITEDHEALTHCARE INSURANCE COMPANY,
UNITEDHEALTHCARE OF NEW ENGLAND, INC.
UNITEDHEALTHCARE OF PENNSYLVANIA, INC.,

Defendants.

COMPLAINT

AND NOW, Plaintiffs Emergency Care Services of Pennsylvania, P.C., and Emergency Physician Associates of Pennsylvania, P.C., by and through their undersigned counsel, bring this action against Defendants UnitedHealth Group, Inc., United HealthCare Services, Inc., UnitedHealthCare, Inc., UnitedHealth Networks, Inc., UnitedHealthCare Insurance Company, UnitedHealthCare of New England, Inc., and UnitedHealthCare of Pennsylvania, Inc., and in support thereof, make the

following averments based upon current knowledge and/or information and reasonable belief.

1. Plaintiffs are local hospital-based physician practices who provide emergency medical care to all patients, regardless of insurance coverage or ability to pay.

2. While Plaintiffs are treating patients 24 hours per day, 365 days per year, Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their payment rates to defraud Plaintiffs and deny them reasonable payment for their services, which the law requires.

3. Defendants have reaped millions of dollars from this illegal, unfair, and fraudulent conduct, and stand to reap millions more if their conduct is not stopped.

PARTIES

4. Plaintiff Emergency Care Services of Pennsylvania, P.C. is a professional corporation that provides physicians and advance practice nurses who staff hospital emergency departments in Pennsylvania. It is organized under the laws of the Commonwealth of Pennsylvania with its principal place of business at 1201 Langhorne-Newtown Road, Langhorne, PA 19047.

5. Plaintiff Emergency Physician Associates of Pennsylvania, P.C. is a professional corporation that provides physicians and advance practice nurses to staff hospital emergency departments in Pennsylvania. It is organized under the laws

of the Commonwealth of Pennsylvania with its principal place of business at 2500 Bernville Road, Reading PA 19605. Unless necessary to distinguish between them, Plaintiffs Emergency Physician Associates of Pennsylvania and Emergency Care Services of Pennsylvania, will be collectively referred to as "Plaintiffs."

6. Defendant UnitedHealth Group, Inc. is the largest single health carrier in the United States and is a corporation organized under the laws of the State of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343. Defendant UnitedHealth Group, Inc. is a publicly-traded holding company that is dependent upon monies (including dividends and administrative expense reimbursements) from its subsidiaries, which include Defendant United Healthcare Services, Inc.

7. Defendant United HealthCare Services, Inc. is a corporation organized under the laws of the State of Minnesota with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343. United HealthCare Services, Inc. is one of the entities that pay claims generated by Plaintiffs for services provided to members of Defendants' health insurance products.

8. Defendant UnitedHealthCare, Inc. is a corporation organized under the laws of the State of Delaware with its principal place of business at 9800 Health Care Lane, Minnetonka, Minnesota 55343. It is a subsidiary of Defendant United HealthCare Services, Inc., and provides administrative services to certain health

insurance plans.

9. Defendant UnitedHealth Networks, Inc. is a corporation organized under the laws of the State of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343. It is also a subsidiary of Defendant United HealthCare Services, Inc. and processes claims for certain insurance plans.

10. Defendant UnitedHealthCare Insurance Company is a corporation organized and existing under the laws of the State of Connecticut with its principal place of business at 185 Asylum Avenue, Hartford, CT 06103 and is authorized to provide health insurance in Pennsylvania.

11. Defendant UnitedHealthCare of New England, Inc. is a corporation organized and existing under the laws of the State of Rhode Island with its principal place of business at 475 Kilvert Street, Suite 310, Warwick, Rhode Island 02886, and is an authorized health maintenance organization ("HMO") in Pennsylvania.

12. Defendant UnitedHealthCare of Pennsylvania, Inc. is a corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business at 1388 Beulah Road, Building 801, 4th Floor, Pittsburgh, PA 15235, and is an authorized HMO in Pennsylvania.

13. Defendants UnitedHealthCare Insurance Company, UnitedHealthCare of New England, Inc., and UnitedHealthCare of Pennsylvania, Inc. provide, operate, and/or administer health insurance plans in Pennsylvania.

JURISDICTION AND VENUE

14. This Court has jurisdiction over the federal claims for relief alleged in Counts I, II, and V pursuant to 18 U.S.C. §§ 1961, 1962, 1964 and/or 28 U.S.C. § 1331.

15. This Court has the authority to grant declaratory relief under 28 U.S.C. §§ 2201 and 2202 because there is an actual controversy between Plaintiffs and Defendants.

16. This Court has supplemental jurisdiction pursuant to 28 U.S.C. § 1367 and the doctrine of pendent jurisdiction over the state law claims asserted herein.

17. Venue is proper in this District pursuant to 18 U.S.C. § 1965 and 28 U.S.C. § 1391(b)(2) because a substantial part of the events giving rise to the claims asserted herein occurred in this District and because Defendants conduct business in this District.

FACTUAL ALLEGATIONS

18. Plaintiffs are professional emergency medical group practices that staff hospital emergency departments and treat emergency room patients at thirteen Pennsylvania hospitals.

19. Plaintiffs provide emergency, life-saving care to all who walk through the hospitals' doors, regardless of insurance status.

20. Indeed, federal law requires emergency medical providers, including

Plaintiffs, to provide treatment to patients who present themselves at hospital emergency departments.

21. More specifically, under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. §§ 1395dd(a)-(b), (d), (h), hospitals and the physicians who staff their emergency departments have a duty to screen and stabilize any individual who comes to the emergency department with an emergency medical condition, without inquiry into the individual's method of payment or insurance status. 42 U.S.C. §§ 1395(a)-(b), (h).

22. The emergency services at issue in this litigation include treatment for cardiac arrest, broken bones, burns, shock, and distress. These services are necessary and integral to the health and welfare of the communities in which Plaintiffs practice.

23. Because the law requires that emergency services be provided without regard to insurance status, the law protects emergency service providers from predatory conduct by payors, including the kind of conduct that Defendants have engaged in here.

24. If the law did not do so, emergency service providers would be at the mercy of insurance plans – forced to accept payment at any rate dictated by insurers under threat of receiving no payment, or forced to transfer the financial burden of care entirely onto patients.

25. But providers are protected by law, which requires that, for the claims at issue in this case, the insurer must reimburse Plaintiffs at a reasonable rate.

26. The hospitals where Plaintiffs provide emergency medical services routinely secure signed consents for treatment and assignments of benefits from each patient or the patient's authorized representative.

27. These assignments of benefits state that the patient assigns to the providers of the medical service all rights to benefits under her insurance, including the right to claims and judgments.

The Relationship Between Plaintiffs and Defendants

28. Defendants provide health insurance to their members (*i.e.*, their insureds).

29. In exchange for premiums, fees, and/or other compensation, Defendants assume responsibility for paying for health care services rendered to members covered by their health plans.

30. In addition, Defendants provide services such as building participating provider networks and negotiating rates with providers who join their networks.

31. Defendants offer a range of health insurance plans. Plans generally fall into one of two categories.

32. "Fully Funded" plans are plans in which Defendants collect premiums directly from their members (or from third parties on behalf of their members) and

pay claims directly from the pool of funds created by those premiums.

33. "Employer Funded" plans are plans in which Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

34. Defendants provide coverage for emergency medical services under both types of plans.

35. They are contractually and legally responsible for ensuring that their members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

36. Defendants highlight such coverage in marketing their insurance products, inducing members to purchase their products and rely upon those representations.

37. For example, on the "patient protections" section of the UnitedHealthcare website, uhc.com, Defendants state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

38. Payors typically demand a lower payment rate from contracted participating providers.

39. In return, they offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

40. For all claims at issue in this lawsuit, Plaintiffs were non-participating providers, meaning they did not have an express contract with Defendants to accept or be bound by Defendants' reimbursement policies or in-network rates.

41. Specifically, the reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) at rates below the billed charges and a reasonable payment for the services rendered, (d) as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to herein as the "Non-Participating Claims."

42. The Non-Participating Claims involve only commercial and Exchange Products operated, insured, or administered by the insurance company Defendants. They do not involve Medicare Advantage or Medicaid products.

43. Further, the Non-Participating Claims at issue under Counts III, IV, and V do not involve coverage determinations under any health plan that may be subject

to the federal Employee Retirement Income Security Act of 1974, or claims for benefits based on assignment of benefits.[1]

44. Those counts concern the *rate* of payment to which Plaintiffs are entitled, not whether a *right* to receive payment exists.

45. Defendants bear responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

46. Defendants understand and expressly acknowledge that their members will seek emergency treatment from non-participating providers and that Defendants are obligated to pay for those services.

The Reasonable Rate for Non-Participating Emergency Services is Well-Established

47. For many years, Defendants have allowed payment at 75-90% of billed charges for Plaintiffs' emergency services.

48. Defendants have done so largely through the use of rental networks, which establish a reasonable rate for provider services through arms-length negotiations between the rental network and providers on the one hand, and the rental network and health insurance companies on the other.

[1] Plaintiffs understand, in any event, that Defendants do not require or rely upon assignments from their members in order to pay claims for services provided by Plaintiffs to their members.

49. Rental networks act as "brokers" between non-participating providers and health insurance companies.

50. A rental network will secure a contract with a provider to discount its out-of-network charges.

51. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

52. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

53. For many years, Plaintiffs' contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from Plaintiffs' billed charges for claims adjudicated through the rental network agreement.

54. In practice, nearly all of Plaintiffs' non-participating provider claims submitted under Employer Funded plans from 2008 to 2018 were paid at between 75-90% of billed charges, including the Non-Participating Claims submitted to Defendants.

55. This longstanding history establishes that a reasonable reimbursement rate for Plaintiffs' Non-Participating Claims for emergency services is 75-90% of Plaintiffs' billed charge.

56. Beginning in January 2019, Defendants have slashed their reimbursement rate for Non-Participating Claims to less than half the average reasonable reimbursement rate.

57. Defendants' drastic payment cuts are entirely inconsistent with the established rate and history between the parties.

Defendants Have Tried to Pay Non-Participating Providers Unreasonable Rates

58. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own members.

59. In 2009, Defendant UnitedHealth Group, Inc. was investigated by the New York State Attorney General's Office for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

60. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

61. Defendant UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

62. In a press release announcing the settlement, the New York Attorney

General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

63. Also in 2009, for the same conduct, Defendants United HealthGroup, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc., paid $350 million to settle class action claims alleging that Defendants underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

64. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers.

65. For example, the State of Connecticut uses FAIR Health's database to determine reimbursement for non-participating providers' emergency services under the state's consumer protection law.

66. Defendants tout their use of FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on their website.

67. For non-participating provider claims, the relevant United Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment

on what health care providers in the geographic area are charging.

68. As for plans that do not set rates this way, Defendants' website implies that they are the exception, not the rule, and provides no information about how such plans would set rates.

69. While Defendants give the appearance of holding themselves to independent benchmarks to set reimbursement rates – ones created from money paid to settle their prior deceptive practices – Defendants have found other ways to manipulate their reimbursement rate down from a reasonable rate in order to maximize their profits at the expense of providers such as Plaintiffs.

70. For example, beginning in or around 2009, Defendants imposed significant cuts to Plaintiffs' reimbursement rate for Non-Participating Claims under Defendants' Fully Funded plans, without rationale or justification.

71. Defendants pay claims under Fully Funded plans out of their own pool of funds, so every dollar that is not paid to Plaintiffs is a dollar retained by Defendants for their own use.

72. Defendants' detrimental approach to payments for members in Fully Funded plans continues today: in 2019, Defendants have allowed payment to Plaintiffs at rates as low as 15-20% of billed charges.

73. For example, for patient ZA,[2] who was treated by Plaintiffs on February 23, 2019 and is a member of a Fully Funded plan, Plaintiffs billed Defendants $685 for procedure code 99283, the code used for a moderately severe problem, and Defendants allowed just 15% of billed charges, or $103.98.

74. This claim was reimbursed at a rate significantly below reasonable rates, described further below.

75. As another example, Plaintiffs treated patient ZB, a member of a Fully Funded plan, on February 27, 2019, billed Defendants $1094 for procedure code 99284, the code used for problems of high severity, and Defendants allowed 19% of billed charges, or $204.00.

76. Again, the claim was paid far below a reasonable reimbursement rate.

77. As a result of these deep cuts in payments for services provided to members of Fully Funded plans, Defendants have not paid Plaintiffs a reasonable rate for those services since 2009.

78. In so doing, they have illegally retained those funds.

79. In 2017, Defendants also began to try to avoid paying a reasonable rate on its Employer Funded Plans, further exacerbating the financial damages to Plaintiffs.

[2] For confidentiality purposes, the patient's initials are redacted and are randomized, although the examples herein are true and accurate claim examples.

80. From late 2017 to 2018, Plaintiffs attempted to negotiate with Defendants to be contracted as participating, in-network providers over the course of multiple meetings in person, by phone, and by email correspondence.

81. As part of these negotiations, Plaintiffs met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

82. In or around December 2017, Mr. Rosenthal told Plaintiffs that the Defendants intended to implement a new benchmark pricing program specifically for their Employer Funded plans.

83. Defendants then proposed to Plaintiffs a contractual rate for their Employer Funded plans that was roughly *half* the average reasonable rate at which Defendants had historically reimbursed Plaintiffs – a drastic and unjustified discount from what Defendants had been paying Plaintiffs for years on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market.

84. Defendants' proposed rate was neither reasonable nor fair.

85. Subsequently, in May 2018, Mr. Rosenthal escalated his threats, making clear during a meeting that, if Plaintiffs did not agree to contract for the

drastically reduced rates, Defendants would implement benchmark pricing that would reduce Plaintiffs' non-participating reimbursement by 33%.

86. Dan Schumacher, the President and Chief Operating Officer of UnitedHealthCare and part of the Office of the Chief Executive of Defendant UnitedHealth Group, Inc., then said that, by April 2019, Defendants would cut Plaintiffs' non-participating reimbursement by 50%.

87. Asked why the Defendants were forcing such dramatic cuts on Plaintiffs' reimbursement, Mr. Schumacher said it was simply "because we can."

88. Defendants made good on their threats and knowingly engaged in a fraudulent scheme to slash reimbursement rates to Plaintiffs for non-participating claims submitted under its Employer Funded plans to levels at, or even below, what they had threatened in 2018.

89. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third party, Data iSight,[3] to process Plaintiffs' claims for their Employer Funded plans and to

[3] Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since 2010 with Plaintiffs to secure reasonable rates from payors for Plaintiffs' non-

determine reasonable reimbursement rates.

90. In fact, Defendants are working with Data iSight to hide the fact that they are imposing arbitrary and unreasonable payment rates on Plaintiffs that are not based on objective criteria.

91. At the same time, Defendants have continued to advance their scheme on the negotiation front.

92. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants planned to cut Plaintiffs' rates over three years to just 42% of the average and reasonable rate of reimbursement that Plaintiffs had received in 2018.

93. Mr. Schumacher additionally advised that leadership across the Defendant entities were aware and supportive of the drastic cuts, but provided no objective basis for them.

94. The next day, Angie Nierman, a Vice President of Networks at Defendant UnitedHealth Group, Inc., sent via interstate wires a written proposal reflecting Mr. Schumacher's stated cuts.

95. In addition to denying Plaintiffs what is owed to them for the Non-Participating Claims, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

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participating emergency services. Plaintiffs have no contract with Data iSight, and the Non-Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement.

RICO Defendants' Fraudulent Scheme to Deprive Plaintiffs of Reasonable Reimbursement Violated the Racketeer Influenced and Corrupt Organizations Act (RICO)

96. Defendants UnitedHealth Group, Inc., United HealthCare Services, Inc., UnitedHealthcare Inc., and UnitedHealth Networks, Inc. (the "RICO Defendants") violated the Racketeering Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1961 et seq., and in particular, 18 U.S.C. § 1962(c) and 18 U.S.C. § 1962(d) in connection with a scheme that the RICO Defendants devised, conducted, and participated in with unnamed third parties, including, but not limited to, Data iSight.

97. The RICO Defendants conducted and participated directly or indirectly in the affairs of an association-in-fact enterprise ("the Enterprise") through a scheme that formed a pattern of racketeering activity.

98. As part of this scheme, the RICO Defendants and Data iSight conspired to, and did knowingly and unlawfully, reduce Plaintiffs' reimbursement rates for the Non-Participating Claims to amounts significantly below the reasonable rate for services rendered to RICO Defendants' members, to the detriment of Plaintiffs and to the benefit and financial gain of RICO Defendants and Data iSight.

99. To carry out the scheme and in furtherance of the conspiracy, RICO Defendants and Data iSight engaged in conduct that violated federal laws, including, *inter alia*, mail fraud in violation of 18 U.S.C. § 1341, and wire fraud in violation of

18 U.S.C. § 1343.

100. As a result of the scheme, RICO Defendants violated 18 U.S.C. § 1962(c) and 18 U.S.C. § 1962(d).

RICO Defendants and Data iSight's Activities Constitute a Pattern of Unlawful Racketeering Activity

101. RICO Defendants and Data iSight have committed, and continue to commit, related predicate acts of racketeering activity involving mail and wire fraud in violation of 18 U.S.C. §§ 1341 and 1343, such that they have engaged in a "pattern of racketeering activity" under 18 U.S.C. § 1961(5) and pose a continued threat of racketeering activity, as described below.

102. RICO Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to Plaintiffs for the emergency services that Plaintiffs provided to Defendants' members, to the financial gain of the RICO Defendants and Data iSight.

103. As a direct and proximate result of those activities, Plaintiffs have suffered millions of dollars in discrete financial losses.

The Enterprise and Scheme

104. The Enterprise is comprised of RICO Defendants and third-party entities that develop software used in reimbursement determinations used by RICO Defendants, including Data iSight.

105. RICO Defendants and Data iSight agreed to, and do, manipulate

reimbursement rates and control allowed payments to Plaintiffs through acts of the Enterprise.

106. The Enterprise allows RICO Defendants and Data iSight to conceal their scheme by hiding behind written agreements and false statements.

107. Since at least January 1, 2019, the Enterprise has falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates through the use of Data iSight.

108. In reality, Data iSight is used as a cover-up for RICO Defendants to justify paying reimbursement to Plaintiffs that is far less than the reasonable payment rate that Plaintiffs have historically received and are entitled to under the law.

109. This scheme is concealed through the use of false statements on Data iSight's website and in RICO Defendants' and Data iSight's communications with providers, including Plaintiffs.

110. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between RICO Defendants and Data iSight.

The Enterprise's False Statements

Transparency

111. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate

payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

112. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

113. This concealment was designed by the Enterprise to, and does, prevent providers such as Plaintiffs from receiving a reasonable payment for the services they provide.

114. For claims whose reimbursement is determined by Data iSight, non-participating providers receive an Explanation of Benefit form ("EOB") from Defendants with "IS" in the "Remark/Notes" column.

115. Over the past six months, an ever-increasing number of Non-Participating Claims have been processed by Data iSight with drastically reduced payment amounts.

116. By the end of June 2019, just over half of Non-Participating Claims submitted to RICO Defendants were being processed for payment by Data iSight.

117. Yet RICO Defendants and Data iSight do not state, on the face of the EOBs, or anywhere else, any reason for the dramatic cut.

118. Instead, the EOBs contain a note to call a toll-free number if there are questions about the claim.

119. In June 2019, Plaintiffs contacted Data iSight via that number to discuss two claims for the same procedure code, performed at the same facility, that had both been billed at $700, but for which Data iSight had allowed reimbursement at only 42% and 59% of billed charges ($295.28 and $413.39, respectively).

120. After Plaintiffs left messages at Data iSight's phone number for approximately two weeks, a Data iSight representative, Phina (Last Name Unknown) ("LNU"), finally connected with Plaintiffs; however, she was unable to explain why the two claims – for the same procedure at the same facility and billed at the same charge – were allowed at different rates.

121. Further, when asked to provide the basis for the dramatic cut in payment for the claims, the representative did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all.

122. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

123. Instead, the representative simply stated that the rates were developed by Data iSight and Defendants.

124. When Plaintiffs continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations,

James LNU responded that "it is just an amount that is recommended and sent over to United [Defendants]."

125. When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

126. Further attempts to understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight executives have also been futile.

127. Data iSight and the RICO Defendants know that the rates that Data iSight have allowed for Plaintiffs' claims in 2019 are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

128. They know this because when a provider challenges the payment, Data iSight and RICO Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the provider persists long enough in the process.

129. This process to contest the unreasonable payment takes weeks to conclude for the provider and is impracticable to follow for every claim – a fact that RICO Defendants and Data iSight understand.

130. For example, and as evidence of this fraudulent practice, Plaintiffs contested the allowed amounts on the two claims discussed above.

131. Eventually, Carol LNU from Data iSight's "Quality Control" team

offered to allow payment of both claims at 85% of their respective billed charges.

132. Thus, absent providers taking the time to chase every claim, Data iSight and RICO Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

133. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until Plaintiffs challenge its determinations continually harms Plaintiffs, in that, even if Plaintiffs eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens Plaintiffs with excessive administrative time and expense and deprives Plaintiffs of their right to prompt payment of clean claims under Pennsylvania's Prompt Payment Act and related regulation.

Defensible and Market Tested

134. The Enterprise's claim to "transparency" is not its only fraudulent claim.

135. The Enterprise, through Data iSight, also falsely claims, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

136. Claims processed by Data iSight contain the following note:

> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NTEWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835-

> 4022 OR VISIT DATAISIGHT.COM, THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT, WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT. (emphasis added).

137. This note is intended to, and does, lead providers to believe that the reimbursement calculations are tied to external, objective data.

138. Further, in its provider portal, Data iSight describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

139. Data iSight's parent company, MultiPlan, similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and notes that it has been "[v]alidated by statisticians as effective and fair."

140. These statements are also false.

141. Data iSight's rates are not data-driven: they match the rate threatened by RICO Defendants in 2018 and are whatever RICO Defendants want, and direct Data iSight, to allow.

142. For example, over three months, Plaintiffs submitted claims for three

patients who are members of Employer Funded plans under the procedure code 99285 (encompassing symptoms such as blunt trauma, severe infections, severe burns, and chest pain requiring multiple diagnostic tests), but received reimbursement in very different allowed amounts:

a. Patient AA was treated by Plaintiffs on February 2, 2019. Plaintiffs billed RICO Defendants $1,463 for procedure code 99285, and RICO Defendants allowed $1,316.70 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by RICO Defendants to Plaintiffs for non-participating provider services for many years.

b. But, for patient AB, who was treated by Plaintiffs only six weeks later on March 13, 2019, RICO Defendants, through Data iSight, allowed only $609.28, which is only 42% of billed charges.

c. Then, for patient AC, who was treated by plaintiffs on May 18, 2019, only eight weeks after AB, Plaintiffs billed $1,562 for the same procedure code[4] but RICO Defendants, through Data iSight, allowed only $435.20, or 29% of billed charges.

[4] The billed charge for patient AC differed slightly from billed charges for patients AA and AB because patient AC was seen at a different facility from patients AA and AB.

PATIENT	DATE OF SERVICE	PLAN TYPE	PROCEDURE CODE	BILLED AMOUNT	ALLOWED AMOUNT	ALLOWED AMOUNT (%)
AA	2/2/19	Employer Funded	99285	$1,463	$1,316.70	90%
AB	3/13/19	Employer Funded	99285	$1,463	$609.28	42%
AC	5/18/19	Employer Funded	99285	$1,562	$435.20	29%

143. In another example, Plaintiffs submitted claims under the procedure code 99284 (encompassing symptoms such as respiratory illness and chest or abdominal pain requiring limited diagnostic testing) for patients in Employer Funded plans, again within weeks of each other, but RICO Defendants reimbursed at dramatically different and decreasing levels, negating any claim RICO Defendants have that their reimbursement determinations are tied to a reasonable, defensible, market-tested standard:

a. Patient AD was treated by Plaintiffs on February 7, 2019. Plaintiffs billed RICO Defendants $1,094 for procedure code 99284, and RICO Defendants, through MultiPlan, allowed $984.60, which is 90% of Plaintiffs' billed charge.

b. But, for patient AE, who was treated by Plaintiffs five weeks later on March 13, 2019, the RICO Defendants, through Data iSight, allowed only $413.39, which is approximately 38% of Plaintiffs' billed charge.

c. Then, for patient AF, who was seen by Plaintiffs on May 11,

2019, eight weeks after AE, the RICO Defendants allowed only $295.28, which is approximately 28% of the billed charge of $1,073.

PATIENT	DATE OF SERVICE	PLAN TYPE	PROCEDURE CODE	BILLED AMOUNT	ALLOWED AMOUNT	ALLOWED AMOUNT (%)
AD	2/7/19	Employer Funded	99284	$1,094	$984.60	90%
AE	3/13/19	Employer Funded	99284	$1,094	$413.39	38%
AF	5/11/19	Employer Funded	99284	$1,073	$295.28	28%

144. This lock-step reduction, consistent with RICO Defendants' 2018 threats to drastically reduce rates even further if Plaintiffs failed to agree to their proposed contractual rates, spans a significant number of Plaintiffs' claims for payment for services to RICO Defendants' members.

145. From the above examples, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable reimbursement rate, as its rates are not consistent, defensible, or reasonable.

146. Rather, RICO Defendants, in complicity with Data iSight, increasingly reimburse for Plaintiffs at entirely unreasonable rates, in retaliation for Plaintiffs' objections to their reimbursement scheme, and completely contrary to their false assertions designed to mislead Plaintiffs and similar providers into believing that they will receive payment at reasonable rates.

147. This reimbursement is dictated by RICO Defendants, to the financial

detriment of Plaintiffs.

Geographic Adjustment

148. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

149. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

150. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

151. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with RICO Defendants to cut uniformly out-of-network provider payments across geographic locations.

152. For example, patient WY was treated in Wyoming on January 21, 2019.

The provider billed RICO Defendants $779 for procedure code 99284, and RICO Defendants, via Data iSight, allowed $413.39.

153. Four days later, patient NH was treated on the other side of the country in New Hampshire. The provider billed RICO Defendants $1,047 for procedure 99284, and RICO Defendants, via Data iSight, again allowed $413.39.

154. On February 8, 2019, patient OK was treated in Oklahoma. The provider billed RICO Defendants $990 for procedure code 99284, and RICO Defendants, via Data iSight, allowed $413.39.

155. Two days later, patients KS and NM were treated in Kansas and New Mexico, respectively. The providers billed RICO Defendants $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, RICO Defendants, via Data iSight, allowed exactly $413.39.

156. One month later, patient CA was treated in California. The provider billed RICO Defendants $937.00 for procedure code 99284. RICO Defendants, via Data iSight, yet again allowed exactly $413.39.

157. Two months later, on May 20, 2019, Plaintiff Emergency Physician Associates of Pennsylvania treated patient PA in Pennsylvania. Plaintiff billed RICO Defendants $1,094 for procedure code 99284, and RICO Defendants, via Data iSight, allowed, unsurprisingly, exactly $413.39.

PATIENT	LOCATION	DATE OF SERVICE	BILLED AMOUNT	PROCEDURE CODE	ALLOWED AMOUNT
WY	Wyoming	1/21/19	$779	99284	$413.39
NH	New Hampshire	1/25/19	$1047	99284	$413.39
OK	Oklahoma	2/8/19	$990	99284	$413.39
KS	Kansas	2/10/19	$778	99284	$413.39
NM	New Mexico	2/10/19	$895	99284	$413.39
CA	California	3/25/19	$937	99284	$413.39
PA	Pennsylvania	5/20/19	$1,094	99284	$413.39

158. Defendants falsely claim on their website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

159. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed $413.39:

LOCATION	PROCEDURE CODE	80th PERCENTILE OF FAIR HEALTH BENCHMARK
Wyoming	99284	$1105
New Hampshire	99284	$753
Oklahoma	99284	$1076
Kansas	99284	$997
New Mexico	99284	$1353
California	99284	$795
Pennsylvania	99284	$859

The Enterprise's Predicate Acts

160. To perpetuate the scheme and conceal it from Plaintiffs, in or around 2018 RICO Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

161. Under those contracts, Data iSight would handle claims determinations for services rendered to RICO Defendants' members under pre-agreed thresholds set by RICO Defendants.

162. By no later than 2019, RICO Defendants and Data iSight then coordinated and effectuated, via wire communications, the posting of false statements on websites and the communication of false statements to providers, including Plaintiffs, in furtherance of the scheme.

163. These statements include Data iSight and its parent company using interstate wires to post, on its websites, that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

164. Data iSight communicated to Plaintiffs by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United [Defendants]."

165. Finally, after weeks of pressure, Data iSight informed Plaintiffs by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

166. In short, the Enterprise perpetuated its scheme by communicating, via wire communications, threats regarding reimbursement cuts to Plaintiffs in late 2017 and 2018.

167. Then, after making good on those threats, the Enterprise communicated, via wire communications, false and misleading information to Plaintiffs and falsely denied that it had information requested by Plaintiffs about the basis for the drastically-cut and unreasonable reimbursement rates that RICO Defendants sought to impose.

168. In addition, since at least January 1, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to Plaintiffs by means of the United States Postal Service and interstate wires at unlawful rates that were far below reasonable rates for the services provided.

169. For example, on June 11, 2019, RICO Defendants sent Plaintiffs, via wire communications, EOBs for emergency services provided to patients under multiple procedure codes, including the following EOBs for procedure code 99285:

a. Patient BB was treated on May 13, 2019 at a billed charge of $1,048.00, for which RICO Defendants, via Data iSight, allowed $435.20.

b. Patient BC was treated on May 15, 2019 at a billed charge of $1,542.00, for which RICO Defendants, via Data iSight, allowed $435.20.

c. Patient BD was treated on May 26, 2019 at a billed charge of $1012.00, for which RICO Defendants, via Data iSight, allowed $435.20.

PATIENT	DATE OF SERVICE	BILLED AMOUNT	PROCEDURE CODE	ALLOWED AMOUNT	ALLOWED AMOUNT (%)
BB	5/13/19	$1,048	99285	$435.20	42%
BC	5/15/19	$1,542	99285	$435.20	28%
BD	5/26/19	$1,012	99285	$435.20	43%

170. RICO Defendants and Data iSight expected that those unreasonable payments would be accepted in full satisfaction of Plaintiffs' claims.

171. RICO Defendants and Data iSight have received, and continue to receive, financial gains from their scheme to defraud Plaintiffs.

172. For the services that Plaintiffs provided to patients under RICO Defendants' Employer Funded plans in 2019, only 36% of the Non-Participating Claims have, to date, been reimbursed at reasonable rates, resulting in millions of dollars in financial loss to Plaintiffs.

173. The purpose of, and the direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse Plaintiffs at unreasonable rates, to the harm of Plaintiffs, and to the benefit of the Enterprise.

COUNT I
Violation of RICO, 18 U.S.C. § 1962(c) (as against the RICO Defendants)

174. Plaintiffs re-allege and restate paragraphs 1 through 173 above as if they were fully set forth herein.

175. Plaintiffs are each a "person" within the meaning of 18 U.S.C. §§ 1961(3) and 1964(c).

176. RICO Defendants are each a "person" within the meaning of 18 U.S.C. § 1961(3).

177. As set forth above, since at least January 2019, RICO Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of 18 U.S.C. § 1961(4), comprised of at least RICO Defendants and Data iSight, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce.

178. Each of the RICO Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

179. RICO Defendants and Data iSight had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates to for their own pecuniary gain, by defrauding Plaintiffs and preventing Plaintiffs from obtaining reasonable payment for the services they

provided to RICO Defendants' members, in retaliation for Plaintiffs' lawful refusal to agree to RICO Defendants' massively discounted and unreasonable proposed contractual rates.

180. As set forth above, the RICO Defendants since at least January 2019, have been and continue to be, engaged in a scheme to defraud Plaintiffs by committing a series of unlawful acts which constitute predicate racketeering acts under 18 U.S.C. §§ 1961(1)(B) and 1962(c), involving multiple instances of mail fraud in violation of 18 U.S.C. § 1341 and multiple instances of wire fraud in violation of 18 U.S.C. § 1343.

181. Each RICO Defendant provides benefits to insured members, processes claims for services provided to members, and/or issues payments for services and knows and willingly participates in the scheme to defraud Plaintiffs.

182. As a direct and proximate result of RICO Defendants' violations of 18 U.S.C. § 1962(c), Plaintiffs were injured in their business, suffering financial losses of millions of dollars within the meaning of 18 U.S.C. § 1964(c).

COUNT II
Violation of RICO conspiracy, 18 U.S.C. § 1962(d) (as against the RICO Defendants)

183. Plaintiffs re-allege and restate paragraphs 1 through 173 above as if they were fully set forth herein.

184. Plaintiffs are each a "person" within the meaning of 18 U.S.C. §§

1961(3) and 1964(c).

185. RICO Defendants are each a "person" within the meaning of 18 U.S.C. § 1961(3).

186. As set forth above, since at least January 2019, RICO Defendants have been and continue to be, part of an association-in-fact enterprise within the meaning of 18 U.S.C. § 1961(4), comprised of at least RICO Defendants and Data iSight, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce.

187. RICO Defendants were and continue to be associated with the Enterprise and knowingly conspired, within the meaning of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting and participating, directly or indirectly, in the conduct and affairs in the Enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. §§ 1961 (1)(B) and 1962(c), including multiple instances of mail fraud in violation of 18 U.S.C. § 1341 and multiple instances of wire fraud in violation of 18 U.S.C. § 1343, in order to defraud Plaintiffs of a reasonable reimbursement of services.

188. As a direct and proximate result of RICO Defendants' violations of 18 U.S.C. § 1962(d), Plaintiffs were injured in their business, suffering financial losses of millions of dollars within the meaning of 18 U.S.C. § 1964(c).

COUNT III
Breach of Implied-in-Fact Contract under Pennsylvania Law (as against all Defendants)

189. The allegations set forth in Paragraphs 1 through 173 above are incorporated herein by reference as though fully set forth.

190. Defendants knew or should have known that Plaintiffs expected reasonable payment for the emergency services they provided.

191. For this reason, Defendants consistently adjudicated the Non-Participating Claims as covered and medically necessary and paid Plaintiffs for such Non-Participating Claims.

192. However, the payments made have been below the reasonable value of the services rendered (1) at all material times, for members under the Fully Funded plans, and (2) since 2019 for members in the Employer Funded plans.

193. Defendants' underpayment of the Non-Participating Claims violates the duty they owe to Plaintiffs.

194. Plaintiffs and Defendants do not voluntarily choose to transact business with each other, and neither party has a choice in the matter.

195. Plaintiffs and Defendants are compelled to operate together as a result of their concomitant legal duties, namely (1) a physician's duty under federal law to treat emergency room patients regardless of their insurance coverage or ability to pay, and (2) Defendants' legal and contractual responsibility to pay for emergency

services.

196. An implied-in-fact contract must therefore be imposed by law to prevent a grave injustice, specifically an enormous economic windfall in Defendants' favor from Plaintiffs' provision of emergency services to Defendants' members without payment of reasonable compensation.

197. In breach of their implied contract with Plaintiffs, Defendants have processed and continue to process the Non-Participating Claims at rates substantially below the reasonable value of the emergency services provided to those members by Plaintiffs (1) at all relevant times, for members in the Fully Funded plans and (2) since 2019 for members in Employer Funded plans.

198. Plaintiffs have performed all obligations under their implied contract with Defendants necessary for Plaintiffs to be reimbursed for the Non-Participating Claims at the reasonable value of the services rendered.

199. At all material times, all conditions precedent have occurred that were necessary for Defendants to perform their obligation to pay Plaintiffs on the Non-Participating Claims at the reasonable value of the emergency services provided by Plaintiffs.

200. Plaintiffs did not agree that the lower reimbursement rates paid by Defendants were reasonable or sufficient to compensate Plaintiffs for the emergency medical services provided to Defendants' members by Plaintiffs.

201. As a result of Defendants' breach of their implied contract to pay Plaintiffs for the Non-Participating Claims at the reasonable and lawful value of the services rendered, Plaintiffs have suffered injury and are entitled to monetary damages from Defendants to compensate them for their injury.

202. Plaintiffs have suffered damages in an amount equal to (1) the difference between the amounts Defendants unilaterally allowed as payable for Non-Participating Claims and the reasonable value of the emergency medical services provided as to such claims, plus (2) Plaintiffs' loss of use of those funds.

COUNT IV
Unjust Enrichment under Pennsylvania Law (as against all Defendants)

203. The allegations set forth in Paragraphs 1 through 173 above are incorporated herein by reference as though fully set forth.

204. Under Pennsylvania law, a cause of action for unjust enrichment is stated where benefits are conferred upon defendant by plaintiff; there is appreciation of such benefits by the defendant; and acceptance and retention of such benefits under such circumstances that it would be inequitable for Defendant to retain the benefit without payment of value.

205. The essential inquiry in any action for unjust enrichment or restitution is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered.

206. Plaintiffs have complied with their legal obligations under federal law to provide and continue to provide emergency services to the Defendants' members in good faith.

207. Defendants are not lawfully permitted to prevent their members from seeking emergency services from Plaintiffs.

208. Given the nature of these relationships, an equitable obligation arises to require that Defendants reasonably compensate Plaintiffs for the emergency services rendered by Plaintiffs to Defendants' members.

209. In the absence of such an obligation, Defendants would enrich themselves unjustly at the expense of Plaintiffs.

210. Thus, Defendants are legally obligated to pay Plaintiffs the reasonable value of the services rendered by Plaintiffs as measured by the community where the services were performed and by the person who provided them.

211. However, as to the Non-Participating Claims, Defendants have failed to reimburse the Plaintiffs for the reasonable value of the services provided by Plaintiffs and Defendants have, therefore, been unjustly enriched by the difference between the reasonable value of the physicians' services and the amount allowed by Defendants (*i.e.*, the amount paid by Defendants plus the individual liability of the members).

212. The emergency services provided by Plaintiffs to Defendants' members

materially benefit Defendants by discharging their contractual obligations to their insureds.

213. The benefit that Defendants receive from the emergency services provided by Plaintiffs is, therefore, significant.

214. In exchange for premiums and/or other compensation, Defendants assume a duty to provide coverage to their members for emergency services. Satisfying this "core obligation" is a material benefit in Defendants' favor.

215. Under these circumstances, it would be unjust and inequitable for Defendants to retain the benefits they received without paying the value of those benefits, *i.e.*, by paying Plaintiffs *quantum meruit,* or the reasonable value of the emergency services provided by Plaintiffs in the context of the Non-Participating Claims.

216. Plaintiffs seek compensatory damages, as permitted by applicable law, in an amount that will continue to accrue through the date of trial as a result of Defendants continuing unjust enrichment, equal to (1) the difference between the amount Defendants processed as payable for those services and the reasonable value of the emergency medicine care provided by the agents, servants, and employees of Plaintiff, plus (2) the loss of use of that money.

COUNT V
Declaratory Relief (as against all Defendants)

217. Plaintiffs incorporate by reference the allegations set forth in

Paragraphs 1 through 173 above as though fully set forth.

218. This is an action for declaratory relief pursuant 28 U.S.C. § 2201, which is necessary and appropriate to clarify the parties' respective rights, status, and legal relations concerning Defendants' payment obligations to Plaintiffs for the emergency services they provide to Defendants' members.

219. All adverse parties are presently before the court.

220. Plaintiffs have been and continue to be harmed by Defendants' underpayments for emergency services that Plaintiffs are legally obligated to render to Defendants' members.

221. Plaintiffs therefore seek a declaration establishing the appropriate reimbursement rates to be paid by Defendants to prevent further harm to Plaintiff.

222. Plaintiffs specifically seek a determination that (1) Defendants have an obligation to reimburse Plaintiffs for the services rendered to Defendants' members at rates equal to the reasonable value of the emergency services rendered; and (2) that the rates Defendants have paid on Non-Participating Claims (a) at all relevant times for members under their Fully Funded plans and (b) since 2019, for members in their Employer Funded plans, are inadequate and violate their obligation to pay Plaintiffs for their services rendered at a reasonable value.

223. To avoid the potential for successive, separate actions enforcing the Plaintiffs' rights, Plaintiffs seek a declaration from the Court stating that the

Defendants are obligated to pay Plaintiffs prospectively for the emergency medical services rendered by Plaintiffs for the Non-Participating Claims at the reasonable value thereof.

JURY DEMAND

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Plaintiffs hereby demand a trial by jury of any issue trial of right by a jury.

RELIEF REQUESTED

WHEREFORE, Plaintiffs respectfully request that this Honorable Court:

(1) Enter judgments against the RICO Defendants and in favor of Plaintiffs pursuant to the First and Second Causes of Action in an amount constituting treble damages resulting from Defendants' underpayments to Plaintiffs for the reasonable value of the emergency services provided to Defendants' members and reasonable attorneys' fees incurred in bringing this action;

(2) Enter judgments against Defendants and in favor of Plaintiffs pursuant to the Third and Fourth Causes of Action in an amount representing the difference between the amounts deemed payable by Defendants and the reasonable value of the emergency services rendered by Plaintiffs together with the loss of use of said funds, as determined after trial, plus interest;

(3) Enter a decree pursuant to 28 U.S.C. § 2201 requiring that Defendants must pay to Plaintiffs prospectively for the emergency medical services

provided by the agents, servants, and employees of Plaintiffs to Defendants' members amounts that represent the reasonable value of said services, as determined after trial; and

(4) Such other relief as the Court determines to be just and proper.

Dated: July 11, 2019

Respectfully submitted,

/s/ *Bridget E. Montgomery*

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Counsel for Plaintiffs Emergency Care Services of Pennsylvania, P.C. and Emergency Physician Associates of Pennsylvania, P.C.

JS 44 (Rev. 06/17)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Emergency Care Services of Pennsylvania, P.C. and Emergency Physician Associates of Pennsylvania, P.C.

(b) County of Residence of First Listed Plaintiff Bucks County
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Bridget E. Montgomery, Esq., Eckert Seamans Cherin & Mellott, LLC, 213 Market St., 8th Floor, Harrisburg, PA 17101; (717) 237-6054

DEFENDANTS

UnitedHealth Group, Inc.; United HealthCare Services, Inc., UnitedHealthCare, Inc., UnitedHealth Networks, Inc., UnitedHealthCare Insurance Company, UnitedHealthCare of New England, Inc., and UnitedHealthCare of Pennsylvania, Inc.,

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☒ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☒ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	☐ 625 Drug Related Seizure of Property 21 USC 881	☐ 422 Appeal 28 USC 158	☐ 375 False Claims Act
☐ 120 Marine	☐ 310 Airplane	☐ 365 Personal Injury - Product Liability	☐ 690 Other	☐ 423 Withdrawal 28 USC 157	☐ 376 Qui Tam (31 USC 3729(a))
☐ 130 Miller Act	☐ 315 Airplane Product Liability	☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	☐ 400 State Reapportionment
☐ 140 Negotiable Instrument	☐ 320 Assault, Libel & Slander	☐ 368 Asbestos Personal Injury Product Liability		☐ 820 Copyrights	☐ 410 Antitrust
☐ 150 Recovery of Overpayment & Enforcement of Judgment	☐ 330 Federal Employers' Liability	PERSONAL PROPERTY	LABOR	☐ 830 Patent	☐ 430 Banks and Banking
☐ 151 Medicare Act	☐ 340 Marine	☐ 370 Other Fraud	☐ 710 Fair Labor Standards Act	☐ 835 Patent - Abbreviated New Drug Application	☐ 450 Commerce
☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	☐ 345 Marine Product Liability	☐ 371 Truth in Lending	☐ 720 Labor/Management Relations	☐ 840 Trademark	☐ 460 Deportation
☐ 153 Recovery of Overpayment of Veteran's Benefits	☐ 350 Motor Vehicle	☐ 380 Other Personal Property Damage	☐ 740 Railway Labor Act	SOCIAL SECURITY	☒ 470 Racketeer Influenced and Corrupt Organizations
☐ 160 Stockholders' Suits	☐ 355 Motor Vehicle Product Liability	☐ 385 Property Damage Product Liability	☐ 751 Family and Medical Leave Act	☐ 861 HIA (1395ff)	☐ 480 Consumer Credit
☐ 190 Other Contract	☐ 360 Other Personal Injury		☐ 790 Other Labor Litigation	☐ 862 Black Lung (923)	☐ 490 Cable/Sat TV
☐ 195 Contract Product Liability	☐ 362 Personal Injury - Medical Malpractice		☐ 791 Employee Retirement Income Security Act	☐ 863 DIWC/DIWW (405(g))	☐ 850 Securities/Commodities/ Exchange
☐ 196 Franchise				☐ 864 SSID Title XVI	☐ 890 Other Statutory Actions
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	IMMIGRATION	☐ 865 RSI (405(g))	☐ 891 Agricultural Acts
☐ 210 Land Condemnation	☐ 440 Other Civil Rights	Habeas Corpus:	☐ 462 Naturalization Application	FEDERAL TAX SUITS	☐ 893 Environmental Matters
☐ 220 Foreclosure	☐ 441 Voting	☐ 463 Alien Detainee	☐ 465 Other Immigration Actions	☐ 870 Taxes (U.S. Plaintiff or Defendant)	☐ 895 Freedom of Information Act
☐ 230 Rent Lease & Ejectment	☐ 442 Employment	☐ 510 Motions to Vacate Sentence		☐ 871 IRS—Third Party 26 USC 7609	☐ 896 Arbitration
☐ 240 Torts to Land	☐ 443 Housing/ Accommodations	☐ 530 General			☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
☐ 245 Tort Product Liability	☐ 445 Amer. w/Disabilities - Employment	☐ 535 Death Penalty			☐ 950 Constitutionality of State Statutes
☐ 290 All Other Real Property	☐ 446 Amer. w/Disabilities - Other	Other:			
	☐ 448 Education	☐ 540 Mandamus & Other			
		☐ 550 Civil Rights			
		☐ 555 Prison Condition			
		☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
18 U.S.C. §§ 1341 and 1343; 18 U.S.C. § 1962(c) and (d); 28 U.S.C. §§ 2201 and 2202

Brief description of cause:
RICO, Breach of Contract, Unjust Enrichment

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE _____ DOCKET NUMBER _____

DATE
07/11/2019

SIGNATURE OF ATTORNEY OF RECORD
/s/Bridget E. Montgomery

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

EXHIBIT 6

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(admitted *pro hac vice*)
Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Emergency Group of Arizona Professional Corp, an Arizona Professional Corporation; Emergency Physicians Southwest, P.C., an Arizona Professional Corporation; Chase Dennis Emergency Medical Group, Inc., a California Corporation,

Plaintiffs,

vs.

UnitedHealth Group, Inc., a Delaware corporation, United Healthcare, Inc., a Delaware Corporation; UnitedHealthcare of Arizona, Inc., an Arizona Corporation; United Health Care Services Inc., a Minnesota Corporation; UMR, Inc., a Delaware Corporation; UnitedHealthcare Integrated Services, Inc., an Arizona Corporation; UnitedHealthcare Specialty Benefits, LLC, a Maine Limited Liability Company; John Does 1-10; Roe Entities 11-20,

Defendants.

Case No.: 2:19-cv-04687-JJT

FIRST AMENDED COMPLAINT

Jury Trial Demanded

Plaintiffs Emergency Group of Arizona Professional Corp; Emergency Physicians Southwest, P.C.; and Chase Dennis Emergency Medical Group, Inc. (collectively, the "Providers"), for their First Amended Complaint against defendants UnitedHealth Group, Inc. ("UHG"); United Healthcare, Inc. ("UHI"); UnitedHealthcare of Arizona, Inc. ("UHC Arizona"); United Health Care Services Inc. ("UHC Services"); UMR, Inc. ("UMR"); UnitedHealthcare Integrated Services, Inc. ("UHC Integrated Services"); UnitedHealthcare Specialty Benefits, LLC ("UHC Specialty Benefits") (collectively "Defendants") assert as follows:[1]

NATURE OF THIS ACTION

1. Providers are professional emergency medicine service groups that staff emergency departments at hospitals located throughout Arizona. Providers Treat Patients 24 hours per day, 7 days a week. In fact, Providers are obligated pursuant to Arizona and Federal law to examine and provide stabilizing care to any individual with an emergency medical condition without regard to the individual's ability to pay or availability of insurance coverage. This action arises out of a dispute concerning the rate of payment at which Defendants reimburse Providers for the emergency medicine services Providers have already provided, and continue to provide, to Patients covered under the health plans underwritten, operated, and/or administered by Defendants (the "Health Plans") (Health Plan beneficiaries for whom Providers performed covered services shall be referred to as "Patients").[1] Collectively Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their third parties payment rates to defraud Providers,

[1] Providers file this First Amended Complaint to, among other things, address concerns expressed by Defendants' counsel during the required meet and confer regarding motions to dismiss and to assert additional Arizona state law claim. *See* ECF No. 6; LRCiv 12.1(c). The filing of the First Amended Complaint addresses Defendants' request for additional information to better identify the state law claims at issue in this litigation. Without waiving the position that Defendants' removal was improper and the Court lacks subject matter jurisdiction (*see* Motion to Remand, ECF No. 8) and the case should be stayed until the Court has an opportunity to adjudicate the Motion to Remand, Providers file this amended pleading and anticipate producing a list of claims at issue in the litigation in conformity with the Court's July 18, 2019 Order (ECF No. 12).

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to deny them reasonable payment for their services which the law requires, and to coerce or extort Providers into contracts that only provide for manipulated rates. Defendants have reaped millions of dollars from their illegal, coercive, fraudulent conducts and will reap millions more if their conduct is not stopped.

2. Providers do not assert any causes of action with respect to any Patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). Providers also do not assert any claims relating to Defendants' managed Medicaid business or with respect to the right to payment under any ERISA plan. Finally, Providers do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members. There is – and was -- no basis to remove this lawsuit to federal court under federal question jurisdiction.

PARTIES

3. Plaintiff Emergency Group of Arizona Professional Corp ("Emergency Group AZ") is a professional emergency medicine services group practice that staffs the emergency departments at Abrazo Arizona Heart Hospital, Abrazo Arrowhead Campus, Abrazo Buckeye Emergency Center, Abrazo Peoria Emergency Center, Abrazo Scottsdale Campus, Abrazo West Campus, and Arizona Central Campus throughout Maricopa County, Arizona.

4. Plaintiff Emergency Physicians Southwest, P.C. ("Emergency Physicians SW") is a professional emergency medicine services group practice that staffs the emergency departments at Banner Baywood Medical Center, Banner Mesa Medical Center, Banner Casa Grande Medical Center, Banner Page Medical Center, and Banner Payson Regional Medical Center throughout Maricopa, Pinal, Coconino and Gila Counties, Arizona.

5. Plaintiff Chase Dennis Emergency Medical Group, Inc. ("Chase Dennis") is a professional emergency medicine services group practice that staffed the emergency

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departments at Carondelet Holy Cross Hospital and Abrazo Maryvale Campus in Maricopa and Santa Cruz Counties, Arizona.

6. Defendant UnitedHealth Group, Inc. ("UHG") is the largest single health carrier in the United States and is a Delaware corporation with its principal place of business in Minnesota. UHG is a publicly-traded holding company that is dependent upon monies (including dividends and administrative expense reimbursements) from its subsidiaries and affiliates which include all of the other Defendant entities named herein.

7. Defendant United HealthCare, Inc. ("UHC") is a Delaware corporation with its principal place of business in Minnesota. UHC is responsible for administering and/or paying for certain emergency medical services at issue. It is a subsidiary of Defendant United Healthcare Services, Inc., and provides administrative services to certain health insurance plans.

8. Defendant UnitedHealthcare of Arizona, Inc. ("UHC Arizona") is an Arizona corporation and affiliate of UHC. UHC Arizona is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. UHC Arizona is a licensed Arizona health care services organization.

9. Defendant United HealthCare Services, Inc. ("UHC Services") is a Minnesota corporation with its principal place of business in Minnesota and affiliate of UHC. UHC Services is responsible for administering and/or paying for certain emergency medical services at issue.

10. Defendant UMR, Inc. ("UMR") is a Delaware corporation with its principal place of business in Minnesota and affiliate of UHC. UMR is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. UMR is a licensed Arizona life and health administrator.

11. Defendant UnitedHealthcare Integrated Services, Inc. ("UHC Integrated Services") is an Arizona corporation and affiliate of UHC. UHC Integrated Services is responsible for administering and/or paying for certain emergency medical services at issue.

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12. Defendant UnitedHealthcare Specialty Benefits, LLC ("UHC Specialty Benefits") is a Maine limited liability company and affiliate of UHC. UHC Specialty Benefits is responsible for administering and/or paying for certain emergency medical services at issue in the litigation.

13. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions, circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of John Does 1-10 and Roe Entities 11-20 are currently unknown to Providers, who sue those defendants by such fictitious names. Providers will seek leave of this Court to amend this First Amended Complaint to insert the proper names of the defendant Does and Roe Entities when such names and capacities become known.

JURISDICTION AND VENUE

14. The amount in controversy exceeds the sum of $300,000, exclusive of interest, attorneys' fees and costs. This action will have voluminous documentary evidence and a large number of fact witnesses.

15. The Superior Court, Maricopa County, Arizona has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. Providers contest this Court's subject matter jurisdiction over the matters alleged herein and have moved to remand to the Superior Court, Maricopa County, Arizona. *See* Motion to Remand (ECF No. 8). Providers do not waive their continued objection to Defendants' removal based on alleged preemption under the Employers' Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Venue is proper in Maricopa County, Arizona.

FACTS COMMON TO ALL CAUSES OF ACTION

The Providers Deliver Necessary Emergency Care to Patients

16. Providers are professional practice groups of emergency medicine physicians and healthcare providers that provide emergency medicine services 24 hours

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per day, 7 days per week to Patients presenting to the emergency departments at hospitals and other facilities in Arizona staffed by the Providers. Providers Emergency Group AZ and Emergency Physicians SW currently provide emergency department services at 12 hospitals located in Maricopa, Pinal, Coconino, Gila, and Santa Cruz Counties, Arizona. Provider Chase Dennis provided emergency department services at 2 hospitals in Santa Cruz and Maricopa Counties, Arizona.

17. Providers, and the hospitals whose emergency departments they staff, are obligated by both federal and Arizona law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; A.R.S. § 20-2803. Providers fulfill this obligation for the hospitals which they staff. In this role, Providers' physicians provide emergency medicine services to all individuals, regardless of insurance coverage or ability to pay, including to Patients with insurance coverage issued, administered and/or underwritten by Defendants.

18. Upon information and belief, Defendants operate as health care services organizations under A.R.S. § 20-1051 *et seq.* and administrators under A.R.S. § 20-485 *et seq.*

19. There is no written agreement between Defendants and Providers for the healthcare claims at issue in this litigation. Providers are therefore designated as "non-participating" or "out-of-network" providers for all of the claims at issue. An implied-in-fact agreement exists between Providers and Defendants, however.

20. Because federal and state law requires that emergency services be provided to individuals by Providers without regard to insurance status or ability to pay, the law protects emergency service providers -- like Providers here -- from predatory conduct by payors, including the kind of conduct that Defendants have practiced leading to this dispute. If the law did not do so, emergency service providers would be at the mercy of such payors. Providers would be forced to accept payment at any rate or no rate at all

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dictated by insurers under threat of receiving no payment, and then Providers would be forced to transfer the financial burden of care in whole or in part onto Patients. Providers are protected by law, which requires that for the claims at issue, the insurer must reimburse Providers at a reasonable rate or the usual and customary rate for services they provide.

21. Providers regularly provide emergency services to Defendants' Patients.

22. Defendants are contractually and legally responsible for ensuring that Patients receive emergency services without obtaining prior approval and without regard to the "in network" or "out-of-network" status of the emergency services provider.

23. The uhc.com website, expressly states:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

24. Providers have provided emergency medicine services to Defendants' Patients on an out-of-network basis as follows:

a. Emergency Group AZ: Since February 1, 2013 at the emergency departments at Abrazo Arizona Heart Hospital, Abrazo Arrowhead Campus, Abrazo Buckeye Emergency Center, Abrazo Peoria Emergency Center, Abrazo Scottsdale Campus, Abrazo West Campus, and Arizona Central Campus;

b. Emergency Physicians SW: From April 1, 2019 through the present and ongoing at the emergency departments at Banner Baywood Medical Center, Banner Mesa Medical Center, Banner Casa Grande Medical Center, Banner Page Medical Center, and Banner Payson Regional Medical Center throughout Maricopa, Pinal, Coconino and Gila Counties, Arizona;

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c. Chase Dennis: Between February 1, 1997 and December 31, 2016, at the emergency department at Carondelet Holy Cross Hospital; and between August 1, 2006 and December 17, 2017 at the emergency department at Abrazo Maryvale Campus.

25. Defendants have generally adjudicated and paid claims with dates of service through April 30, 2019. As the claims continue to accrue, so do Providers' damages. For each of the claims for which Providers seek damages, Defendants have already determined the claim was covered and payable.

The Relationship Between Plaintiffs and Defendants

26. Defendants provide health insurance to their members (*i.e.*, their insureds).

27. In exchange for premiums, fees, and/or other compensation, Defendants assume responsibility for paying for health care services rendered to members covered by their health plans.

28. In addition, Defendants provide services such as building participating provider networks and negotiating rates with providers who join their networks.

29. Defendants offer a range of health insurance plans. Plans generally fall into one of two categories.

30. "Fully Funded" plans are plans in which Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums.

31. "Employer Funded" plans are plans in which Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

32. Defendants provide coverage for emergency medical services under both types of plans.

33. They are contractually and legally responsible for ensuring that their members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

34. Defendants highlight such coverage in marketing their insurance products, inducing members to purchase their products and rely upon those representations.

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35. For example, on the "patient protections" section of the UnitedHealthcare website, uhc.com, Defendants state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

36. Payors typically demand a lower payment rate from contracted participating providers.

37. In return, they offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

38. For all claims at issue in this lawsuit, Plaintiffs were non-participating providers, meaning they did not have an express contract with Defendants to accept or be bound by Defendants' reimbursement policies or in-network rates.

39. Specifically, the reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) at rates below the billed charges and a reasonable payment for the services rendered, (d) as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to herein as the "Non-Participating Claims."

40. The Non-Participating Claims involve only commercial and Exchange Products operated, insured, or administered by the insurance company Defendants. They do not involve Medicare Advantage or Medicaid products.

41. Further, the Non-Participating Claims at issue under Counts III, IV, and V do not involve coverage determinations under any health plan that may be subject to the

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federal Employee Retirement Income Security Act of 1974, or claims for benefits based on assignment of benefits.[2]

42. Those counts concern the *rate* of payment to which Plaintiffs are entitled, not whether a *right* to receive payment exists.

43. Defendants bear responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

44. Defendants understand and expressly acknowledge that their members will seek emergency treatment from non-participating providers and that Defendants are obligated to pay for those services.

The Reasonable Rate for Non-Participating Emergency Services is Well-Established

45. For many years, Defendants have allowed payment at 75-90% of billed charges for Plaintiffs' emergency services.

46. Defendants have done so largely through the use of rental networks, which establish a reasonable rate for provider services through arms-length negotiations between the rental network and providers on the one hand, and the rental network and health insurance companies on the other.

47. Rental networks act as "brokers" between non-participating providers and health insurance companies.

48. A rental network will secure a contract with a provider to discount its out-of-network charges.

49. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

[2] Plaintiffs understand, in any event, that Defendants do not require or rely upon assignments from their members in order to pay claims for services provided by Plaintiffs to their members.

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50. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

51. For many years, Plaintiffs' contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from Plaintiffs' billed charges for claims adjudicated through the rental network agreement.

52. In practice, nearly all of Plaintiffs' non-participating provider claims submitted under Employer Funded plans from 2008 to 2018 were paid at between 75-90% of billed charges, including the Non-Participating Claims submitted to Defendants.

53. This longstanding history establishes that a reasonable reimbursement rate for Plaintiffs' Non-Participating Claims for emergency services is 75-90% of Plaintiffs' billed charge.

54. Beginning in January 2019, Defendants have slashed their reimbursement rate for Non-Participating Claims to less than half the average reasonable reimbursement rate.

55. Defendants' drastic payment cuts are entirely inconsistent with the established rate and history between the parties.

Defendants Paid Providers Unreasonable Rates

56. Defendants arbitrarily began manipulating the rate of payment for claims submitted by Providers. Defendants drastically reduced the rates at which they paid Providers for emergency services for some claims, but not others. Instead of paying a usual and customary rate of the charges billed by Providers, Defendants paid some of the claims for emergency services rendered by Providers at far below the usual and customary rates. Yet, Defendants paid other substantially identical claims (e.g. claims billed with the same Current Procedural Terminology (CPT) Code, as maintained by American Medical Association) submitted by Providers at higher rates and in some instances at 100% of the billed charge.

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a. For example, on April 28, 2019, Defendants' Member #1,[3] presented to the emergency department at Abrazo Arizona Heart Hospital and was treated by Provider Emergency Group AZ. The professional services were billed with CPT Code 99285 (the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function) in the amount $1,809.00; Defendants paid $435.20, which is just 24% of the charges billed. By contrast, on April 26, 2019, Defendants' member #2 presented to the emergency department at Abrazo Scottsdale Campus and was treated by Provider Emergency Group AZ. The professional services were billed with CPT Code 99285 in the amount $1,809.00; Defendants paid $1,809.00, 100% of the charges billed.

b. By way of further example, between February 3 and April 26, 2019, Defendants' Members #3, #4, #5 and #6 all presented to emergency departments staffed by Provider Emergency Group AZ. In each instance the professional services were billed with CPT Code 99285 and Defendants paid 100% of the billed charges. By contrast, on February 3 and 4, 2019, Defendants' Members #7, #8 and #9 all presented to emergency departments staffed by Provider Emergency Group AZ. In each instance, the professional services were billed with CPT Code 99285 and Defendants only paid 40% of the billed charges.

57. Each Provider's claims are identified more specifically as follows:

c. Emergency Group AZ:

i. Dates of service: January 1, 2016 to April 30, 2019 (and ongoing).

ii. Litigation claims: approximately 6,986 claims.

iii. Providers seek payment for all claims paid at less than 75% of billed charges.

d. Emergency Physicians SW:

i. Dates of service: April 1 to April 30, 2019 (and ongoing).

[3] To protect identity and personal health information, Providers have assigned numbers to each individual identified. Upon request, Providers will provide Defendants with additional identifying information for the examples provided.

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ii. Litigation claims: approximately 729 claims.

iii. Providers seek payment for all claims paid at less than 75% of billed charges.

e. Chase Dennis:

i. Dates of service: January 6, 2016 to December 14, 2017.

ii. Litigation claims: approximately 155 claims.

iii. Providers seek payment for all claims paid at less than 75% of billed charges.[4]

f. Providers do not assert any of the foregoing claims pursuant to, or in reliance on, any assignment of benefit by Defendants' Members. Upon information and belief, Defendants do not require or rely upon assignment of benefits from their Members in order to pay claims for services provided by Providers.

58. Defendants generally paid lower reimbursement rates for services provided to Members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to Members of employer funded plans or those plans under which they provide administrator services only.

59. Providers have continued to provide emergency medicine treatment, as required by law, to Patients covered by Defendants plan who seek care at the emergency departments where they provide coverage.

60. Defendants bear responsibility for paying for emergency medical care provided to their Members regardless of whether the treating physician is an in-network or out-of-network provider.

61. Defendants expressly acknowledges that their Members will seek emergency treatment from non-participating providers and that they are obligated to pay for those services.

[4] None of these examples include any claims that were denied in whole by any of the Defendants, or any individual evaluation and management (E/M) code that was denied as part of a claim for which Defendants otherwise deemed eligible for payment.

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62. In emergency situations, individuals go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the opportunity to determine in advance which hospitals and physicians are in-network under their health plan. Defendants are obligated to reimburse Providers at the usual and customary rate for emergency services Providers provided to their Patients, or alternatively for the reasonable value of the services provided.

63. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from Providers' physicians: treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

64. From January 2016 to the present, Providers provided treatment for emergency services to thousands of Patients who were Members in Defendants' Health Plans. The total underpayment amount for these related claims is in excess of $300,000.00 and continues to grow. Defendants have likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

65. Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to Providers. Defendants implemented this program to coerce, influence and leverage business discussions with Providers to become participating providers at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

66. Defendants failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims as legally required.

67. Providers contested the unsatisfactory rate of payment received from Defendants in connection with the claims that are the subject of this action.

68. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

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69. Providers bring this action to compel Defendants to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the emergency services that it provided and will continue to provide Patients and to stop Defendants from profiting from their manipulation of payment rate data.

Defendants' Prior Manipulation of Reimbursement Rates

70. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own Members.

71. In 2009, defendant UnitedHealth Group, Inc., was investigated by the New York Attorney General for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

72. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

73. Defendant UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

74. In a press release announcing the settlement, the New York Attorney General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

75. Also in 2009, for the same conduct, defendants United HealthGroup, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid $350 million to settle class action claims alleging that they underpaid non-participating providers for services in T*he American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

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76. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers.

77. For example, the State of Connecticut uses FAIR Health's database to determine reimbursement for non-participating providers' emergency services under the state's consumer protection law.

78. Defendants tout the use of FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website.

79. As stated on UnitedHealthCare's website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for non-participating provider claims, the relevant United Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging.

80. While Defendants give the appearance of remitting reimbursement to non-participating providers that meet usual and customary rates and/or the reasonable value of services based on geography that is measured from independent benchmark services such as the FAIR Health database, Defendants have found other ways to manipulate the reimbursement rate downward from a usual and customary or reasonable rate in order to maximize profits at the expense of Providers.

81. For example, beginning in or around 2009, Defendants imposed significant cuts to Providers' reimbursement rate for out-of-network claims under Defendants' fully funded plans, without rationale or justification.

82. Defendants pay claims under fully funded plans out of their own pool of funds, so every dollar that is not paid to Providers is a dollar retained by Defendants for their own use.

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83. Defendants' detrimental approach to payments for members in fully funded plans continues today, Defendants have made payment to Providers at rates less than 20% of billed charges.

84. For example, for Member #10 who, upon information and belief, is a member of a fully funded plan treated by Provider Emergency Group AZ on April 22, 2019, Providers billed Defendants $1,212.00 for CPT Code 99284, the code used for a moderately severe problem, and Defendants allowed just 19.2% of billed charges, or $233.22, a rate significantly below reasonable rates.

85. As another example, on April 23, 2019, Provider Emergency Group AZ treated Member #11 who, upon information and belief, is a member of a fully funded plan, and billed Defendants $1,212.00 for CPT Code 99284. Defendants allowed 20% of billed charges, or $246.34.

86. As a result of these deep cuts in payments for services provided to Members of fully funded plans, Defendants have not paid Providers a reasonable rate for those services since 2009.

87. In so doing, Defendants have illegally retained those funds.

Defendants' Current Schemes

88. In 2017, Defendants also attempted to pay less than a reasonable rate on their employer funded plans, further exacerbating the financial damages to Providers.

89. From late 2017 to 2018, over the course of multiple meetings in person, by phone, and by email correspondence, Providers' representatives tried to negotiate with Defendants to become participating, in-network providers.

90. As part of these negotiations, Providers' representatives met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

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91. Around December 2017, Mr. Rosenthal told Providers' representatives that Defendants intended to implement a new benchmark pricing program specifically for their employer funded plans to decrease the rate at which such claims were to be paid.

92. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically reimbursed providers – a drastic and unjustified discount from what Defendants have been paying Providers for years on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market.

93. Defendants' proposed rate was neither reasonable nor fair.

94. In May 2018, Mr. Rosenthal escalated his threats, making clear during a meeting that, if Providers did not agree to contract for the drastically reduced rates, Defendants would implement benchmark pricing that would reduce Plaintiffs' non-participating reimbursement by 33%.

95. Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare Inc. and part of the Office of the Chief Executive of Defendant UnitedHealth Group, Inc., said that, by April 2019, Defendants would cut Providers' non-participating reimbursement by 50%.

96. Asked why Defendants were forcing such dramatic cuts on Providers' reimbursement, Mr. Schumacher said simply "because we can."

97. Defendants made good on their threats and knowingly engaged in a fraudulent scheme to slash reimbursement rates paid to Providers for non-participating claims submitted under their employer funded plans to levels at, or even below, what they had threatened in 2018.

98. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third party, Data iSight, to process Providers' claims for employer funded plans and to determine reasonable reimbursement rates.

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99. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since 2011 with Providers Emergency Physicians SW and Chase Dennis and since 2013 with Provider Emergency Group AZ to secure reasonable rates from payors for Providers' non-participating emergency services. Providers have no contract with Data iSight, and the non-participating claims identified in this action are not adjudicated pursuant to the MultiPlan agreement.

100. Since January 2019, Defendants have engaged in a scheme and conspired with Data iSight to impose arbitrary and unreasonable payment rates on Providers under the guise of utilizing an independent, objective database purportedly created by Data iSight to dictate the rates imposed by Defendants.

101. Defendants also continued to advance this scheme on the negotiation front.

102. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants planned to cut Providers' rates over three years to just 42% of the average and reasonable rate of reimbursement that Providers had received in 2018 if Providers did not formally contract with them at the rate dictated by Defendants.

103. Mr. Schumacher additionally advised that leadership across the Defendant entities were aware and supportive of the drastic cuts and provided no objective basis for them.

104. The next day, Angie Nierman, a Vice President of Networks at UnitedHealth Group, Inc., sent a written proposal reflecting Mr. Schumacher's stated cuts.

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105. In addition to denying Providers what is owed to them for the Non-Participating Claims, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

RICO Defendants' Fraudulent Schemes to Deprive Providers of Reasonable Reimbursement Violates Arizona's Civil Racketeering Statute

106. Each Defendant, UnitedHealth Group, Inc., United Healthcare, Inc., UnitedHealthcare of Arizona, Inc., United Health Care Services Inc., UMR, Inc.; UnitedHealthcare Integrated Services, Inc. and UnitedHealthcare Specialty Benefits, LLC (collectively, the "RICO Defendants") violated AZ RICO (A.R.S. § 13-2301 *et seq.*), and in particular, A.R.S. § 13-2314.04 in connection with a scheme or artifice to defraud Providers through a pattern of unlawful activity in which the RICO Defendants devised, conducted, and participated in with unnamed third parties, including, but not limited to, Data iSight, in order to obtain benefits by means of false or fraudulent pretenses, representations, promises and material omissions.

107. The Enterprise, as defined in A.R.S. § 13-2301(D)(2), consists of the RICO Defendants, non-parties Data iSight and other entities that develop software used in reimbursement determinations used by the RICO Defendants (the "Enterprise"). The participants of the Enterprise are associated, upon information and belief, by virtue of contractual agreement(s) and/or other arrangement(s) wherein they have agreed to undertake a common goal of reducing payments to Providers for the benefit of the Enterprise. The Enterprise participants communicate routinely through telephonic and electronic means as they unilaterally impose reimbursement rates based on their manipulated "data" but which is nothing more than a transparent attempt to impose artificially reduced reimbursement rates that the RICO Defendants threatened during business-to-business negotiations.

108. The RICO Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight, through a pattern of unlawful activity.

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109. As part of this scheme, the RICO Defendants prepared to, and did knowingly and unlawfully, reduce Providers' reimbursement rates for the non-participating claims to amounts significantly below the reasonable rate for services rendered to RICO Defendants' Members, to the detriment of Providers and to the benefit and financial gain of RICO Defendants and Data iSight.

110. To carry out the scheme and in furtherance of the conspiracy, RICO Defendants and Data iSight engaged in conduct that violated Arizona laws, including, *inter alia*, A.R.S. §§ 13-2310, 13-2312.

111. Since January 2019, the Enterprise worked together to manipulate and artificially lower non-participating provider reimbursement data that coincides and matches the earlier threats made by United Health Group in an effort to avoid paying Providers for the usual and customary fee or rate and/or for the reasonable value of the services provided to Defendants' Members for emergency medicine services. The unilateral reduction in reimbursement rates is not founded on actual statistically sound data, and is not in line with reimbursement rates that can be found through sites such as the FAIR Health database, a recognized source for such reimbursement rates. Each time the RICO Defendants direct payment using manipulated reimbursement rates and issue Providers a remittance, the RICO Defendants further their scheme or artifice to defraud Providers because the RICO Defendants retain the difference between the amount paid based on the artificially reduced reimbursement rate and the amount paid that should be paid based on the usual and customary fee or rate and/or the reasonable value of services provided, to the detriment of the Providers who have already performed the services being billed. Further, Providers' representatives have contacted Data iSight and have been informed that acceptable reimbursement rates are actually influenced and/or determined by Defendants, not Data iSight.

112. As a result of the scheme, RICO Defendants have injured Providers in their business or property by a pattern of unlawful activity in violation of A.R.S. § 13-2314.04.

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RICO Defendants and Data iSight's Activities Constitute a Pattern of Unlawful Activity

113. RICO Defendants and Data iSight committed, and continue to commit, related predicate acts of unlawful activity, pursuant to a scheme or artifice to defraud, knowingly obtain benefits by means of false or fraudulent pretenses, representations, promises or material omissions and illegally controlled an enterprise through unlawful acts, such that they have engaged in a "pattern of racketeering activity" under A.R.S. § 13-2310 and § 13-2312 and pose a continued threat of unlawful activity, as described below.

114. RICO Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to Providers for the emergency services that Providers provided to Defendants' Members, to the financial gain of the RICO Defendants and Data iSight.

115. The pattern of unlawful activity has happened on more than two occasions that have happened within five years of each other. In fact, the RICO Defendants have processed and submitted a substantial number of artificially reduced payments to Providers since January 2019.

116. As a direct and proximate result of those activities, Providers have suffered in excess of one million dollars in discrete and direct financial loss that stem from the RICO Defendants' knowing retention of payment that is founded on a scheme to manipulate payment rates and payment data to their benefit.

The Enterprise and Scheme

117. The Enterprise is comprised of RICO Defendants and third-party entities, to include Data iSight, that developed software used in reimbursement determinations by RICO Defendants.

118. RICO Defendants and Data iSight agreed to, and do, manipulate reimbursement rates and control allowed payments to Providers through acts of the Enterprise.

119. The RICO Defendants and Data iSight conceal their scheme by hiding behind written agreements and/or other arrangements, and false statements.

120. Since at least January 1, 2019, the RICO Defendants, by virtue of their engagement and use of Data iSight, have falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates.

121. In reality, Data iSight is used as a cover for RICO Defendants to justify paying reimbursement to Providers at rates that are far less than the reasonable payment rate that Providers have historically received and are entitled to under the law. The reimbursement rates purportedly collected and employed by Data iSight are nothing more than an instrumentality for the RICO Defendants' unilateral decision to stop paying Providers the usual and customary fee and/or the reasonable value of the services provided.

122. This scheme is concealed through the use of false statements on Data iSight's website and in RICO Defendants' and Data iSight's communications with providers, including Providers' representatives.

123. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between RICO Defendants and Data iSight.

The Enterprise's False Statements: Transparency

124. By the end of June 2019, just over half of non-participating claims submitted to RICO Defendants were being processed for payment by Data iSight.

125. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

126. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

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127. This concealment was designed by the Enterprise to, and does, prevent Providers from receiving a reasonable payment for the services they provide.

128. For claims whose reimbursement is determined by Data iSight, non-participating providers receive a Provider Remittance Advice form ("Remittance") from Defendants with "IS" or "1J" in the "Remark/Notes" column.

129. Over the past six months, an ever-increasing number of non-participating claims have been processed by Data iSight with drastically reduced payment amounts.

130. Yet RICO Defendants and Data iSight do not state, on the face of the Remittance, or anywhere else, any reason for the dramatic cut.

131. Instead, the Remittances contain a note to call a toll-free number if there are questions about the claim.

132. In July 2019, a representative of Provider Emergency Group AZ contacted Data iSight via that number to discuss a claim with CPT Code 99284 (emergency department visit, problem of high severity) which had been billed at $1,190.00, but for which Data iSight had allowed and paid $295.28, just 24.8% of billed charges.

133. After Provider's representative spoke with Data iSight's intake representative, a Data iSight representative, Michele Ware ("Ware"), called back and claimed the billed charges were paid based on a percentage of the Medicare fee schedule. Provider's representative challenged the reasonableness of the $295.28 payment. After learning that Provider had not yet billed Defendants' Member for the difference, Ware stated "ok – so you're willing negotiate" and offered to pay 80% of billed charges. In response, Provider's representative asked for payment of 85% of billed charges – $1,011.50 – to which Ware promptly agreed.

134. Immediately thereafter, Ware sent a written agreement for Provider's representative to review and sign, confirming payment of $1,011.50 as payment in full and an agreement not to balance bill Defendants Services' Member or Member's Family.

135. Providers' representatives have experienced this same trend across the country with Data iSight. In one instance, when asked to provide the basis for the

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dramatic cut in payment for the claims, a Data iSight representative by the name of Phina (Last Name Unknown) ("LNU"), did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

136. Instead, the representative simply stated that the rates were developed by Data iSight and Defendants. When Providers continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that "it is just an amount that is recommended and sent over to United [HealthCare]." When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

137. Further attempts to understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight executives have also been futile.

138. Data iSight and the RICO Defendants know that the rates that Data iSight have allowed for Providers' claims in 2019 are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

139. Defendants know this because when a provider challenges the payment, Data iSight and RICO Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the Provider persists long enough in the process.

140. This process to contest the unreasonable payment takes weeks to conclude for the Provider and is impracticable to follow for every claim – a fact that RICO Defendants and Data iSight understand.

141. For example, as evidence of this fraudulent practice Providers' representatives contested the allowed amounts on the claims discussed above.

142. Eventually, Data iSight's "Quality Control" team, offered to allow payment of both claims at 85% of their respective billed charges.

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143. Absent providers taking the time to chase every claim, Data iSight and RICO Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

144. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until Providers challenge its determinations continually harms Providers, in that, even if Providers eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens Providers with excessive administrative time and expense and deprives Providers of their right to prompt payment.

The Enterprise's False Statements: Representations that Payment Rates Are "Defensible and Market Tested"

145. The Enterprise's claim to "transparency" is not its only fraudulent representation.

146. The Enterprise, through Data iSight, also falsely represents, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

147. Claims processed by Data iSight contain the following note:

> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835- 4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

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148. This note is intended to, and does, mislead Providers to believe that the reimbursement calculations are tied to external, objective data.

149. Further, in its provider portal, Data iSight describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

150. Data iSight's parent company, MultiPlan, similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and notes that it has been "[v]alidated by statisticians as effective and fair."

151. These statements are false.

152. Data iSight's rates are not data-driven: they match the rate threatened by RICO Defendants in 2018 and are whatever RICO Defendants want, and direct Data iSight, to allow.

153. For example, over three months, Providers submitted claims for three patients who, upon information and belief, are members of employer funded plans under CPT Code 99284, but received reimbursement in very different allowed amounts:

a. Member #12 was treated by Provider Emergency Group of AZ on January 31, 2019. Provider billed RICO Defendants $579.00 for procedure code 99284, and RICO Defendants allowed $521.10 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by RICO Defendants to Provider for non-participating provider services.

b. But, for Member #13, who was treated by Provider Emergency Group AZ on January 3, 2019, RICO Defendants, through Data iSight, allowed only $295.28, which is only 24% of billed charges ($1,190.00).

c. For Member #14, who was treated by Provider on January 25, 2019, Provider billed $1,212.00 for the same procedure code and RICO Defendants, through Data iSight, allowed only $413.39, or 34% of billed charges.

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154. In another example, Plaintiffs submitted claims under CPT Code 99285 for patients in, upon information and belief, employer funded plans, again within weeks of each other, but RICO Defendants reimbursed at dramatically different and decreasing levels, negating any claim RICO Defendants have that their reimbursement determinations are tied to a reasonable, defensible, market-tested standard:

d. Member #15 was treated by Provider Emergency Group AZ on January 27, 2019. Provider billed RICO Defendants $568.00 for CPT Code 99284, and RICO Defendants, through MultiPlan, allowed $511.20, which is 90% of Provider's billed charge.

e. Then, for Member #16, who was seen by Provider Emergency Group AZ on January 1, 2019, the RICO Defendants, through Data iSight, allowed only $413.39, which is approximately 34% of Provider's billed charges of $1,190.00.

155. This lock-step reduction, consistent with RICO Defendants' 2018 threats to drastically reduce rates even further if Providers failed to agree to their proposed contractual rates, spans a significant number of Providers' claims for payment for services to RICO Defendants' Members.

156. From the above examples, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable reimbursement rate, as its rates are not consistent, defensible, or reasonable.

157. Rather, RICO Defendants, in complicity with Data iSight, increasingly reimburse for Providers at entirely unreasonable rates, in retaliation for Providers' objections to their reimbursement scheme, and completely contrary to their false assertions designed to mislead Providers and similar providers into believing that they will receive payment at reasonable rates.

158. This reimbursement is dictated by RICO Defendants, to the financial detriment of Providers.

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The Enterprise's False Statements: Geographic Adjustment

159. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

160. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

161. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

162. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with RICO Defendants to cut uniformly out-of-network provider payments across geographic locations.

163. For example, Member WY was treated in Wyoming on January 21, 2019. The provider billed RICO Defendants $779 for procedure code 99284, and RICO Defendants, via Data iSight, allowed $413.39.

164. Four days later, on January 25, 2019, Provider Emergency Group of AZ treated Member AZ in Arizona and billed RICO Defendants $1,212.00 for CPT Code 99284 and RICO Defendants, via Data iSight, allowed exactly $413.39.

165. On the same date, Member NH was treated on the other side of the country in New Hampshire. The provider billed RICO Defendants $1,047 for procedure 99284, and RICO Defendants, via Data iSight, again allowed $413.39.

166. On February 8, 2019, Member OK was treated in Oklahoma. The provider billed RICO Defendants $990 for procedure code 99284, and RICO Defendants, via Data iSight, allowed $413.39.

167. Two days later, Members KS and NM were treated in Kansas and New Mexico, respectively. The providers billed RICO Defendants $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, RICO Defendants, via Data iSight, allowed exactly $413.39.

168. One month later, Member CA was treated in California. The provider billed RICO Defendants $937.00 for procedure code 99284. RICO Defendants, via Data iSight, yet again allowed exactly $413.39.

169. Two months later, on May 20, 2019, a provider treated Member PA in Pennsylvania and billed RICO Defendants $1,094 for procedure code 99284, and RICO Defendants, via Data iSight, allowed exactly $413.39.

Patient	Location	Date of Service	Billed Amount	CPT Code	Allowed Amount
WY	Wyoming	1/21/19	$779	99284	$413.39
AZ	Arizona	1/25/19	$1,212	99284	$413.39
NH	New Hampshire	1/25/19	$1047	99284	$413.39
OK	Oklahoma	2/8/19	$990	99284	$413.39
KS	Kansas	2/10/19	$778	99284	$413.39
NM	New Mexico	2/10/19	$895	99284	$413.39
CA	California	3/25/19	$937	99284	$413.39
PA	Pennsylvania	5/20/19	$1,094	99284	$413.39

170. RICO Defendants falsely claim on their website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

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171. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed $413.39:

Location	CPT Code	80th Percentile of Fair Health Benchmark
Wyoming	99284	$1,105
New Hampshire	99284	$753
Oklahoma	99284	$1,076
Kansas	99284	$997
New Mexico	99284	$1,353
California	99284	$795
Pennsylvania	99284	$859
Arizona	99284	$1,265

The Enterprise's Predicate Acts

172. To perpetuate the scheme and conceal it from Providers, in or around 2018, RICO Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

173. Under those contracts, Data iSight would handle claims determinations for services rendered to RICO Defendants' Members under pre-agreed thresholds set by RICO Defendants.

174. By no later than 2019, RICO Defendants and Data iSight then coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including Providers, in furtherance of the scheme.

175. These statements include Data iSight and its parent company posting that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

176. Data iSight communicated to Providers' representatives by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could

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not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United [HealthCare]."

177. Finally, after weeks of pressure, Data iSight informed Providers by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

178. In short, the Enterprise perpetuated its scheme by communicating threats regarding reimbursement cuts to Providers in late 2017 and 2018.

179. Then, after making good on those threats, the Enterprise communicated false and misleading information to Providers and falsely denied that it had information requested by Providers about the basis for the drastically-cut and unreasonable reimbursement rates that RICO Defendants sought to impose.

180. In addition, since at least January 1, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to Providers at rates that were far below usual and customary rates and/or reasonable rates for the services provided.

181. For example, on March 5, 2019, RICO Defendants sent Plaintiffs, a Remittance for emergency services provided to Members under multiple procedure codes, including the following for CPT Codes 99284 and 99285:

f. Member #17 was treated on January 1, 2019 at a billed charge of $1,190.00 (CPT Code 99284), for which RICO Defendants, via Data iSight, allowed $413.39.

g. Member #18 was treated on January 30, 2019, at a billed charge of $1,890.00 (CPT Code 99285), for which RICO Defendants, via Data iSight, allowed $435.20.

h. Member #19 was treated on May 26, 2019, at a billed charge of $862.00 (CPT Code 99285), for which RICO Defendants, via Data iSight, allowed $291.86.

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i. Yet, Member #20 was treated on January 21, 2019, at a billed charge of $1,190.00 (CPT Code 99284), for which RICO Defendants, via MultiPlan, allowed $1,071.00 which is 90% of billed charges. This a reasonable rate, in line with the reasonable rates historically paid by RICO Defendants to Providers for non-participating provider services.

182. RICO Defendants and Data iSight expected that those unreasonable payments would be accepted in full satisfaction of Providers' claims.

183. RICO Defendants and Data iSight have received, and continue to receive, financial gains from their scheme to defraud Providers.

184. For the services that Providers provided to RICO Defendants' Members in 2019, only 26% of the non-participating claims have, to date, been reimbursed at reasonable rates, resulting in millions of dollars in financial loss to Providers.

185. The purpose of, and the direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse Providers at unreasonable rates, to the harm of Providers, and to the benefit of the Enterprise.

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

186. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

187. At all material times, Providers were obligated under federal and Arizona law to provide emergency medicine services to all Patients presenting at the emergency departments they staff, including Defendants' Members.

188. At all material times, Defendants were obligated to provide coverage for emergency medicine services to all of its Members. *See e,g.* A.R.S. § 20-2803.

189. At all material times, Defendants knew that Providers were non-participating emergency medicine groups that provided emergency medicine services to Patients.

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190. Providers have undertaken to provide emergency medicine services to Defendants' Members, and Defendants have undertaken to pay for such services provided to Defendants' Members.

191. At all material times, Defendants were aware that Providers were entitled to and expected to be paid at rates in accordance with the standards established under Arizona law.

192. At all material times, Defendants have received Providers' bills for the emergency medicine services Providers provided and continue to provide to Defendants' Members, and Defendants have consistently adjudicated and paid, and continues to adjudicate and pay, Providers directly for the non-participating claims, albeit at amounts less than usual and customary and/or reasonable rates.

193. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by Providers to Defendants' Members, the parties implicitly agreed, and Providers had a reasonable expectation and understanding, that Defendants would reimburse Providers for non-participating claims at rates in accordance with the standards acceptable under Arizona law and in accordance with rates Defendants pay for other substantially identical claims also submitted by Providers.

194. Under Arizona common law, including the doctrine of quantum meruit, Defendants, by undertaking responsibility for payment to Providers for the services rendered to Defendants' Patients, impliedly agreed to reimburse Providers at rates, at a minimum, equivalent to the reasonable value of the professional emergency medical services provided by Providers.

195. Defendants, by undertaking responsibility for payment to Providers for the services rendered to Defendants' Members, impliedly agreed to reimburse Providers at rates, at a minimum, equivalent to the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services provided by Providers.

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196. In breach of its implied contract with Providers, Defendants have and continues to unreasonably and systemically adjudicate the non-participating claims at rates substantially below both the usual and customary fees in the geographic area and the reasonable value of the professional emergency medical services provided by Providers to the Defendants' Patients.

197. Providers have performed all obligations under its implied contract with Defendants concerning emergency medical services to be performed for Patients.

198. At all material times, all conditions precedent have occurred that were necessary for Defendants to perform its obligations under their implied contract to pay Providers for the non-participating claims, at a minimum, based upon the "usual and customary fees in that locality" or the reasonable value of Providers' professional emergency medicine services.

199. Providers did not agree that the lower reimbursement rates paid by Defendants were reasonable or sufficient to compensate Providers for the emergency medical services provided to Patients.

200. Providers have suffered damages in an amount equal to the difference between the amounts paid by Defendants and the usual and customary fees professional emergency medicine services in the same locality, that remain unpaid by Defendants through the date of trial, plus Providers' loss of use of that money; or in an amount equal to the difference between the amounts paid by Defendants and the reasonable value of its professional emergency medicine services, that remain unpaid by Defendants through the date of trial, plus Providers' loss of use of that money.

201. As a result of Defendants' breach of the implied contract to pay Providers for the non-participating claims at the rates required by Arizona law, Providers have suffered injury and is entitled to monetary damages from Defendants to compensate it for that injury in an amount in excess of $300,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

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SECOND CLAIM FOR RELIEF

(Breach of the Implied Covenant of Good Faith and Fair Dealing)

202. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

203. Providers and Defendants have a valid implied-in-fact contract as alleged herein.

204. A special element of reliance or trust between Providers and Defendants, such that, Defendants were in a superior or entrusted position of knowledge.

205. That Providers did perform all or substantially all of their obligations pursuant to the implied-in-fact contract.

206. By paying substantially low rates that did not reasonably compensate Providers the usual and customary rate or alternatively for the reasonable value of the services provided, Defendants performed in a manner that was unfaithful to the purpose of the implied-in-fact contract, or deliberately contravened the intention and sprit of the contract.

207. That Defendants' conduct was a substantial factor in causing damage to Providers.

208. As a result of Defendants' breach of the implied covenant of good faith and fair dealing, Providers have suffered injury and are entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $300,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

209. The acts and omissions of Defendants as alleged herein were attended by circumstances of malice, oppression and/or fraud, thereby justifying an award of punitive or exemplary damages in an amount to be proven at trial.

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THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

210. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein. This claim is pled in the alternative.

211. Providers rendered valuable emergency services to the Patients.

212. Defendants received the benefit of having their healthcare obligations to their plan Members discharged and their Members received the benefit of the emergency care provided to them by Providers.

213. As insurers or plan administrators, Defendants were reasonably notified that emergency medicine service providers such as Providers would expect to be paid by Defendants for the emergency services provided to Patients.

214. Defendants accepted and retained the benefit of the services provided by Providers at the request of the Members of its Health Plans, knowing that Providers expected to be paid a usual and customary fee based on locality, or alternatively for the reasonable value of services provided, for the medically necessary, covered emergency medicine services it performed for Defendants' Members.

215. Defendants have received a benefit from Providers' provision of services to its Patients and the resulting discharge of its healthcare obligations owed to its Members.

216. Under the circumstances set forth above, it is unjust and inequitable for Defendants to retain the benefit it received without paying the value of that benefit; i.e., by paying Providers at usual and customary rates, or alternatively for the reasonable value of services provided, for the claims that are the subject of this action and for all emergency medicine services that Providers will continue to provide to Defendants' Members.

217. Providers seek compensatory damages in an amount which will continue to accrue through the date of trial as a result of Defendants' continuing unjust enrichment.

218. As a result of Defendants' actions, Providers have been damaged in an amount, exclusive of interest, costs and attorneys' fees, which will be proven at the time of trial.

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219. Providers sue for the damages caused by Defendants' conduct and are entitled to recover the difference between the amount Defendants paid for emergency care Providers rendered to their Members and the reasonable value of the service that Providers rendered to Defendants by discharging its obligations to their plan members.

FOURTH CLAIM FOR RELIEF

(Violation of A.R.S. § 20-442)

220. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

221. Arizona law provides that "[n]o person shall engage in this state in any trade practice which is prohibited by this article, or defined in this article as, or determined pursuant to this article to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." A.R.S. § 20-442.

222. The acts and omissions detailed herein are violative of A.R.S. § 20-442.

223. By way of example only, Arizona law prohibits an insurer from engaging in unfair settlement practices. A.R.S. § 20-461. Prohibited unfair claim settlement practices include: (1) "Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." A.R.S. § 20-461(A)(6); and (2) "Failing to promptly provide a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim or for the offer of a compromise settlement." A.R.S. § 20-461(A)(14).

224. As detailed above, Defendants have failed to comply with A.R.S. § 20-461 by failing to pay Providers' medical professionals the usual and customary rate for emergency care provided to Defendants' members. By failing to pay Providers' medical professionals the usual and customary rate Defendants have violated Arizona law and committed an unfair settlement practice.

225. Providers are therefore entitled to recover the difference between the amount Defendants paid for emergency care Providers rendered to their members and the usual and customary rate, plus court costs and attorneys' fees.

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226. Providers are entitled to damages in an amount, exclusive of interest, costs and attorneys' fees, that will be proven at the time of trial.

227. Defendants have acted in bad faith regarding their obligation to pay the usual and customary fee; therefore, Providers are entitled to recover punitive damages against Defendants.

FIFTH CLAIM FOR RELIEF

(Violation of AZ Consumer Fraud Statute)

228. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

229. The Arizona Consumer Fraud Statute prohibits Defendants from engaging in "any deception, deceptive or unfair act or practice, fraud, false pretense, false promise, misrepresentation, or concealment, suppression or omission of any material fact with intent that others rely on such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice." A.R.S. § 44-1522.

230. The Arizona Consumer Fraud Statute provides for a private right of action.

231. Defendants have violated the AZ Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay Providers for the medically necessary, covered emergency services Providers provided to Members in order to gain unfair leverage against Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Providers to accept lower amounts than it is entitled for their services; (b) engaging in systematic efforts to delay adjudication and payment of Providers' claims for their services provided to Defendants' members in violation of Defendants' legal obligations; and (c) misrepresenting that the use of Data iSight for its claims processing was founded on

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transparent actual statistically sound data, rates that are defensible and market tested and geographically based.

232. As a result of Defendants' violations of the Consumer Fraud Statute, the Providers are entitled to damages in an amount to be determined at trial.

233. Due to the willful and knowing engagement in consumer fraud practices, the Providers are entitled to recover damages, including statutory civil penalties permitted under § 44-1522 or otherwise, and all profits derived from the knowing and willful violation.

SIXTH CLAIM FOR RELIEF

(Declaratory Judgment)

234. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

235. This is a claim for declaratory judgment and actual damages pursuant to A.R.S. 12-1831 *et seq.*

236. As explained above, pursuant to federal and Arizona law, Defendants are required to cover and pay Providers for the medically necessary, covered emergency medicine services Providers have provided and continues to provide to Defendants' members.

237. Under Arizona law, Defendants are required to pay Providers the usual and customary rate for that emergency care. Instead of reimbursing Providers at the usual and customary rate or for the reasonable value of the professional medical services, Defendants has reimbursed Providers at reduced rates with no relation to the usual and customary rate.

238. As alleged herein, Providers became out-of-network with the Defendants. Since then, Defendants have demonstrated their refusal to timely settle insurance claims submitted by Providers and has failed to pay the usual and customary rate based on this locality in violation of Defendants' obligations under the Arizona Insurance Code, the

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parties' implied-in-fact contract and pursuant to Arizona law of unjust enrichment and quantum merit.

239. An actual, justiciable controversy therefore exists between the parties regarding the rate of payment for Providers' emergency care that is the usual and customary rate that Defendants are obligated to pay.

240. Pursuant to A.R.S. 12-1831 *et seq.*, Providers therefore request a declaration establishing the usual and customary rates that Providers are entitled to receive for all claims at up to and through trial, as well as a declaration that Defendants are required to pay to Providers at a usual and customary rate for claims submitted thereafter.

SEVENTH CLAIM FOR RELIEF

(Violation of A.R.S. § 13-2314.04 - RICO Defendants)

241. Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

242. Arizona law allows for a private cause of action for injury resulting from a pattern of unlawful activity. A.R.S. § 13-2301 *et seq.* Specifically, A.R.S. § 13–2314.04(A) provides that:

> A person who sustains reasonably foreseeable injury to his person, business or property by a pattern of racketeering activity, or by a violation of § 13–2312 involving a pattern of racketeering activity, may file an action in superior court for the recovery of up to treble damages and the costs of the suit, including reasonable attorney fees for trial and appellate representation.

243. "Racketeering" includes, among things, any act or preparatory act committed for financial gain, chargeable or indictable under the law where the act occurred and punishable by more than a year's imprisonment. A.R.S. § 13-2301(D)(4)(b).

244. A pattern of unlawful activity includes, among other things, a person who engages in illegally controlling an enterprise and a scheme or artifice to defraud that results in knowingly obtaining a financial benefit by means of false or fraudulent

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pretenses, representations, promises or material omissions. A.R.S. § 13-2301(D)(4)(b)(xv); A.R.S. § 13-2310; A.R.S. § 13-2312.

245. A "pattern of racketeering activity" means, among things, that there must be at least two related and continuous acts of "racketeering" defined in § 13-2301(D)(4), including, but not limited to, item (xv). A.R.S. § 13-2314.04(T)(3)(a). Additionally, a pattern of unlawful activity requires relatedness, continuity and occurrence within five years of one another.

246. Since at least January 2019, Providers sustained reasonably foreseeable injury to their business by a pattern of unlawful activity and/or by violation of A.R.S § 13-2312 involving a pattern of unlawful activity.

247. Providers are a "person" within the meaning of A.R.S. § 13-2314.04(A).

248. The RICO Defendants are a "person" within the meaning of A.R.S. § 13-2310.

249. Since at least January 2019, the RICO Defendants, have been and continue to be, engaged in preparations and implementation of a scheme to defraud Providers by committing a series of unlawful acts designed to obtain a financial benefit by means of false or fraudulent pretenses, representations, promises or material omissions which constitute predicate unlawful activity under A.R.S. § 13-2310, in violation of in violation of A.R.S. § 13-2314.04. The RICO Defendants have engaged in more than two related and continuous acts amounting to a pattern of unlawful activity pursuant to a scheme or artifice to defraud and to which the RICO Defendants have committed for financial benefit and gain to the detriment of Providers. The RICO Defendants, on more than two occasions, have schemed with Data iSight to artificially and without foundation substantially decrease non-participating provider reimbursement rates while continuing to represent that the reimbursement rates are based on legitimate cost data or paid data.

250. The foregoing acts establish a pattern of unlawful activity are related to each other in that they further the joint goal of unfairly and illegally retaining financial benefit to the detriment of Providers. In each of the examples provided herein, the acts alleged

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to establish a pattern of unlawful activity are related because they have the same or similar purposes, results, participants, victims and/or methods of commission.

251. Since at least January 2019, RICO Defendants have been and continue to be, a part the Enterprise within the meaning of A.R.S. § 13-2301(D)(2), comprised the RICO Defendants and Data iSight, and which Enterprise was and is illegally controlled by the RICO Defendants and/or being illegally conducted through a pattern of unlawful activity or participating directly or indirectly in the conduct of the Enterprise.

252. Each of the RICO Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

253. RICO Defendants and Data iSight had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding Providers and preventing Providers from obtaining reasonable payment for the services they provided to RICO Defendants' Members, in retaliation for Providers' lawful refusal to agree to RICO Defendants' massively discounted and unreasonable proposed contractual rates.

254. Each RICO Defendant provides benefits to insured members, processes claims for services provided to members, and/or issues payments for services and knows and willingly participates in the scheme to defraud Providers.

255. As a direct and proximate result of RICO Defendants' violations of A.R.S. § 13-2314.04, Providers have sustained a reasonably foreseeable injury in their business by a pattern of unlawful activity, suffering direct and substantial financial losses within the meaning of A.R.S. § 13-2314.04. Specifically, but for the unlawful acts of the RICO Defendants in falsely representing the validity of Data iSight statistical data, Providers would not have suffered the loss of millions of dollars in underpaid claims which the RICO Defendants repeatedly represented were reasonable/usual and customary rates of payment.

256. RICO Defendants have been and continue to be, a part of an enterprise within the meaning of A.R.S. § 13-2301(D)(2).

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257. The RICO Defendants have and are illegally controlling the Enterprise by acquiring or maintaining, by investment or otherwise, control of any enterprise through a pattern of unlawful activity or their proceeds; and/or illegally conducting an enterprise, i.e., a person employed by or associated with enterprise is conducting the affairs of the Enterprise through a pattern of unlawful activity or participating directly or indirectly in the conduct of any enterprise that the person knows is being conducted through a pattern of unlawful activity. A.R.S. § 13-2312(A)-(B).

258. For purposes of A.R.S. § 13-2301(D)(1), the RICO Defendants "control" the Enterprise because they possess sufficient means to permit substantial direction over the affairs of the Enterprise. A.R.S. § 13-2301(D)(1).

259. As an Enterprise that acquired financial benefit or property through violation of A.R.S. § 13-2312, the RICO Defendants are involuntary trustees, and the involuntary trustees, must hold the property, their proceeds and their fruits in constructive trust for the benefit of persons entitled to remedies under A.R.S. § 13-2314.04. A.R.S. § 13-2314.04(D)(6).

260. Providers are entitled to damages in an amount, exclusive of interest, costs and attorneys' fees, that will be proven at the time of trial.

261. Providers are entitled to treble damages and the costs of the suit, including reasonable attorney fees for trial and appellate representation pursuant to A.R.S. § 13-2314.04.

PRAYER FOR RELIEF

WHEREFORE, Providers pray for judgment as follows:

A. Judgment in their favor on their First Amended Complaint;

B. Awards of actual, consequential, general, and special damages in an amount which will be proven at trial;

C. An award of punitive damages, the exact amount of which will be proven at trial;

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D. A declaratory judgment that Defendants' failure to pay Providers a usual and customary fee or rate for this locality or alternatively, for the reasonable value of their services, violates Arizona law, breaches the parties' implied-in-fact contract, is a tortious breach of the implied covenant of good faith and fair dealing, and violates Arizona common law;

E. An order permanently enjoining Defendants from paying rates that do not represent usual and customary fees or rates for this locality or alternatively, that do not compensate Providers for the reasonable value of their services; and enjoining Defendants from engaging in acts or omissions that are violative of Arizona law;

F. Judgment against the RICO Defendants and in favor of Providers pursuant to the Seventh Claim for Relief in an amount constituting treble damages resulting from Defendants' underpayments to Providers for the reasonable value of the emergency services provided to Defendants' Members and reasonable attorneys' fees and costs incurred in bringing this action;

G. Providers' costs and reasonable attorneys' fees pursuant to A.R.S. §§ 12-341 and 12-341.01;

H. Pre-judgment and post-judgment interest at the highest rates permitted by law; and

I. Such other and further relief as the Court may deem just and proper.

JURY DEMAND

Providers hereby demand trial by jury on all issues so triable.

DATED this 9th day of August, 2019.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*
Pat Lundvall (admitted *pro hac vice*)
Kristen T. Gallagher (admitted *pro hac vice*)
Amanda M. Perach (admitted *pro hac vice*)

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VERIFICATION PURSUANT TO A.R.S. § 13-2314.04(O)

Under penalties of perjury, the undersigned declares that he is a representative of the Plaintiffs named in the foregoing First Amended Complaint and knows the contents thereof; that the pleading is true of his knowledge, except as to those matters stated on information and belief, and that as to such matters he believes it to be true.

Executed: August 9, 2019.

Kent Bristow

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 9th day of August 2019, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via the U.S. District Court's CM/ECF filing system and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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/s/ *Marianne Carter*
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EXHIBIT 7

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA

CASE NO. _____

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC. UNITED HEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

NOTICE OF REMOVAL

PLEASE TAKE NOTICE that pursuant to 28 U.S.C. §§ 1331, 1441, and 1446, Defendant, MultiPlan, Inc. ("MultiPlan"), by and through undersigned counsel, and with a full reservation of rights, hereby removes the above-titled matter, *Gulf-to-Bay Anesthesiology Associates, LLC v. United Healthcare of Florida, Inc., et al.*, bearing Case No. 20-CA-008606, from the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida, where it is currently pending, to the United States District Court for the Middle District of Florida, and as grounds therefor, alleges as follows:

INTRODUCTION

1. As discussed in more detail below, MultiPlan removes this matter on the basis of federal question jurisdiction pursuant to 28 U.S.C. § 1331 because certain state law causes of action alleged by Plaintiff, Gulf-to-Bay Anesthesiology Associates, LLC ("GTB" or "Plaintiff"), relate to self-funded employee health and welfare benefit plans and therefore arise under and are subject

to federal law pursuant to the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA").

2. This action is properly removed to this Court, as it has original jurisdiction based on ERISA's complete preemption doctrine. It is removable without regard to the citizenship or residence of the parties.

Background and Procedural History

3. On or about November 2, 2020, Plaintiff GTB filed a complaint (the "Complaint" or "Compl.") in the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida, in an action styled as *Gulf-to-Bay Anesthesiology Associates, LLC vs. United HealthCare of Florida, Inc., UnitedHealthcare Insurance Co., UMR, Inc., and MultiPlan, Inc.*, and bearing Case No. 20-CA-008606 (the "State Court Action").

4. MultiPlan was served with process on November 12, 2020. Thus, this Notice of Removal is timely, as it is being filed within thirty (30) days of the date that MultiPlan was served with a copy of the Complaint in accordance with 28 U.S.C. §§ 1441 and 1446.

5. Pursuant to 28 U.S.C. § 1446(a), true and correct copies of all process, pleadings, and orders served upon MultiPlan in the State Court Action are attached hereto as Composite **Exhibit A**.

6. MultiPlan is not the only defendant named in the Complaint. United Healthcare of Florida, Inc. ("UHC of Florida"), UnitedHealthcare Insurance Co. ("UHIC"), and UMR, Inc. ("UMR" and, together with UHC of Florida and UHIC, "United" or the "United Defendants") are also named as defendants.

7. As evidenced by the Notice of Consent to Removal, which is attached hereto as **Exhibit B**, United consents to removal of the State Court Action to this Court in accordance with 28 U.S.C. §§ 1446(b)(2)(A) and (C).

Plaintiff's Allegations

8. GTB provides professional "anesthesia care for surgical and pain management services at over twenty (20) healthcare facilities in Central Florida." [Compl., ¶¶ 1, 17]. GTB allegedly became an out-of-network, nonparticipating provider with United on May 21, 2017, and "[a]t no time since May 21, 2017," has GTB "been a participating provider with any United Defendant" or "been a party to a direct and express contract with United […] that governs the reimbursement, or any other aspect, of the services provided by [GTB] to United['s …] Members." [*Id.* ¶¶ 4–5, 30]. In-network, participating providers, by contrast, enter into participation agreements with United that govern reimbursement rates.

9. According to the Complaint, UHC of Florida "operates […] as a health maintenance organization," whereas UHIC "operates […] as a life and health insurer" and UMR "operates […] as a third-party administrator." [Compl., ¶¶ 18–20]. However, the United Defendants are "all subsidiaries" operating under the "common control" and "common ownership of UnitedHealth Group," the "largest health insurer in the United States," and when they "enter into participating provider agreements in Florida, [they] do so on behalf of themselves and all 'Affiliates,' which are defined to include 'entities controlling, controlled by or under common control' with each other." [*Id.* ¶¶ 21–22, 279]. Accordingly, a participating provider agreement entered into by one of the United Defendants covers the benefit claims submitted by the participating provider for UHC of Florida, UHIC, and UMR, "among other of the United Defendants' related entities." [*Id.* ¶¶ 22, 279]. Additionally, the United Defendants allegedly

"operate in concert with one another, as they direct that all claims for reimbursement for anesthesia services be uploaded to the same electronic filing portal." [*Id.* ¶¶ 23, 280].

10. The United Defendants allegedly "assume responsibility to pay for health care services rendered to Members covered by their health plans" in exchange for premiums, fees, or other compensation and offer a range of health plans, which "generally fall into one of two categories:" (i) fully-funded plans, "in which United Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds generated by those premiums;" and (ii) employer-funded plans, "in which United Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer." [Compl., ¶¶ 48–50].

11. Regardless of whether a given health plan is fully-funded (i.e., insured by United) or employer-funded (i.e., administered by United as third-party administrator), GTB uses the term "Member" to refer to any individual covered under a health plan that was issued or administered by United. [*See* Compl., ¶ 1].

12 In its Complaint, GTB seeks to recover "full payment" for the "medically necessary anesthesia services" it allegedly rendered "to Florida patients insured by" United or by "an employer-funded health plan for which the United Defendants serve as a third-party administrator." [Compl., ¶¶ 1, 6]. GTB alleges that all of the benefit claims at issue in this action "are for reimbursement for services [GTB] provided at times when it was a non-participating (or 'out-of-network') provider" with United. [*Id.* ¶ 31]. GTB further alleges that it "already sued certain of the Defendants for inadequate reimbursement of out-of-network claims from May 21, 2017 through February 29, 2020, in the case styled *Gulf-to-Bay Anesthesiology Associates, LLC*

v. UnitedHealthcare of Florida, Inc. and UnitedHealthcare Insurance Co., Case No.: 17-CA-011207, in and for the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida" ("*Gulf-to-Bay* I"), and that the at-issue claims in this case "are for the period of time commencing March 1, 2020 and forward." [*Id.* ¶ 14].

13. As set forth in the Complaint, GTB and United were formerly bound by a Participation Agreement from May 20, 2003 until May 20, 2017. [Compl., ¶ 2]. While that Participation Agreement was in effect, GTB rendered anesthesia services to United's members "at a *modest* discount [rate] off of [GTB's] standard billed charges" in GTB's capacity as a "participating provider in United Defendants' provider network." [Compl., ¶¶ 2–3 (emphasis in original)]. But on May 21, 2017, the Participation Agreement ended, and GTB became an "out-of-network provider" with United. [*Id.* ¶¶ 4–5].

14. GTB claims that, "[d]espite its out-of-network status," it has continued to provide "medically necessary, covered anesthesiology services" to United's members, but that, "[i]stead of reimbursing [GTB] at either its billed charges or the usual and customary charges for [its] services," United has "dramatically underpaid" GTB for the services it rendered to United's members "by utilizing extraordinarily deficient reimbursement rates […] generated and supplied to [United] by MultiPlan through MultiPlan's Data iSight 'service.'" [Compl., ¶¶ 6–9, 32–34].

15. Accordingly, the Complaint seeks relief for what GTB describes as "unlawful discounted payments" for the anesthesia services it rendered to United's members, "caused by Defendants' unlawful scheme to deprive [GTB] of its property (claims to and the rights to receive lawful reimbursement amounts) under Florida law." [Compl., ¶¶ 15, 34].

16. Each count in the Complaint rests on the premise that GTB is allegedly entitled to "charges" or "billed charges" [*see* Compl., ¶ 7, 12, 35, 45–46, 70, 232] under Section 641.513(5)

of the Florida Statutes. GTB also alleges that Section 641.513(5) warrants payment of certain benefits regardless of whether such benefits are covered under the health plans in which United's members participate. [*See, e.g.*, *id.* ¶¶ 35–37]. Importantly, however, GTB specifically acknowledges United's obligation to "determine[]" whether claims for benefits are "***to be covered and allowed as payable***" under the terms of its members' health plans. [*Id.* ¶¶ 12, 45 (emphasis added)].

17. That premise in the Complaint—that GTB is entitled to "charges" or "billed charges" under Section 641.513(5)—is fundamentally flawed for at least two reasons. First, it is in tension with GTB's allegation that this lawsuit "arises only from claims involving United Defendants' commercial plans and products."[1] [Compl., ¶ 11]. Second, the Complaint repeatedly refers to United's "Members" who received services from GTB [*id.* ¶¶ 1–2, 5–6, 11–12, 32, 34, 41–43, 59, 70, 72, 227, 244, 296, 300, 308, 317], and these "Members" include participants in ERISA plans. [*See id.* ¶ 1 (alleging that GTB is seeking payment in this lawsuit "for the anesthesiology medical care it has rendered to Florida patients insured […] by an employer-funded

[1] For example, § 641.513(5) of the Florida Statutes does not, by its express terms, apply to private employers that self-fund their health plans, and no court has permitted a provider to apply that statute to such plans.

health plan for which the United Defendants serve as a third-party administrator"); *see also* ¶¶ 48–51].[2]

18. Additionally, while GTB contends that the benefit claims at issue "do not relate to or involve [GTB's] *right* to payment, […] but rather the *rate* of payment [GTB] is entitled to receive for its services" [Compl., ¶ 13 (emphasis in original)], this is expressly belied by GTB's admission that, "[t]hrough this action, [it] seeks to recover the damages […] caused by Defendants' unlawful scheme to deprive [GTB] of its property (claims to and ***the rights to receive lawful reimbursement amounts***) under Florida law." [*Id.* ¶¶ 15, 71 (emphasis added)].

19. At bottom, GTB seeks to recover benefits under ERISA plans. Therefore, GTB's causes of action necessarily fall within the scope of ERISA and are completely preempted.

20. Specifically, Counts I and II of the Complaint allege claims against all Defendants for violation of Florida's Racketeer Influenced and Corrupt Organization ("RICO") Act pursuant to Fla. Stat. § 895.03(3) and for conspiracy to violate Florida's RICO Act pursuant to Fla. Stat. § 895.03(4), which are premised on allegations that GTB "was paid substantially less than its charges or a usual and customary rate" for the anesthesia services it rendered to United's members [Compl., ¶ 232], and that "[e]ach Defendant provides benefits to insured Members, processes claims for

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[2] ERISA applies to employee welfare benefit plans, which are defined to include:
> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C.A. § 1002.

services provided to Members, purports to determine and recommend a reimbursement rate for such services, and/or issues payments for services." [*Id.* ¶ 298; *see also* ¶¶ 227–41, 272, 286–89, 296, 300, 306, 308]. Counts I and II are therefore completely preempted by ERISA. *See All. Med, LLC v. Blue Cross & Blue Shield of Ga., Inc*., 2016 WL 3208077, at *3 (N.D. Ga. June 10, 2016) (holding that claims for "misrepresentation, fraud, unfair trade practices, theft by deception, and RICO conspiracy" were completely preempted by ERISA).

21. Similarly, Counts III and IV of the Complaint allege claims against all Defendants for violation of Florida's Civil Remedies for Criminal Practices Act ("CRCPA") pursuant to Fla. Stat. § 772.103(3) and for conspiracy to violate CRCPA under Fla. Stat. § 772.103(4) based on allegations that "Defendants had, and continue to have, the common and continuing purpose of depriving [GTB] of the reimbursement to which [it is] entitled" for services rendered to United's members, and that "[e]ach Defendant provides benefits to insured Members, processes claims for services provided to Members, purports to determine and recommend a reimbursement rate for such services, and/or issues payments for services, and knowingly and willingly participants in the scheme to defraud [GTB] and retain funds allocated to [GTB] for anesthesia services rendered to United Defendants' Members." [Compl., ¶¶ 315, 317]. Counts III and IV are therefore completely preempted by ERISA.

22. Finally, Count V of the Complaint asserts a claim against MultiPlan only for violation of Florida's Deceptive and Unfair Trade Practices Act ("FDUTPA"), which claim is based solely on underpayment allegations, [*see, e.g.*, Compl. ¶ 333: GTB "has received deficient reimbursements from United on all of the Claims at amounts less than [GTB] is entitled to receive;" *see also* ¶¶ 331–32], and thus is completely preempted by ERISA. *See Ehlen Floor Covering, Inc. v. Lamb*, 2008 WL 4097712, at *5 (M.D. Fla. Sept. 3, 2008) (finding that all of the plaintiffs'

claims, including their FDUTA claim, were subject to the ERISA complete preemption doctrine); *Weinberger v. Aetna Health, Inc.*, 2008 WL 11333422, at *15 (S.D. Fla. Apr. 15, 2008), *report and recommendation adopted*, 2008 WL 11333408 (S.D. Fla. May 27, 2008) (holding that Plaintiff's FDUTA claim was completely preempted by ERISA).

BASIS FOR REMOVAL

Federal Question Jurisdiction – Complete Preemption

23. This Court has jurisdiction under 28 U.S.C. § 1331 because GTB's causes of action are completely preempted by ERISA.

24. Although federal question jurisdiction ordinarily is governed by the well-pleaded complaint rule, "[a]n exception to this rule is when Congress so completely pre-empt[s] a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Brown v. Connecticut Gen. Life Ins. Co.*, 934 F.2d 1193, 1196 (11th Cir. 1991) (internal quotation omitted). "The effect of this exception is to convert what would ordinarily be a state claim into a claim arising under the laws of the United States." *Id.*; *see also Ehlen Floor Covering, Inc. v. Lamb*, 660 F.3d 1283, 1287 (11th Cir. 2011).

25. State court actions that fall within the scope of § 502(a) of ERISA, such as a claim for improper denial of benefits under state law, are "displaced" by ERISA's civil enforcement mechanism and are therefore "removable to federal court." *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 60 (1987); *see also Lamb*, 660 F.3d at 1287 ("Regardless of its characterization as a state law matter, a claim will be re-characterized as federal in nature if it seeks relief under ERISA."). In fact, when a "federal statute [such as ERISA] completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207-08 (2004).

26. A state law cause of action is subject to complete preemption under ERISA when: (i) the plaintiff "could have brought [its] claim under ERISA § 502(a)(1)(B)"; and (ii) "there is no other independent legal duty that is implicated by a defendant's actions." *Davila*, 542 U.S. at 210.

27. With respect to prong one of the *Davila* test, a claim for relief can be brought under ERISA § 502(a)(1)(B) by a "participant or beneficiary […] to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). This prong is satisfied if a plaintiff has standing to sue and the claim "fall[s] within the scope of ERISA." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1350 (11th Cir. 2009).

28. By its own admission, GTB has already sued two of the United Defendants, UHC of Florida and UHIC "for inadequate reimbursement of out-of-network claims from May 21, 2017 through February 29, 2020," [*see* Compl., ¶ 14], and that litigation contains evidence that, when GTB submitted the benefit claims to UHIC in order to elicit the payment of available benefits under the terms of the "Members'" plans, GTB represented that the relevant patients/members had assigned their rights to benefits under their health plans to GTB, and that GTB had accepted those assignments.

29. Similarly, an initial investigation of GTB's claims and allegations in the instant case[3] reveals that, when GTB submitted benefit claims to the United Defendants in order to elicit the payment of available benefits under the terms of the "Members'" plans, GTB specifically represented that the patients had assigned their rights to benefits under the terms of their health plans to GTB.[4] Therefore, GTB—by allegedly stepping into the shoes of its patients—obtained the derivative right to sue and are "beneficiaries" of the health plan for purposes of complete preemption under ERISA. *See, e.g.*, *Conn. State Dental*, 591 F.3d at 1351 (finding that claim forms submitted by dentists to the defendant ERISA plan insurer "suffice to show an assignment of benefits" and confer ERISA standing for removal purposes); *Borrero v. United Healthcare of New York, Inc.*, 610 F.3d 1296, 1302–04 (11th Cir. 2010) (rejecting the arguments raised by medical provider Plaintiff who contested the adequacy of claim forms as the basis for finding they possessed derivative standing under ERISA for removal purposes).

30. GTB also submitted reimbursement benefit claims directly to the United Defendants and received payments from the United Defendants for certain of the benefit claims. [*See* Compl. ¶¶ 6–7, 32–34]. These direct payments further support prong one of the *Davila* test. *See Conn. State Dental*, 591 F.3d at 1353; *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701

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[3] Aside from ¶¶ 120–122 of the Complaint, where GTB loosely identifies six (6) exemplary claims that it submitted to the United Defendants during the time period allegedly at issue, GTB fails to provide any claim-specific identifying information for the claims it purports to place at issue in this lawsuit. This omission has limited MultiPlan's ability to collect and present evidence to the Court along with this Notice. However, MultiPlan's investigation continues, and MultiPlan specifically reserves the right to submit additional evidence in opposition to any motion to remand that GTB may file. MultiPlan also reserves the right to seek permission to conduct limited jurisdictional discovery to resolve any factual disputes presented herein, including with respect to GTB's receipt of assignment of benefits and/or the nature of the claims or underlying health benefit plans allegedly at issue. *See, e.g.*, *United Surgical Assistants, LLC v. Aetna Life Ins. Co.*, 2014 WL 1268659, at *3 (M.D. Fla. March 27, 2014) (granting motion to allow post-removal jurisdictional discovery regarding assignment of benefits in case involving question of federal subject matter jurisdiction on basis of ERISA preemption).

(7th Cir. 1991) ("The possibility of direct payment is enough to establish subject-matter jurisdiction.").

31. With respect to prong two of the *Davila* test, there is no legal duty implicated here independent of the members' plans. "If the right to payment derives from the ERISA benefit plan as opposed to another independent obligation, the resolution of a right to payment dispute requires an interpretation of the plan." *Gables Ins. Recovery v. United Healthcare Ins. Co.*, 39 F. Supp. 3d 1377, 1388 (S.D. Fla. 2013).

32. Here, this distinction is irrelevant because GTB repeatedly alleges that it is "out-of-network" and "has not been part[y] to a contract with United that governs the reimbursement, or any other suspect, of the services provided by" GTB to United's Members since May 21, 2017, [Compl., ¶¶ 5–6, 30–33]; thus, there is no independent contractual right to reimbursement at rates higher than what is afforded under the members' health plans. *See, e.g.*, *Sarasota Cty. Pub. Hospital Bd. v. Blue Cross and Blue Shield of Fla., Inc.,* 2019 WL 2567979, at *3 (M.D. Fla. June 21, 2019) (dismissing counts for breach of provider agreements as "irrelevant" to the question of standing where plaintiff brought other counts asserting ERISA right-to-payment claims, which conferred standing to sue). The reimbursement amounts that the United Defendants have paid to GTB for the services at issue in this lawsuit—as a non-participating provider—are set by the

[4] Attached hereto as **Exhibit D** is the benefit claim submission data (redacted to exclude personal health information) and a provider remittance advice form ("PRAs") (redacted to exclude personal health information) related to certain benefit claims that GTB submitted to the United Defendants on or after March 1, 2020. Specifically, **Exhibit D(1)** contains the benefit claim submission data and a PRA relating to patient RB, who is identified in ¶ 120 of the Complaint. This benefit claim submission data contains authorization and assignment acknowledgements (*see* Boxes 12 and 13), whereby GTB represented that benefits were assigned to it, meaning that it obtained a signed authorization and assignment of benefits from the plan member or beneficiary, allowing GTB to receive benefits under the applicable employee benefit plan. *See also* **Exhibits D(2)** and **D(3)**.

coverage terms of the members' health plans. *See Gables Ins. Recovery*, 39 F. Supp. 3d at 1388 (finding ERISA completely preempted state law claims and holding, "any determination of benefits under the terms of an ERISA plan, even regarding a seeming independent breach of oral or implied contract based on verification of those benefits, falls under ERISA and is a legal duty dependent on, not independent of, the ERISA plan."). Thus, determining the core issue of whether GTB has been denied payment or coverage for the services at issue in this lawsuit will necessarily require the Court to interpret those member's health plans, squarely bringing these claims within the scope of ERISA preemption. *See id.* ("If the right to payment derives from the ERISA benefit plan as opposed to another independent obligation, the resolution of a right to payment dispute requires an interpretation of the plan.").

33. Any attempt to rely on a purported distinction between so-called "right to payment" claims and "rate of payment" claims to oppose preemption is unavailing. The Eleventh Circuit Court of Appeals has applied this distinction only in cases where a healthcare provider has an express written participation agreement with a managed care organization and is suing for breach of contract under that express agreement.[5] Here, as GTB repeatedly alleges, there is no participating provider agreement that independently supplies either a right to payment or a rate of

[5] *See Conn. State Dental*, 591 F.3d at 1350; *see also Apex Toxicology, LLC v. United Healthcare Ins. Co.*, No. 16-CV-62768, 2017 WL 7806152, at *5 (S.D. Fla. June 26, 2017) (concluding that the benefit claims at issue involved the denial of benefit claims under ERISA because "[t]he distinction between 'rate of payment' and 'right of payment' […] is irrelevant in cases involving out-of-network providers because a 'rate of payment' dispute is governed by the provider agreement.") (citing *Conn. State Dental*, 591 F.3d at 1349); *See also Alliance Med, LLC v. Blue Cross and Blue Shield of Georgia, Inc.*, 15-cv-00171-RWS, 2016 WL 3208077, at *3 (N.D. Ga. June 10, 2016) ("Although Plaintiffs rely on the distinction between 'rate of payment' and 'right of payment,' this distinction is irrelevant in cases involving out of network providers because a 'rate of payment' dispute is governed by the provider agreement. Plaintiffs in this case are not in-network providers and thus do not hold a provider agreement with Defendants. Therefore, these claims are within the scope of ERISA.") (citing *Conn. State Dental*, 591 F.3d at 1349).

payment. For that reason, it is irrelevant whether the right to payment or rate of payment is implicated by Plaintiffs' claims.[6]

34. Even if this "rate of payment" versus "right to payment" dichotomy applies in the case of a plaintiff-provider that admits it has no contract with the defendants (which is the case), GTB's claims in this case still implicate "right to payment" issuesand thus are completely preempted by ERISA. *See generally Borrero*, 610 F.3d at 1301–05 (citing *Conn. State Dental*, 591 F.3d at 1350–54)). GTB actually concedes this point when it asserts that, "[t]hrough this action, [it] seeks to recover the damages […] caused by Defendants' unlawful scheme to deprive [GTB] of its property (claims to and ***the rights to receive lawful reimbursement amounts***) under Florida law." [Compl., ¶¶ 15, 71 (emphasis added)].

35. GTB further acknowledges and refers to the United Defendants' obligation to "Members," including referencing the determination of coverage under the members' health plans insured or administered by United. [*See, e.g.*, Compl., ¶ 12]. Accordingly, GTB cannot evade ERISA preemption by incorrectly describing its claims as implicating only a "rate of payment," when those claims actually implicate a "right to payment" under the operative ERISA health benefit plans, including contracts between the United Defendants and members of fully-insured ERISA plans. For example, GTB alleges on numerous occasions that Florida law has been violated because "the united Defendants have dramatically underpaid [GTB] for its services" rendered to United's members. [*See, e.g.*, *id.* ¶ 7]. But GTB was aware of how such benefit payment

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[6] *See*, *e.g.*, *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182 (5th Cir. 2015*); Emerus Hosp. v. Health Care Serv. Corp.*, 2020 WL 1675665, at *5 (N.D. Ill. Apr. 6, 2020); *Hill Country Emergency Med. Assocs, P.A. v. UnitedHealthCare Ins. Co.*, No. 19-cv-00548-RP, Order at 7–8 (W.D. Tex. Dec. 10, 2019); *Bassel v. Aetna Health Ins. Co. of N.Y.*, 2018 WL 4288635, at *6 (E.D.N.Y. Sept. 7, 2018); *Apex Toxicology, LLC v. United Healthcare Ins. Co.*, 2017 WL 7806152, at *5 (S.D. Fla. June 26, 2017); *Sportscare of Am., P.C. v. Multiplan, Inc.*, 2011 WL 223724, at *4 (D.N.J. Jan. 24, 2011).

determinations would be made in relation to United's Members, including by the United Defendants "process[ing] claims for services provided to Members" and determining claims "to be covered and allowed as payable," consistent with the terms of the members' benefit plans. [*Id.* ¶¶ 12, 45, 298].

36. GTB also repeatedly refers to "covered" services—i.e., services covered under the terms of the members' benefit plans. [Compl. ¶¶ 12, 32, 45]. An initial investigation into GTB claims and allegations reveals that at least some of the benefit claims that GTB submitted during the relevant time period were made from ERISA plans and are comprised of claim lines that reflect either partial payment of some claim lines and denials of other claim lines or reductions based on the terms of the patient's health benefit plan.[7] *See Borrero*, 610 F.3d at 1302 (applying Eleventh Circuit precedent concluding that providers' complaint "challenged both the rate of payment and the right to payment under the ERISA plan because it alleged that the administrator both paid them the wrong rate and denied payment altogether for 'medically necessary' services, a coverage determination defined by the beneficiary's ERISA plan.") (citing *Conn. State Dental*, 591 F.3d at 1350–51). GTB purports not to pursue "any claims in which benefits were denied," [*see* Compl., ¶ 13], but at the same time specifically admits that "the reimbursement claims within the scope of this action are ones that were determined to be covered and allowed as payable by the United Defendants but [… were] paid [by the United Defendants] at rates below both the billed charges

[7] **Exhibits D(2)** and **D(3)** contain claim submission data (redacted to exclude personal health information) and PRAs (redacted to exclude personal health information) related to certain claims that GTB submitted to the United Defendants on or after March 1, 2020, pursuant to employer-sponsored health benefit plans. The PRAs included in **Exhibits D(2)** and **D(3)** reflect that the claims submitted included multiple claims lines, some of which were partially paid, and some of which were denied. Additionally, **Exhibit D(1)** contains claim submission data and a PRA relating to patient RB, who is identified in ¶ 120 of the Complaint. The PRA included in Exhibit "D(1)" reflects that payment on the claim was reduced based on the plan terms and benefits, which implicates the question of whether GTB has a "right to payment" of that portion of the claim.

and the usual and customary provider charges for similar services in the community where [GTB] rendered such services to United's Members […] for the period of time commencing March 1, 2020 and forward," [*id.* ¶¶ 12, 14], which necessarily includes such "hybrid" claims—i.e., claims comprised of claim lines for services that were partially paid and claim lines that were denied—that the Eleventh Circuit has concluded come within ERISA. *Borrero*, 610 F.3d at 1302–03. For this additional reason, the Complaint implicates GTB's "right to payment" for the benefit claims, as coverage determinations are directly at issue.

37. At its core, GTB's Complaint challenges benefit determinations based upon GTB's submission of reimbursement benefit claims under various health plans insured or administered by the United Defendants. GTB's attempt to cast its causes of action under state-law principles of state statutory violations, conspiracy, and unfair trade practices does not allow GTB to circumvent ERISA preemption: "[m]erely referring to labels affixed to claims to distinguish between preempted and non-preempted claims is not helpful because doing so would elevate form over substance and allow parties to evade the pre-emptive scope of ERISA." *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Florida, Inc.*, 813 F.3d 1333, 1337 n.2 (11th Cir. 2015) (internal quotation and citation omitted).[8]

38. The ERISA plans associated with each of the reimbursement benefit claims at issue in the Complaint must be examined in order to consider the merits of the benefit claim

[8] Recently, the court in *Sarasota County Public Hospital Board v. Blue Cross and Blue Shield of Florida, Inc.* denied a motion to remand on account of ERISA preemption because the complaint "appears to include coverage denials under ERISA-regulated plans," and noted that "even a dispute about a single coverage determination under an ERISA-regulated plan establishes complete preemption." 2019 WL 2567979, at *3 (M.D. Fla. June 21, 2019). The court further held that "because several of the purported breach of contract claims challenge the defendants' coverage determinations, ERISA, and not an independent legal duty, controls these claims." *Id.* The same reasoning applies here.

adjudications that GTB contests, as each plan will establish its own standard for determining allowed amounts for out-of-network services.[9] Therefore, regardless of how GTB has labeled its causes of action, each count of the Complaint is necessarily preempted by ERISA.

Supplemental Jurisdiction

39. As GTB's own allegations make clear, at least some of the reimbursement benefit claims at issue in the Complaint are subject to complete preemption under ERISA insofar as they relate to an employer-sponsored benefit plan that is subject to ERISA. However, to the extent that complete preemption does not apply to, and federal question jurisdiction does not exist for, all of the reimbursement benefit claims contested by GTB, those claims should still remain in this Court under 28 U.S.C. § 1367(a), because GTB's claims "are so related [… that they] form part of the same case or controversy under Article III of the United States Constitution." *Ala. Dental Ass'n v. Blue Cross and Blue Shield of Ala., Inc.*, 2007 WL 25488 at *8 (M.D. Ala. Jan. 3, 2007).

40. In deciding whether a state-law claim is part of the same case or controversy as a federal issue, such that the court should exercise supplemental jurisdiction over the former, courts look to whether the claims arise from the same facts or involve similar occurrences, witnesses or evidence. *Anesthesiology Assocs. of Tallahassee, Fla. P.A. v. Blue Cross and Blue Shield of Fla, Inc.*, 2005 WL 6717869 at *3 (11th Cir. Mar. 18, 2005) ("Both sets of [plaintiff's] claims are based on the plan participants' rights to reimbursement from BCBS for medical service expenses performed."). Here, GTB's claims all relate to the same common nucleus of facts because they all relate to whether, as GTB contends, it is entitled, under benefit plans insured or administered by

[9] Because self-funded benefit plans are free from any state insurance regulation, their provisions constitute the sole source of payment obligations. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (announcing that state insurance regulations "do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.").

the United Defendants, to reimbursement at "either its billed charges or the usual and customary charges," or whether the amount payable on the health benefit claims submitted by GTB should be as specified under the terms of the members' health plans insured or administered by United. [*See, e.g.*, Compl. ¶¶ 1, 7]. Accordingly, this Court should exercise jurisdiction over the entire controversy presented in the Complaint. *See Current Wave Medical Sys., Inc. v. Cigna Corp.*, 2007 WL 5389120, at *3, n.1 (M.D. Fla. Aug. 3, 2007).

41. And while there may be claims for benefits that implicate non-ERISA plans, any such claims are still properly before this Court under its supplemental jurisdiction, and therefore, removal of GTB's Complaint in its entirety is appropriate. *See* 28 U.S.C. § 1367(a); *Current Wave Med. Sys., Inc. v. Cigna Corp.*, 2007 WL 5389120, *3, n.1 (M.D. Fla. Aug. 3, 2007).

PROCEDURAL REQUIREMENTS FOR REMOVAL

42. The procedural requirements for removal in 28 U.S.C. § 1446 are all satisfied here.

43. Subsection (a) of that provision requires the removing party to file a notice of removal, signed in accordance with Federal Rule of Civil Procedure 11, "in the district court of the United States for the district and division within which such action is pending," which MultiPlan has done through the filing of this Notice.

44. Additionally, under 28 U.S.C. § 1441(a), removal is appropriate "to the district court of the United States for the district and division embracing the place where such action is pending." Venue is therefore proper in this Court pursuant to § 1441(a) and § 1446(a), as the Circuit Court for the Thirteenth Judicial District in and for Hillsborough County, Florida, in which the State Court Action is pending, is within the jurisdictional confines of the Middle District of Florida.

45. MultiPlan was served with process on November 12, 2020, and the United Defendants consent to the removal of this action as evidenced by the written consent attached hereto as **Exhibit B**. Because this Notice is being filed within thirty (30) days after the receipt by MultiPlan, through service of process or otherwise, of a copy of Plaintiff's Complaint, removal is timely under 28 U.S.C. § 1446(b).

46. Upon the filing of this Notice, MultiPlan has, at the same time, provided notice to Plaintiff pursuant to 28 U.S.C. § 1446(d), by furnishing a copy of this Notice and all attachments hereto to Plaintiff, through its counsel of record as identified in the Complaint, and will simultaneously provide notice to the Clerk of Court for the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida, through the filing of this Notice and a separate Notice to State Court of Removal of Civil Action, a copy of which is attached hereto as **Exhibit C**, into the record of the State Court Action.

47. MultiPlan files this Notice without waiving any defenses, arguments, objections, obligations, or principles of law or equity that may exist in its favor in state or federal court, including, but not limited to, the right to object to jurisdiction over the person, service of process, or the sufficiency of process, or the right to seek dismissal of the Complaint, compel arbitration, or both, as permitted by the Federal Rules of Civil Procedure or by state or federal law, and expressly reserves its right to assert any and all defenses and objections to which it may be entitled in subsequent proceedings.

48. The allegations of this Notice are true and correct and within the jurisdiction of the United States District Court for the Middle District of Florida, and for the reasons set forth above, Plaintiff's claims and causes of actions are believed to be removable to this Court pursuant to 28

U.S.C. §§ 1331, 1441, and 1446. MultiPlan therefore requests that this Court assume full jurisdiction over this action.

49. If any question arises as to the propriety of this removal, MultiPlan requests the opportunity to present written and oral argument in support of removal and also requests the right to conduct jurisdictional discovery.

WHEREFORE, MultiPlan respectfully gives notice to this Court that the above-styled civil action has been removed from the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida to the United States District Court for the Middle District of Florida in accordance with the foregoing legal authorities and pursuant to 28 U.S.C. §§ 1331, 1441, and 1446, for further proceedings and disposition, and that the parties are to take no further action with regard to this matter in the State Court Action. MultiPlan also prays that it be granted all such other and further relief as this Court deems just and proper on the grounds asserted in this Notice and states that no previous application has been made for the relief prayed for herein.

RESPECTFULLY SUBMITTED this 11th day of December, 2020.

/s/ Bret M. Feldman
BRET M. FELDMAN, FBN 370370
PHELPS DUNBAR LLP
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Tampa, Florida 33602-5315
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(813) 472-7570 (Fax)
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ATTORNEYS FOR MULTIPLAN, INC.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the foregoing was filed with the Clerk of Court via the CM/ECF e-filing portal and that a true and correct copy of the foregoing was served upon all parties who have registered for electronic service with the Court's e-filing portal on this 11th day of December, 2020.

/s Bret M. Feldman
Bret M. Feldman

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Gulf-To-Bay Anesthesiology Associates, LLC

(b) County of Residence of First Listed Plaintiff Hillsborough
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Please see attachment.

DEFENDANTS

United Healthcare of Florida, Inc., United Healthcare Insurance Co., UMR, Inc. and MultiPlan, Inc.

County of Residence of First Listed Defendant Outside the State of Flor
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*
Please see attachment.

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	☐ 625 Drug Related Seizure of Property 21 USC 881	☐ 422 Appeal 28 USC 158	☐ 375 False Claims Act
☐ 120 Marine	☐ 310 Airplane	☐ 365 Personal Injury - Product Liability	☐ 690 Other	☐ 423 Withdrawal 28 USC 157	☐ 376 Qui Tam (31 USC 3729(a))
☐ 130 Miller Act	☐ 315 Airplane Product Liability	☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	☐ 400 State Reapportionment
☐ 140 Negotiable Instrument	☐ 320 Assault, Libel & Slander	☐ 368 Asbestos Personal Injury Product Liability		☐ 820 Copyrights	☐ 410 Antitrust
☐ 150 Recovery of Overpayment & Enforcement of Judgment	☐ 330 Federal Employers' Liability	PERSONAL PROPERTY	LABOR	☐ 830 Patent	☐ 430 Banks and Banking
☐ 151 Medicare Act	☐ 340 Marine	☐ 370 Other Fraud	☐ 710 Fair Labor Standards Act	☐ 835 Patent - Abbreviated New Drug Application	☐ 450 Commerce
☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	☐ 345 Marine Product Liability	☐ 371 Truth in Lending	☐ 720 Labor/Management Relations	☐ 840 Trademark	☐ 460 Deportation
☐ 153 Recovery of Overpayment of Veteran's Benefits	☐ 350 Motor Vehicle	☐ 380 Other Personal Property Damage	☐ 740 Railway Labor Act	☐ 880 Defend Trade Secrets Act of 2016	☐ 470 Racketeer Influenced and Corrupt Organizations
☐ 160 Stockholders' Suits	☐ 355 Motor Vehicle Product Liability	☐ 385 Property Damage Product Liability	☐ 751 Family and Medical Leave Act	SOCIAL SECURITY	☐ 480 Consumer Credit (15 USC 1681 or 1692)
☐ 190 Other Contract	☐ 360 Other Personal Injury		☐ 790 Other Labor Litigation	☐ 861 HIA (1395ff)	☐ 485 Telephone Consumer Protection Act
☐ 195 Contract Product Liability	☐ 362 Personal Injury - Medical Malpractice		☒ 791 Employee Retirement Income Security Act	☐ 862 Black Lung (923)	☐ 490 Cable/Sat TV
☐ 196 Franchise				☐ 863 DIWC/DIWW (405(g))	☐ 850 Securities/Commodities/ Exchange
				☐ 864 SSID Title XVI	☐ 890 Other Statutory Actions
				☐ 865 RSI (405(g))	☐ 891 Agricultural Acts
					☐ 893 Environmental Matters
				FEDERAL TAX SUITS	☐ 895 Freedom of Information Act
				☐ 870 Taxes (U.S. Plaintiff or Defendant)	☐ 896 Arbitration
				☐ 871 IRS—Third Party 26 USC 7609	☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
					☐ 950 Constitutionality of State Statutes

REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	IMMIGRATION
☐ 210 Land Condemnation	☐ 440 Other Civil Rights	Habeas Corpus:	☐ 462 Naturalization Application
☐ 220 Foreclosure	☐ 441 Voting	☐ 463 Alien Detainee	☐ 465 Other Immigration Actions
☐ 230 Rent Lease & Ejectment	☐ 442 Employment	☐ 510 Motions to Vacate Sentence	
☐ 240 Torts to Land	☐ 443 Housing/ Accommodations	☐ 530 General	
☐ 245 Tort Product Liability	☐ 445 Amer. w/Disabilities - Employment	☐ 535 Death Penalty	
☐ 290 All Other Real Property	☐ 446 Amer. w/Disabilities - Other	Other:	
	☐ 448 Education	☐ 540 Mandamus & Other	
		☐ 550 Civil Rights	
		☐ 555 Prison Condition	
		☐ 560 Civil Detainee - Conditions of Confinement	

V. ORIGIN *(Place an "X" in One Box Only)*

☐ 1 Original Proceeding ☒ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
28 U.S.C. §§ 1331, 1441, and 1446

Brief description of cause:
ERISA

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P. **DEMAND $** CHECK YES only if demanded in complaint: **JURY DEMAND:** ☐ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions):* JUDGE _____ DOCKET NUMBER _____

DATE 12/11/2020

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

Attachment to Civil Cover Sheet

Plaintiff	**Attorneys**
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Defendant	**Attorneys**
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MultiPlan, Inc.	Bret Feldman PHELPS DUNBAR LLP 100 South Ashley Drive, Ste. 2000 Tampa, Florida 33602-5315 (813) 472-7879 Errol J. King PHELPS DUNBAR LLP II City Plaza 400 Convention St., Ste. 1100 Baton Rouge, LA 70802 (225) 376-0207

EXHIBIT A

Filing # 116022363 E-Filed 11/02/2020 07:46:35 PM

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT IN AND FOR HILLSBOROUGH COUNTY, FLORIDA

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.
_____/

COMPLAINT

Plaintiff Gulf-to-Bay Anesthesiology Associates, LLC, ("Plaintiff" or "Physician Practice") by and through undersigned counsel, hereby sues Defendants United Healthcare of Florida, Inc. ("United HMO"); UnitedHealthcare Insurance Co. ("United PPO"); UMR, Inc. ("UMR"); and MultiPlan, Inc. ("MultiPlan") (collectively, "Defendants"). Collectively, "United HMO," "United PPO," and "UMR" are sometimes referred to herein as the "United Defendants." In support of thereof, Physician Practice alleges as follows:

INTRODUCTION

1. Physician Practice is comprised of board certified anesthesiologists and certified registered nurse anesthetists who are the exclusive providers of anesthesia care for surgical and pain management services at over twenty (20) healthcare facilities in Central Florida. This action arises out of Defendants' scheme to deprive Physician Practice of its property – the full payment it is entitled to by law for the anesthesiology medical care it has rendered to Florida patients insured

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by the United Defendants or by an employer-funded health plan for which the United Defendants serve as a third-party administrator (the "Members").

2. Beginning on or around May 20, 2003 and continuing until May 20, 2017, Physician Practice and United Defendants were parties to a participation agreement ("Participation Agreement"). Pursuant to the Participation Agreement, Physician Practice agreed to provide anesthesia services to United Defendants' Members and accept payment from United Defendants at a *modest* discounted off of Physician Practice's standard billed charges in exchange for the benefits associated with being a participating provider in United Defendants' provider network.[1]

3. While the Participation Agreement remained in effect, Physician Practice was a participating provider in United Defendants' provider network.

4. On May 21, 2017, the Participation Agreement terminated.

5. Physician Practice and United Defendants have not renewed, reinstated, or otherwise replaced the Participation Agreement between them. Since May 21, 2017, Physician Practice has not been a party to a direct and express contract with United Defendants that governs the reimbursement, or any other aspect, of the services provided by Physician Practice to United Defendants' Members. Thus, Physician Practice has been an "out-of-network" provider with respect to the United Defendants since May 21, 2017.

6. Despite Physician Practice's status as an "out of network" provider, United Defendants have continuously authorized Physician Practice to provide medically necessary anesthesia services to United Defendants' Members, knowing that Physician Practice expected the United Defendants to pay a fair and reasonable rate for those services. Florida statutory and

[1] Pursuant to Section 10.9 of the Participation Agreement, the reimbursement rates are confidential and therefore not specifically identified herein.

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common law is consistent with Physician Practice's expectations, providing that Physician Practice is entitled to reimbursement at a rate equivalent to the lesser of its billed charges or the usual and customary charges for the Physician Practice's services.

7. While, for fourteen years, the United Defendants reimbursed Physician Practice in accordance with the Provider Agreement, and then, after the termination of the Provider Agreement, reimbursed Physician Practice in accordance with applicable law for certain claims for a period of time, the United Defendants began to further slash reimbursement payments in October 2019. Instead of reimbursing Physician Practice at either its billed charges or the usual and customary charges for Physician Practice's services, the United Defendants have dramatically underpaid Physician Practice for its services in violation of Florida law.

8. In their attempt to defraud Physician Practice and illegally retain Physician Practice's property by utilizing extraordinarily deficient reimbursement rates, the United Defendants have conspired with Defendant MultiPlan, Inc. ("MultiPlan") to corruptly cloak the inadequate reimbursements in a false veneer of objectivity and independence. Together, and as explained more fully in the following sections, United and Multiplan have formed a RICO enterprise (the "Enterprise").

9. The United Defendants claim to reimburse Physician Practice in accordance with objective, fact-based calculations of usual and customary reimbursement rates generated and supplied to them by MultiPlan through MultiPlan's Data iSight "service." The United Defendants further represent that MultiPlan acts independently of the United Defendants and is, therefore, credible. None of this is true. In fact, United Defendants' payments to Physician Practice have no objective basis in fact. The reimbursement rates United Defendants purport to "receive" from MultiPlan are in fact rates that United Defendants have ***directed*** MultiPlan to "suggest" to them.

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Through this scheme, MultiPlan and United Defendants endeavor to cloak deficient reimbursements with legitimacy in an effort to deceive, defraud, and steal from healthcare providers, such as Physician Practice.

10. Through their scheme, Defendants have violated the Florida Civil Remedies for Criminal Practices Act (CRCPA), Fla. Stat. § 772.101, *et seq.*, and the Florida Racketeer Influenced and Corrupt Organizations Act (RICO), Fla. Stat. § 895.01, *et seq.* MultiPlan has also violated the Florida Deceptive and Unfair Trade Practices Act (FDUTPA), Fla. Stat. § 501.201, *et seq.*

11. The reimbursement claims within the scope of this action are solely non-participating commercial claims for anesthesiology medical services rendered to United's Members. This lawsuit and the claims asserted herein do not relate to or involve reimbursement claims under any government-sponsored products, such as Medicare Advantage and managed Medicaid. Those products are not at issue in this litigation, which arises only from claims involving United Defendants' commercial plans and products. Without limitation, Physician Practice specifically excludes from this lawsuit any service provided to patients 65 years of age or older as of the date services were rendered.

12. In addition, the reimbursement claims within the scope of this action are ones that were determined to be covered and allowed as payable by the United Defendants but claims that the United Defendants paid at rates below both the billed charges and the usual and customary provider charges for similar services in the community where Physician Practice rendered such services to United's Members. These reimbursement claims are collectively referred to herein as the "Claims."

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13. For clarity, the Claims do not relate to or involve the Physician Practice's *right* to payment, which Defendants do not contest, but rather the *rate* of payment Physician Practice is entitled to receive for its services. This action does not include any claims in which benefits were denied, nor does it challenge any coverage determinations under any health plan that may be subject to the Employee Retirement Income Security Act of 1974.

14. For further clarity, the Physician Practice has already sued certain of the Defendants for inadequate reimbursement of out-of-network claims from May 21, 2017 through February 29, 2020, in the case styled *Gulf-to-Bay Anesthesiology Associates, LLC v. UnitedHealthcare of Florida, Inc. and UnitedHealthcare Insurance Co.*, Case No.: 17-CA-011207, in and for the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida. The Claims are therefore for the period of time commencing March 1, 2020 and forward.

15. Through this action, Physician Practice seeks to recover the damages from Defendants, jointly and severally, caused by Defendants' unlawful scheme to deprive Physician Practice of its property (claims to and the rights to receive lawful reimbursement amounts) under Florida law.

16. In addition to its damages, Physician Practice also requests the Court enter an appropriate injunction in accordance with Fla. Stat. §895.05(1): (i) prohibiting Defendants from utilizing Data iSight, and (ii) prohibiting Defendants from manipulating and conspiring to manipulate the rates of reimbursement for Physician Practice's out-of-network anesthesiology services, including without limitation, through the utilization of Data iSight.

PARTIES

17. Physician Practice, Gulf-to-Bay Anesthesiology Associates, LLC, is a limited liability company formed under the laws of Delaware. Physician Practice's principal place of

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business is located in Hillsborough County, Florida. At all times relevant to the allegations stated herein, Physician Practice has been the exclusive anesthesia provider at the facilities where Physician Practice provided the anesthesia services to United's Members.

18. Defendant United HMO is a Florida for-profit corporation with its principal place of business in Hillsborough County, Florida. United HMO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a health maintenance organization ("HMO") in Florida under Fla. Stat. § 641.17, *et seq.*

19. Defendant United PPO is a foreign for-profit corporation with its principal place of business in Hartford, Connecticut. As a preferred provider organization, United PPO operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a life and health insurer in Florida under Fla. Stat. § 624.01, *et seq.*

20. Defendant UMR is a foreign for-profit corporation with its principal place of business in Wausau, Wisconsin. UMR operates under a certificate of authority issued by the Florida Office of Insurance Regulation as a third-party administrator in Florida under Fla. Stat. § 624.01, *et seq.*

21. The United Defendants operate under common control and ownership. The United Defendants are all subsidiaries under common ownership of UnitedHealth Group ("UNH"), a publicly traded company. UNH and its more than 1,200 subsidiaries, which include the United Defendants, comprise the largest health insurer in the United States, reporting $6.7 billion in profits for the second quarter of 2020, a 97 percent increase from the same period in 2019.

22. Moreover, on information and belief, when the United Defendants enter into participating provider agreements in Florida, the United Defendants do so on behalf of themselves and all "Affiliates," which are defined to include "entities controlling, controlled by or under

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common control" with each other. These participating provider agreements thus cover claims submitted by the participating provider for United HMO, United PPO, and UMR, among other of the United Defendants' related entities.

23. Additionally, the United Defendants operate in concert with one another, as they direct that all claims for reimbursement for anesthesia services be uploaded to the same electronic filing portal.

24. Defendant MultiPlan is a foreign for-profit corporation with its principal place of business in New York, New York. MultiPlan is not a health insurer nor is MultiPlan regulated by the Florida Office of Insurance Regulation.

JURISDICTION AND VENUE

25. This Court has jurisdiction pursuant to Fla. Stat. § 26.012(2) because this dispute involves an amount in controversy in excess of $15,000.

26. Defendants are engaged in substantial activity within Florida and maintain offices in Florida.

27. Pursuant to Fla. Stat. § 47.051, venue is proper in Hillsborough County because each Defendant conducts substantial business in Hillsborough County and has, or usually keeps, an office for transaction of their customary business in Hillsborough County. Additionally, Defendants' conduct giving rise to this suit occurred in Hillsborough County, and Physician Practice's causes of action against Defendants have accrued, in whole or in part, in Hillsborough County.

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28. The United Defendants are subject to personal jurisdiction in this Court for causes of action arising from the following acts as alleged below: (i) operating, conducting, engaging in, or carrying on a business in this state (§48.193(1)(a)1, Fla. Stat.); (ii) committing a tortious act within this state (§48.193(1)(a)2, Fla. Stat.); (iii) contracting to insure a person, property, or risk located within this state at the time of contracting (§48.193(1)(a)4, Fla. Stat.); (iv) causing injury to persons or property within this state arising out of an act or omission by the defendant outside this state, if, at or about the time of the injury, either: (a) the United Defendants were engaged in solicitation or service activities within this state; or (b) things processed or serviced by the United Defendants were used or consumed within this state in the ordinary course of commerce, trade, or use (§48.193(1)(a)6, Fla. Stat.); and (v) engaging in substantial and not isolated activity within this state (§48.193(2), Fla. Stat).

29. Multiplan is subject to personal jurisdiction in this Court for causes of action arising from the following acts as alleged below: (i) operating, conducting, engaging in, or carrying on a business in this state (§48.193(1)(a)1, Fla. Stat.); (ii) committing a tortious act within this state (§48.193(1)(a)2, Fla. Stat.); (iii) causing injury to persons or property within this state arising out of an act or omission by the defendant outside this state, if, at or about the time of the injury, either: (a) MultiPlan was engaged in solicitation or service activities within this state; or (b) things processed or serviced by MultiPlan were used or consumed within this state in the ordinary course of commerce, trade, or use (§48.193(1)(a)6, Fla. Stat.); and (iv) engaging in substantial and not isolated activity within this state (§48.193(2), Fla. Stat).

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FACTS

Physician Practice Is An Out-of-Network Provider

30. At no time since May 21, 2017 has Physician Practice been a participating provider with any United Defendant.

31. All of the Claims are for reimbursement for services Physician Practice provided at times when it was a non-participating (or "out-of-network") provider with the United Defendants.

32. Despite its out-of-network status, Physician Practice has provided medically necessary, covered anesthesiology services to United Defendants' Members. The United Defendants authorized its Members to receive medically necessary services, which authorization included an authorization for Physician Practice to provide anesthesiology services. In so doing, the United Defendants agreed to pay Physician Practice an appropriate reimbursement rate.

33. Even though Physician Practice is an out-of-network provider and has not agreed directly to accept discounted reimbursement rates from the United Defendants, for certain claims, the United Defendants abruptly, and without reason, began paying Physician Practice substantially less than the rates the United Defendants previously paid, and Physician Practice previously accepted, for the same anesthesiology services. At no time material to this action has the Physician Practice agreed to accept these substantially reduced reimbursement rates for these disputed and underpaid claims.

34. Accordingly, for the Claims, the United Defendants have made unlawful discounted payments to Physician Practice for the anesthesia services Physician Practice has rendered to United Defendants' Members, and the unlawfully underpaid Claims continue to accrue.

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United Defendants' Failure to Reimburse Physician Practice in Accordance with Florida Law

35. Fla. Stat. § 641.513(5), which is part of Florida's HMO Act and applicable to HMOs including United HMO, provides that reimbursement for emergency services by providers such as Physician Practice "who do[] not have a contract with the [HMO] shall be the lesser of: (a) The provider's charges; (b) The usual and customary provider charges for similar services in the community where the services were provided; or (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

36. Florida law further requires HMOs to fully reimburse hospital-based providers like Physician Practice for authorized non-emergent care rendered at hospitals and ambulatory surgery centers where the HMO has a contract with the hospital and ambulatory surgery center. All of the HMO claims at issue in this dispute were provided at hospitals and ambulatory surgery centers where the United Defendants have a contract.

37. Florida law further requires that insurers, including PPOs, like United PPO, reimburse out-of-network health care providers, such as Physician Practice, for both the non-emergency and emergency services that such providers render to the insurer's members in accordance with the provisions of Fla. Stat. § 641.513(5). *See* Fla. Stat. § 627.64194(4) ("An insurer must reimburse a nonparticipating provider of services under subsections (2) and (3) as specified in s. 641.513(5), reduced only by insured cost share responsibilities as specified in the health insurance policy, within the applicable timeframe provided in s. 627.6131.").

38. Florida common law also requires the United Defendants to pay Physician Practice the fair value of the medically necessary and authorized services for the Claims at a "usual and customary" rate.

39. For the Claims, Physician Practice has not reached any agreement with any United Defendant regarding any charges within sixty days of the submittal of the Claims.

40. For the Claims, the United Defendants have underpaid Physician Practice by reimbursing it substantially less than its charges and substantially less than the "usual and customary provider charges for similar services in the community where the services were provided."

41. Fully aware of their obligations to appropriately reimburse Physician Practice, United Defendants (a) knew that Physician Practice would be providing emergency services to the Members (for which no pre-authorization was required) or (b) authorized and/or approved Physician Practice's rendering of anesthesiology services for non-emergent services to their Members.

42. The United Defendants are aware that Physician Practice provided emergent and authorized/approved non-emergent anesthesiology services to United Defendants' Members with the reasonable expectation and understanding that the United Defendants would lawfully reimburse Physician Practice.

43. With full knowledge of their obligations under Florida law described above, the United Defendants have continued to authorize their Members to receive anesthesiology services from Physician Practice at medical facilities throughout Tampa, Naples, and Orlando Florida. However, when issuing said authorization, and unbeknownst to Physician Practice, the United Defendants did not intend to reimburse Physician Practice at either its billed charges or the usual and customary rate.

44. The United Defendants' authorization of such services and their acknowledgement of their responsibility for payment is further confirmed by the fact that, at all material times, they

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have regularly and consistently issued payment on Physician Practice's claims for those services, albeit at rates far lower than what Physician Practice is owed under Florida law.

45. The United Defendants consistently (a) authorized the services rendered, (b) determined the Claims to be covered and medically necessary and (c) paid Physician Practice for the Claims. However, the United Defendants' payments for the Claims have been far below both the Physician Practice's charges and the usual and customary provider charges for similar services in the community where the services were rendered.

46. United Defendants' efforts to deprive Physician Practice of the payments to which it is entitled under Florida law have caused, and continue to cause, Physician Practice to suffer damages in an amount equal to the difference between the amounts paid by United Defendants' and the lesser of Physician Practice's charges or the usual and customary provider charges for the services Physician Practice rendered, plus the benefit of that money.

47. The Physician Practice is also entitled to pre-judgment interest on the amounts due and owing on the Claims.

The Relationship Between Physician Practice and United

48. In exchange for premiums, fees, and/or other compensation, the United Defendants assume responsibility to pay for health care services rendered to Members covered by their health plans.

49. The United Defendants offer a range of health insurance plans. Plans generally fall into one of two categories: Fully Funded plans and Employer Funded plans.

50. "Fully Funded" plans are plans in which United Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums. "Employer Funded" plans are plans in

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which United Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

51. The United Defendants provide coverage for anesthesiology medical services under both types of plans.

52. In addition, the United Defendants provide services such as building participating provider networks and negotiating rates with providers who join their networks. Payors, like United Defendants, typically negotiate a lower payment rate from contracted participating providers.

53. In return for those lower payment rates, payors, like United Defendants, offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

54. The United Defendants bear responsibility for paying for anesthesiology care provided to their Members whether the treating physician is an in-network or out-of-network provider.

55. With respect to emergency anesthesiology services, the United Defendants are contractually and legally responsible to their Members for ensuring they can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider. United Defendants highlight such coverage in marketing their insurance products, inducing Members to purchase their products and rely upon those representations.

56. For example, in the "patient protections" section of the UnitedHealthcare website, applicable to all United Defendants, uhc.com, United states:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

57. Thus, for emergency anesthesiology services, the United Defendants do not require prior authorization and indeed, are prohibited from requiring prior authorization.

58. With respect to non-emergent anesthesia services, United Defendants understand and expressly acknowledge that their Members often receive anesthesiology treatment from non-participating providers and that United Defendants are obligated to pay for those services.

59. Indeed, for the non-emergent anesthesiology services in question, which comprise the majority of Claims in this dispute, the United Defendants authorized the services before they were provided and did so with full knowledge and approval that Physician Practice would be providing the pre-authorized anesthesiology services to United Defendants' Members.

60. Each United Defendant understood and expressly acknowledged its liability for all of the anesthesiology services at issue in this action by previously determining the Claims to be covered and medically necessary and paying Physician Practice for the Claims, albeit at less than the applicable rate.

The Reasonable Rate for Non-Participating Anesthesiology Services is Well Established

61. Prior to the termination of the Provider Agreement, the parties had established an in-network reimbursement rate at a *modest* discount off of Physician Practice's billed charges.

62. After the termination, United Defendants reimbursed certain of the out-of-network medical claims submitted by Physician Practice at acceptable rates. These acceptable reimbursement rates included, for example: (a) payment of Physician Practices full billed charges;

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and/or (b) negotiated rates between the United Defendants and Physician Practice at 90% of Physician Practices full billed charges.

63. In addition, acceptable reimbursement rates were established at payment between 80-100% of full billed charges based upon Physician Practices' agreement with rental networks. Rental networks act as "brokers" between non-participating providers and health insurance companies. A rental network will negotiate a contract with a provider to discount its out-of-network charges. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates. As a result of this process, rental networks' negotiated rates can serve as a proxy for a reasonable rate of reimbursement for out-of-network anesthesiology services, both in the industry as a whole and for particular payors.

64. This history establishes that a reasonable reimbursement rate for Physician Practice's Claims for anesthesiology services is not less than 80-90% of Physician Practice's billed charges.

65. Despite this history, the United Defendants have slashed their reimbursement rate for Claims to less than half the reasonable reimbursement rate, and the number of Claims have been increasing.

66. The United Defendants' drastic payment cuts are entirely inconsistent with the established rates, the parties' historic course of dealing, industry standards, and Florida law.

The Physician Practice Has No Recourse for United Defendants' Underpayments Except Against United and MultiPlan

67. The United Defendants' drastic payment cuts have an immediate harmful impact on Physician Practice. Under Florida law, Physician Practice is precluded from seeking payment from patients for the difference between the amounts allowed as reimbursement by United

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Defendants and the lesser of Physician Practice's charges or the usual and customary charges in the community for the emergent medical services and/or authorized non-emergent medical services provided. *See* Fla. Stat. §§ 641.3154, 627.64194.

68. Indeed, to this end, the Provider Remittance Advice documents ("PRAs") United Defendants send with their underpayments to Physician Practice instruct Physician Practice not to bill patients for any amounts beyond the amount of the deductible, copay, and coinsurance applied to the service.

69. The PRAs the United Defendants generate and remit to Physician Practice further identify the "Patient Responsibility" (or "PR") for Physician Practice's services as being limited to applicable deductibles, copays, or coinsurance amounts. That is, the United Defendants take the position that their Members are not liable for the differential between Physician Practice's billed charges and the inadequate amounts allowed as payable by the United Defendants.

70. The United Defendants knew Physician Practice expected payment for the anesthesiology services they provided. Based on their course of dealing, the United Defendants and Physician Practice have demonstrated their mutual agreement and understanding that the United Defendants would reimburse Physician Practice at their billed charges or at a usual and customary rate. By assuming responsibility for paying for the medical care provided to their Members, the United Defendants agreed to reimburse Physician Practice at either its charges or the usual and customary provider charges.

71. Nevertheless, as discussed below, United Defendants and MultiPlan have formed a RICO Enterprise for the purpose of depriving Physician Practice of its property (claims to and the rights to receive lawful reimbursement amounts) by defrauding Physician Practice and illegally

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retaining Physician Practice's property by utilizing extraordinarily deficient reimbursement rates for the anesthesia services Physician Practice renders to United Defendants' Members.

72. Indeed, United Defendants' and MultiPlan's acts of defrauding and illegally retaining Physician Practice's property by utilizing extraordinarily deficient reimbursement rates for the anesthesia services Physician Practice renders to United Defendants' Members are ongoing and are part of the Defendants' regular way of doing business.

United Defendants' History of Fraudulently Manipulating Out-of-Network Reimbursement Rates

73. The current scheme is not the first time the United Defendants have knowingly used fake and fraudulent data in an effort to avoid paying providers the full amount to which they are entitled for their services.

74. The United Defendants have a history of fraudulently manipulating reimbursement rates to non-participating providers in order to maximize their own profits at the expense of others.

75. In 2009, UnitedHealth Group, Inc., the parent company of the United Defendants, was investigated by the New York State Attorney General's Office for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

76. The investigation revealed that Ingenix utilized a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

77. Andrew Cuomo, then New York Attorney General, explained of United's scheme: "The lack of accuracy, transparency, and independence surrounding United's process for setting a 'reasonable and customary rate' is astounding. United's ownership of Ingenix coupled with the inherent problems with the data it is using clearly demonstrate a broken reimbursement system designed to rip off patients and steer them towards in-network-doctors that cost the insurer less

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money." *See* "Cuomo Announces Industry-wide Investigation Into Health Insurers; Fraudulent Reimbursement Scheme" (Feb. 13, 2008), *available at* https://ag.ny.gov/press-release/2008/cuomo-announces-industry-wide-investigation-health-insurers-fraudulent.

78. Like MultiPlan here, Ingenix "serve[d] as a conduit for rigged data to the largest insurers in the country." *Id.* Of particular concern was the fact that United Defendants' "ownership of Ingenix created a clear conflict of interest because their relationship gave Ingenix an incentive to set rates that benefited United and its subsidiaries." *Id.*

79. Similarly, Defendant United HealthCare Insurance Co. and affiliates thereof also faced class action claims alleging that they engaged in a rate manipulation scheme and intentionally underpaid non-participating providers for medical services in *American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.). Defendant United HealthCare Insurance Co. and affiliates paid $350 million to settle those claims in 2009.

80. Likewise, in settling the lawsuit filed by the New York State Attorney General's Office, UnitedHealth Group, Inc., the parent company of the United Defendants, ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

81. In announcing settlement with United Healthgroup, Inc., the New York Attorney General explained, "[f]or the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry." *See* "Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice Of Manipulating Rates To Overcharge Patients By Hundreds Of Millions Of Dollars" (Jan. 13, 2009), *available at*

https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-health-insurance-reform-ends.

82. The New York Attorney General declared that the settlement would "end conflicts of interest" in United Healthgroup, Inc.'s determinations of the "usual and customary" rate. *Id.* Or so he thought. On information and belief, immediately upon the heels of the expiration of the settlement's requirement that United Defendants utilize the FAIR Health database to determine out of network reimbursement rates, the United Defendants entered into agreements with MultiPlan.

83. Since that time, through MultiPlan and its software tool, Data iSight, the United Defendants have endeavored to revive the same fraudulent scheme that the New York Attorney General shut down a decade ago.

FAIR Health Affords Payers and Providers a Database of Usual and Customary Rates

84. United Defendants could have avoided this litigation if they had actually utilized FAIR Health and employed a reasonable method for determining Physician Practice's payments.

85. Since its inception as a tool to combat rate manipulation by United Defendants (and other would-be rate manipulators), FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers. For example, numerous states recognize FAIR Health's database as an official source for healthcare cost data to determine reimbursement for non-participating providers' medical services.

86. The United Defendants purport to use FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website. For example, the United Defendants represent that, where payment for out-of-network services is to be made at the

usual and customary rate, United "most commonly refer[s] to a schedule of charges created by FAIR Health, Inc. ('FAIR Health') to determine the amount of the payment." *See* "Information on Payment of Out-of-Network Benefits," *available at* https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits. UMR's website contains the identical representations. *See*

https://fhs.umr.com/oss/export/sites/default/UMR/SharedDocuments/Website_disclosure.pdf?forcemainsite=true&csrf=af5d9ca2-e2fe-434f-928a-1b2e00d93d82

87. As the United Defendants recognize, a usual and customary rate is "base[d] . . . on what other healthcare professionals in a geographic area charge for their services." *Id.*

88. While United tries to create the appearance of holding itself to independent benchmarks to set reimbursement rates, in fact, the United Defendants have engaged in fraudulent conduct in an effort to avoid their legal responsibility to reimburse Physician Practice at the usual and customary rate. The United Defendants are not using FairHealth to determine a usual and customary rate. Instead, the United Defendants are conspiring with MultiPlan to — yet again — manipulate and artificially depress reimbursements for out-of-network services.

89. While Defendants make representations about Data iSight and its supposed accuracy and objectivity, they never disclose how it actually produces results so dramatically inconsistent with historical experience or objective, non-profit groups such as FAIR Health. The reason is that Data iSight is an elaborate sham concocted to provide a veneer of justification for a scheme to deprive providers of the reimbursement to which they are entitled by law.

The Defendants' False Statements

90. Although United Defendants continue to access the rental network for the payment of some claims, United Defendants have increasingly utilized MultiPlan's Data iSight program for the pricing of Physician Practice's claims.

91. Defendants through the Enterprise have falsely claimed to provide transparent and objective determinations of reimbursement rates through the use of Data iSight.

92. In reality, as set forth herein, Defendants use Data iSight as a pretext to justify paying reimbursements to Physician Practice that are far less than the reasonable payment rate that Physician Practice has historically received and is entitled to under the law.

93. Defendants attempt to conceal the scheme through the use of false statements on MultiPlan's website, Data iSight's website, and in United's and Data iSight's communications with providers, including Physician Practice.

94. Data iSight is not what Defendants claim it is. To the extent that Data iSight relies on any data at all, that data is fabricated or manipulated to generate results desired by Defendants, without regard to objective reality. This is demonstrated by several facts.

95. First, there is no objective support for any contention that the reasonable rate of reimbursement for anesthesia services in Florida abruptly dropped by fifty percent or more. The only change was Defendants' use of Data iSight's false and fraudulent data as an excuse to slash reimbursements.

96. Second, the reimbursements paid by Defendants are arbitrary and inconsistent. Defendants often pay substantially different amounts for the same services provided by the same providers in the same communities and in the same time frame.

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97. As shown below, Defendants often pay different reimbursement rates for the same procedure code, representing the same treatment provided by the same provider type at the same facility in the same community.

98. Third, the reimbursements paid by Defendants are dramatically different from those developed by independent non-profit organizations, such as FAIR Health, and based on over a decade of data.

A. Transparency

99. The Data iSight website claims to offer "Transparency for You, the Provider," and represents that the "website makes the process for determining appropriate payment transparent to [providers] . . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

100. This representation is patently false. Data iSight produces reimbursement rates that have nothing to do with usual and customary reimbursements. When questioned or challenged about its methodology, Data iSight cannot explain that methodology and, to the extent it gives any explanations at all, those explanations are factually inconsistent. Despite Data iSight's sweeping representations, in practice, when the reimbursement rates determined by the Enterprise are questioned or challenged, Defendants cannot justify or explain those rates.

101. By way of example, and not limitation, several specific examples of this recurring phenomena are set forth below.

102. For claims for which reimbursement is determined by Data iSight, non-participating providers receive an Explanation of Benefit form ("EOB") from United with "IS" in the "Remark/Notes" column.

103. Over the past twenty months, an ever-increasing number of Claims have been processed by the United Defendants using Data iSight, resulting in drastically reduced payment amounts.

104. The United Defendants do not state on the face of the EOBs, or anywhere else, any reason for these drastic cuts.

105. Instead, each EOB contains a note to call a toll-free number at Data iSight if there are questions about the claim.

106. But, as shown below, no one at that number can or will explain how Data iSight produces these drastic and inconsistent cuts.

107. Defendants know that the rates that Defendants, using Data iSight, pay for Physician Practice's Claims do not reflect and are not, in fact, based on objective, reliable data designed to arrive at the usual and customary rates for the services in question.

108. Defendants know that the initial reimbursement rates they pay are insufficient because, at times prior to October 2019, when Physician Practice challenged the rate of payment, United Defendants authorized Data iSight to change the allowed amount by increasing it to a fair, usual and customary rate at 90% of Physician Practice's billed charges. The United Defendants did this only if Physician Practice persisted long enough in the process.

109. The process to contest the arbitrary and deficient payments took weeks, and it is impracticable to employ for each inadequately reimbursed claim — which is precisely what Defendants intend.

110. Moreover, the Defendants' scheme of refusing to reimburse at usual and customary rates unless and until Physician Practice challenge its determinations continually harms Physician Practice, in that, even if Physician Practice eventually receives reasonable reimbursement after

contesting the rate, this scheme imposes excessive administrative time and expense on Physician Practice and deprives it of its right to prompt payment of claims under Florida's Prompt Payment Statute.

111. Nevertheless, starting in October 2019, Defendants reduced the amount that United Defendants would pay for the challenged claims and as of April 2020, Defendants ceased negotiating with Physician Practice. All of this is part of Defendants' unlawful scheme.

B. Defensible and Market Tested

112. Defendants, through Data iSight, also falsely claim on Data iSight's website to set reimbursement rates in a "defensible, market tested" way.

113. EOBs for claims processed pursuant to Data iSight contain the following or a similar note: "Calculated using Data iSight, which utilizes cost data if available (facilities) or paid data (professionals)."

114. The United Defendants further advise as follows in EOBs for many of the claims paid purportedly pursuant to Data iSight:

> In order to help save you and the plan money, [United] uses a service called Data iSight to review select out-of-network claims and recommend a reduced payment amount for out-of-network covered services. . . . Based on the Data iSight review, the recommended amount for the covered services provided is shown on your explanation of benefits (EOB). Your provider will be informed of that recommendation.

115. These notes are an attempt to deceive providers into believing that the reimbursement calculations are based upon external, objective data.

116. Further, in its provider portal, the Data iSight website describes its "methodology" for reimbursement determinations as being "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

117. MultiPlan similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and asserts that it has been "[v]alidated by statisticians as effective and fair."

118. These statements are false.

119. Data iSight's rates are not fair. Instead, as set forth herein, they are manipulated to match the rates United has directed MultiPlan to produce. United and MultiPlan know and intend that these rates fall well below fair market value.

120. For example, Physician Practice submitted claims to the United Defendants for the same CPT code (00731) with the same charge ($1,176.00) for anesthesia services rendered at the same surgery center in Tampa to two different patients. For patient LC, who received anesthesia services on June 12, 2020, United Defendants accessed a rental network and allowed 90% of the billed charges, or $1,058. In contrast, for patient RB who received services on July 13, 2020, United Defendants, via Data iSight, allowed only 22% of the billed charges, or $256.

121. Similarly, Physician Practice submitted claims to the United Defendants for the same CPT code (00731) with the same charge ($1,386.00) for anesthesia services rendered at the same Tampa Hospital to two different patients. For patient RF, who received anesthesia services on May 26, 2020, United Defendants accessed a rental network and allowed 90% of the billed charges, or $1,247. In contrast, for patient TS, who received anesthesia services on August 6, 2020, United Defendants, via Data iSight, allowed on 20% of the billed charges, or $277.

122. Nor are United Defendants consistent when they only utilize Data iSight. For example, Physician Practice submitted claims to the United Defendants for the same CPT code (00731) with the same charge ($1,188.00) for anesthesia services rendered at the same Orlando hospital to two different patients. For patient AH, who received anesthesia services on April 19,

2020, United Defendants, via Data iSight, allowed 37% of the billed charges, or $442. However, for patient KM, who received anesthesia services on July 3, 2020, United Defendants, via Data iSight, allowed only 21% of billed charges, or $244.

PATIENT	DATE OF SERVICE	PROCEDURE CODE	BILLED AMOUNT	ALLOWED AMOUNT	ALLOWED AMOUNT (%)
LC	6/12/2020	00731	$1,176.00	$1,050.00	90%
RB	7/13/2020	00731	$1,176.00	$256.00	22%
RF	5/26/2020	00731	$1,386.00	$1,247.00	90%
TS	8/06/2020	00731	$1,386.00	$277.00	20%
AH	4/19/2020	00731	$1,188.00	$442.00	37%
KM	7/3/2020	00731	$1,188.00	$244.00	21%

123. From the above examples, it is clear that MultiPlan's Data iSight service does not in fact use an objective, externally-validated methodology to determine usual and customary reimbursement rate.

124. Additionally, it is clear that United and Data iSight know that amounts determined in transactions that are arm's length and freely negotiated result in payments of 90% of the Physician Practice's billed charges, rather than the artificially low amount produced by Data iSight.

125. United also falsely claims on its website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

126. This claim is false because the 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, would be substantially greater than the allowed amounts via Data iSight:

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PATIENT	PROCEDURE CODE	80th PERCENTILE OF FAIR HEALTH BENCHMARK[2]	ALLOWED AMOUNT
RB	00731	$627.88	$256.00
TS	00731	$723.48	$277.00
AH	00731	$786.84	$442.00
KM	00731	$786.84	$244.00

127. To perpetuate the scheme and conceal it from Physician Practice and other out of network providers, Defendants entered into written agreements with each other.

128. Under those contracts, MultiPlan, through Data iSight, would handle claims determinations for services rendered to United Defendants' members under pre-agreed thresholds set by United Defendants.

129. Between May 2017 and October 2019, United Defendants provided certain pricing and negotiation authority to MultiPlan for the pricing of Physician Practice's claim. Although the initial pricing authority was well below usual and customary rates, as set forth above, the negotiation authority provided by United Defendants permitted MultiPlan to negotiate rates up to a fair market amount if Physician Practice (or other out-of-network providers) challenged the initial Data iSight pricing. However, in late 2019 United Defendants and MultiPlan doubled down on their rate manipulation scheme, and the Defendants agreed to implement a new pricing ceiling for Physician Practice's claims, which further slashed United Defendants' reimbursements to Physician Practice. This underpayment scheme was implemented in October 2019.

130. As such, by no later than 2019, Defendants coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including Physician Practice, in furtherance of the scheme.

[2] The benchmark figures listed in this table are the applicable 80th-percentile rates for the relevant geographic market in which the referenced patient received medical treatment.

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131. These statements include MultiPlan's use of wire communications to post, on its websites and the website for Data iSight, that it would provide transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment processes for providers.

132. Although MultiPlan, acting on behalf of United Defendants, previously would sometimes allow reasonable rates of reimbursement, it did so only in response to complaints and challenges regarding specific bills and reimbursement payments. In other words, while MultiPlan would concede payment of a reasonable rate in response to a specific complaint, the Defendants revert to their standard dishonest mode of reimbursement with regard to all or most other claims.

133. However, as set forth above, United Defendants further reduced MultiPlan's negotiation authority, and the Defendants ceased paying a reasonable rate in response to Physician Practice's complaints by April 2020.

134. Specifically, in response to Physician Practice's inquiries about below-market reimbursements, Data iSight admitted by email in April 2020 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low pricing of Claims–other than stating that "[o]ur Data iSight bill review protocol . . . benchmarks each CPT code against the Medicare value for the CPT code at a multiple of 200% . . . ." Data iSight was no more transparent in response to Physician Practice's inquiries about disputed reimbursement amounts that Physician Practice was attempting to negotiate, and it opaquely responded that, "[u]nder our provider inquiry appeal guidelines set by United Healthcare, Data iSight is to help explain the pricing methodologies applied for the claims in question with the hope that the provider is able to accept the reimbursement determinations."

135. In response to Physician Practice's additional inquiries, neither MultiPlan nor Data iSight ever explained the actual pricing methodology.

136. The reason Defendants have never explained the actual pricing methodology is that it is a fraudulent scheme to deceive providers and deprive them of the reimbursements to which they are entitled by law.

MultiPlan's Data iSight Program

137. MultiPlan Inc. promotes itself across the health insurance industry as an "unregulated" cost management company. MultiPlan offers a menu of services for "cost control." Some of the services are legitimate, but, on information and belief, others are fraudulent.

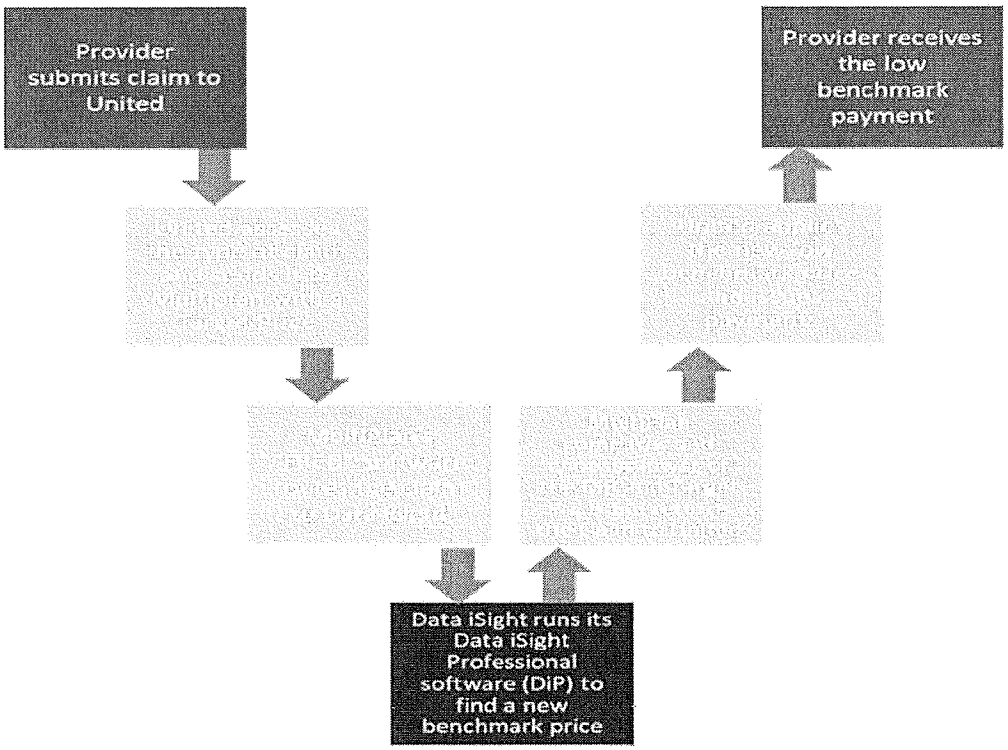
138. Specifically, MultiPlan promotes the Data iSight program, which Multiplan bills as "[t]he most effective, defensible way to value a medical claim when an agreed reduction isn't available."

139. MultiPlan also represents in its marketing material that its services are "completely transparent."

140. MultiPlan offers a host of mechanisms for "cost-containment." To this end, on information and belief, MultiPlan has an internal engine, known within the company as FRED.

141. On information and belief, FRED takes inputs from the claims United Defendants forward it, and routes them to the respective repricing tool, runs the respective tool, and produces an output.

142. On information and belief, Data iSight can be generally summarized by the following flowchart:



143. In fact, Data iSight's calculations are not completely or even partially transparent; i.e. they are deliberately opaque. On information and belief, Data iSight is a complex product implemented by a software engine that is designed to cull the lowest possible number from a flawed, proprietary database of healthcare claims data that is wholly unrepresentative of amounts actually charged by, or paid to, similar medical providers in Physician Practice's surrounding area.

144. As payment for use of Data iSight, on information and belief, MultiPlan receives a percentage of the difference between a target rate of payment set by United Defendants and the artificially low number Data iSight delivers as a rate of payment. The artificially low Data iSight number is based solely on a manipulated rate that has no basis in objectively gathered and analyzed data.

145. All of the Claims were drastically underpaid. United Defendants conspired with MultiPlan to utilize Data iSight to generate and pay artificially depressed payment rates for the

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Claims with no resemblance to the methodology United Defendants claimed to have used in mailed correspondence, electronic correspondence, its published media, and telephone conferences with Physician Practice.

Claims Submission Mechanics

146. Physician Practice submits invoices to United Defendants for anesthesia services rendered to United Defendants' Members using standardized claims forms called HCFA-1500 forms. Every Claim was submitted directly to United Defendants, all via the same common portal.

147. After the Claims were received, they were processed, approved for payment, the payment amount was then determined, and the Claims were paid to Physician Practice with accompanying notes about how much the patient owed and United Defendants' explanation for the amount they paid.

148. Within the billing process, known in the healthcare industry as the "revenue cycle," United Defendants used MultiPlan's Data iSight in a scheme to underpay Physician Practice's claims for Defendants' benefit.

149. Instead of looking at the law to determine how much to pay for the Claims, and despite having (i) billions of lines of claim data and years of claims history to reference, (ii) the FAIR Health Database – a database of payment information United Defendants paid to create, and (iii) their own in-house data analytics company, United Defendants enlisted the help of MultiPlan.

150. The lower the rate that MultiPlan produced, the more money MultiPlan was paid.

151. Multiplan literally has the FAIR Health data at its fingertips, built into its computer systems, but chooses not to use it.

152. MultiPlan offered United Defendants a menu of pricing tools that it knew would be used to derive different payment rates for the same quoted insurance term, i.e. "amounts charged for services by similar providers in a similar geographic area."

153. MultiPlan offered three general categories of services to United Defendants: 1) United Defendants could rent access to MultiPlan's contracts with providers through "rental-network" agreements; 2) United Defendants could have MultiPlan negotiate individual claims on behalf of United Defendants for individual agreements with providers for payment; or 3) United Defendants and MultiPlan could use Data iSight to calculate payment rates.

154. For the Claims, United Defendants and MultiPlan agreed to use Data iSight instead of MultiPlan's negotiations or rental network services.

155. United Defendants opted to use Data iSight pricing because it knew, based on MultiPlan's marketing and on meetings between United Defendants and Data iSight, that the payment rates Data iSight would produce would be artificially low.

The Data iSight Product

156. The following summary represents a high-level overview of the Data iSight product for pricing claims.

157. On information and belief, in general, Data iSight derives a rate, then compares the rate to the "benchmark" or Target Price selected by United Defendants. If the Data iSight rate is lower than the Target Price and the provider's billed charges, then the Data iSight rate is used to pay claims.

158. On information and belief, the pricing process starts with United Defendants forwarding a claim to MultiPlan. At its sole discretion, United Defendants chooses which claims

to price internally, which claims to send for one of MultiPlan's other pricing products, and which claims to price through Data iSight.

159. United Defendants send claim information to MultiPlan electronically via a software "electronic data interchange" program (hereinafter "EDI"). On information and belief, the EDI process allows United to communicate several critical inputs to MultiPlan:

- Claims Information (Policy Type, Charge Amount, CPT/HCPCS Billing Codes);
- Routing to Designated Repricing Tool: i.e. whether to route the claim to Data iSight or to other Multiplan pricing products such as "Negotiations" or "Rental Networks;"
- The Benchmark "Target Price" for the claim (i.e. the benchmark price that determined MultiPlan's compensation); or
- The percentile of Data iSight's proprietary database to use to set a benchmark rate.

160. Once MultiPlan received information from United Defendants, it started the repricing process by sending United Defendants' inputs through its "Claims Savings Engine" known internally as FRED, which routed the claim to Data iSight.

161. The most commonly used and pernicious repricing method utilized by Data iSight, "DiP," is discussed below.

162. Significantly, on information and belief, the FRED system has FAIR Health usual and customary data loaded into it, available at the click of a mouse, but Multiplan consciously chooses not to use it every time.

A. DiP: The Data iSight Software Engine

163. On information and belief, upon receipt of the data, Data iSight deployed its proprietary claims repricing method. The method first classified and sorted claims information

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based on type of care. For hospital or facility services, the claims are then sent to the next step in the Data iSight process that is used to determine payment.

164. On information and belief, professional claims, like those billed by Physician Practice in this action, are distinct from hospital or facility claims. The professional claims are for the treatment provided directly by physicians, like Physician Practice in this case. Professional claims were priced by a specific Data iSight process known internally at MultiPlan as "DiP," internal shorthand for "Data iSight Professional."

165. DiP is a computer program that takes the codes transmitted by United Defendants and applies a convoluted algorithm to "edit" and recalculate claims payment rates.

B. Claims Editing

166. On information and belief, Data iSight's first step in processing claims is to apply 'edits.' "Editing" claims modifies the billing codes on providers' billing forms to reduce the payment rates that the engine generates. Claims editing (or how to underpay the specific claim) is conducted pursuant to input from the financial marketing departments, rather than a medical or clinical department, at MultiPlan.

167. On information and belief, United Defendants and MultiPlan each oversee different aspects of the claims editing, further evidence of their joint management and control of the Enterprise.

168. On information and belief,, three technical variables fuel the rates the Data iSight engine produces: Conversion Factors, Relative Value Units, and Geographic Practice Cost Indices. Data iSight borrowed these terms and their application from the Medicare Program.

169. On information and belief, the DiP software applies cost adjustments from Medicare in calculating physician payments. DiP adjusts the payment amounts based on

"Conversion Factors" (hereinafter "CFs"), "Relative Value Units" (hereinafter "RVUs"), and "Geographic Practice Cost Index" (hereinafter GPCI) inputs.

170. On information and belief, the CFs Data iSight applies is derived from a database created by Intercontinental Medical Statistics ("IMS"), a company that purchases data from pharmacies, insurers, and electronic medical record software, anonymizes it, and sells the data back, primarily to drug companies.

171. While MultiPlan represents that the IMS database contains billions of claims, on information and belief, it actually only contains tens of millions of claims. In terms of scale, the FAIR Health dataset contains approximately 100 data points for every one contained within the IMS dataset.

172. IMS is now known as IQVIA. The database is not public, is not vetted, is not comprehensive, and is designed to sell itself. On information and belief, MultiPlan paid hundreds of thousands of dollars a year to access the information IMS compiled. MultiPlan chose this database despite having access to the FAIR Health Database discussed above.

173. By using the IQVIA data set, the payment rate that is ultimately calculated through Data iSight is even further removed from the usual and customary rate than was the Ingenix rate. The deeply flawed Ingenix data set contained commercial charge data, albeit heavily manipulated. The IQVIA data set contains only Medicare data.

174. Similarly, RVUs and GPCIs are components that are used to calculate the amount that Medicare will pay for a claim. They are not based on usual and customary rates; instead, the Medicare formula is based on the resources that Medicare believes go into providing a specific service.

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C. Target Pricing: Meet or Beat

175. Once the engine yields the DiP, on information and belief, United Defendants and Data iSight engaged the second phase of the underpayment scheme: the "meet or beat."

176. On information and belief, DiP was always compared to a target payment, or benchmark, amount. Within MultiPlan this was known as the "meet or beat" price.

177. On information and belief, the target payment is an initial amount United Defendants provide that is to be passed with the claim as it goes through FRED and subsequent processes, and which serves as the benchmark because the final payment amount should be less than the target payment in pricing terms ("Target Price").

178. In all cases, United Defendants had complete control over the Target Price, and MultiPlan had complete control over its implementation over Data iSight.

179. On information and belief, the Data iSight engine's objective was to beat United Defendants' Target Price.

180. Regardless, for the Claims, the compensation structure agreed upon between MultiPlan and United Defendants incentivized artificially low payments.

D. Post Payment Concealment

181. For every Claim, documents concealing the true means and basis for payment were issued electronically, in the mail, and on inquiry, over the phone.

182. Provider Remittance Advice letters ("PRAs") were mailed documents that allegedly provided a detailed explanation of the price reductions. In most PRA documents, the role of Data iSight in determining the rate of payment was admitted, but the description of Data iSight in its methodology was designed to deceive Physician Practice and other providers into accepting reduced rates.

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183. The PRAs contained standardized notes allegedly explaining payment reductions. The Claims received inconsistent PRA notes, none of which accurately explained that United Defendants and MultiPlan had conspired to pay the Claims at artificially reduced rates. Instead, the codes provided generic notes or no notes at all. The purpose of the notes on every PRA was to pass the Claims prices off as legitimate and objective. The PRA notes were part of the scheme to deceive providers into accepting the reduced rates.

184. The information contained in the Data iSight Portal also contributed to the scheme. The Data iSight Portal purported to describe a transparent basis for the reductions in billed amounts. In every single case, the Data iSight Portal contained numerous misrepresentations, including that the Claims were paid at median levels, claims about the objectivity and transparency of the IMS database, and claims about relationships to amounts similar providers accepted for similar codes. Furthermore, Claims Edits, and the basis for them, were never disclosed in any explanations of payments received.

E. The DiP Misrepresentations

185. DiP misrepresented the "reasonable" payment amount, concealed how the price was arrived at, and defrauded Physician Practice at several steps.

186. On information and belief, claims edits are illegitimate, secret modifications to prices. Claim "editing" changed the billed service inputs. The practice of claim editing causes inputs to the Data iSight software to be false and fraudulent from the start.

187. On information and belief, the Data iSight engines applies its claims edits secretly, for reasons solely driven by cost reduction, with no clinical basis. The editing is performed by persons without clinical training and without consultation of clinical records.

188. Any representation that numbers derived from the Data iSight database are commensurate with the service billed are, thus, false and fraudulent because the inputs to the Data iSight engine are not equivalent to the services billed and rendered.

189. On information and belief, the IMS Database that fuels the underpayment scheme is statistically invalid, inadequate, unvetted, and secret. Its inputs are undisclosed, and its purpose is to produce prices lower than the objectively provided prices available from the FAIR Health database. MultiPlan represents and markets transparency, but never provides the true basis for the data it uses to price claims.

190. As a result, any representation that payments are based on amounts charged for similar services by similar providers in the same geographic area is false.

191. Meet or Beat pricing incentivizes and causes deviation from objective pricing. The secret goal of the Defendants to, through the Enterprise, underpay claims and retain for themselves a substantial portion of the funds designated to pay Physician Practice for its services, belies their many representations that the rates the Data iSight engine produces are transparent, objective, and/or fair.

192. Post-payment concealment via PRAs, the Data iSight portal information, and telephone conversations are fraudulent and intended to further the purposes of the Defendants.

Marketing the Conspiracy

193. MultiPlan markets Data iSight to United Defendants and other insurers as a product capable of underpaying claims discreetly and with minimal complaints from health care providers. MultiPlan explained to United Defendants that its Data iSight tool could be deployed to drastically reduce United Defendants' payments to non-participating anesthesia providers.

194. MultiPlan and United Defendants developed and implemented a scheme to underpay Physician Practice and other out-of-network providers without facing pushback, precisely because patient responsibility is limited by statute.

195. United Defendants believe that use of the "independent" Data iSight product will shield it from liability.

196. United Defendants also misrepresent to insureds and insurance plans how much they pay out in claims by claiming certain amounts of "savings."

197. Neither healthcare providers nor insureds agree to the "savings" as implemented by United Defendants and MultiPlan.

198. On information and belief, this Enterprise has allowed United Defendants and MultiPlan to make billions of dollars at the expense of Physician Practice and other providers.

199. MultiPlan and United Defendants worked out the details of their Enterprise through frequent in-person meetings, electronic and wire communications, and the exchange of internal non-public documents called Whitepapers.

MultiPlan's Secret Annual Events: Meetings of the Enterprise

200. On information and belief, MultiPlan secretly discussed the Data iSight Professional ("DiP") methodology with United Defendants at annual events hosted by the Client Advisory Board of MultiPlan ("CAB"). The "CAB" consists of the senior marketing individuals at MultiPlan including Susan Mohler, MultiPlan's Vice President of Marketing; Dale White, Executive Vice President of Sales; Bruce Singleton, Senior Vice President of Network Strategy Network; and Michael McEttrick, Vice President Healthcare Economics.

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201. At these events, United Defendants, MultiPlan, and Multiplan's other customers would come together, at various discrete locations around the country, to discuss, among other topics, the DiP repricing scheme and how to make more money off it.

202. These secret meetings established a forum for United Defendants to form an Enterprise with MultiPlan to suppress the rates paid to healthcare providers.

203. During these events, MultiPlan presents slide shows outlining the profits and "savings" that could be made using DiP methodology.

204. The DiP methodology is specifically designed to be adapted and customized based on input and direction from the insurer, and these events and the Road Shows described below allow United Defendants to discuss the customizations they want in the claim pricing with MultiPlan, directly.

205. Both United Defendants and MultiPlan have management and oversight of the Enterprise that they formed to use the DiP methodology in their racketeering activities.

206. The CAB emphasizes the "liability shield" provided by DiP methodology and the ability of the insurer to direct underpayments from behind the false appearance of independence.

207. The CAB emphasizes that MultiPlan's healthcare repricing tools are unregulated.

208. The absence of regulation allows United Defendants and MultiPlan, unfettered, to develop jointly the underpayment scheme.

209. United Defendants partner with MultiPlan to use the DiP methodology so that the "Paid Claims" rate produced through DiP's methodology can be presented as "independent" and "defensible," permitting United Defendants to abdicate their responsibility for the derived rates. All of this is a smokescreen meant to hide the fraud.

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210. On information and belief, MultiPlan emphasizes to United Defendants at these meetings that, if they are ever subject to pushback or scrutiny about their reasonable or usual and customary rates, they need only to point to the unregulated DiP methodology and assert that they relied on DiP's use of supposed "objective" and "data-backed" pricing methodology, the true details of which are never revealed.

211. On information and belief, at the annual meetings, United Defendants and MultiPlan discuss situations where dissatisfied patients and/or providers pushed back or challenged underpaid amounts. In such situations, the DiP methodology and rate are deceitfully presented to patients as a "fair" and "transparent" justification for the underpayment.

212. MultiPlan and United Defendants depended on keeping the actual terms and methodology of DiP secret.

MultiPlan's Secret Road Shows: Further Meetings of the Enterprise

213. On information and belief, MultiPlan's CAB, including representatives Susan Mohler and Dale White of MultiPlan, also brought secret "Road Shows" – or client status updates mixed with sales pitches – directly to United Defendants and presented PowerPoint slideshows detailing the profits that could be realized by insurers using the DiP pricing methodology.

214. During the Road Shows and in subsequent interactions, the CAB produced detailed descriptions of DiP's methodology through internal non-public "Whitepapers" with input from United Defendants on how they would like their claims routed through the myriad of MultiPlan's payment engines, including DiP, to maximize the Defendants' profits through the Enterprise.

215. On information and belief, representatives of United Defendants and MultiPlan discussed the DiP pricing methodology in detail at these Road Shows along with other

methodologies available to illegally lower the prices paid for healthcare services to patients with United Defendants' administered insurance.

216. In particular, representatives such as Rebecca Paradise, Vice President of Out of Network Payment Strategies at United, are involved in these talks.

217. The text of the underpayment methodology is, on information and belief, described in Whitepapers, which are essentially user-manuals for the implementation of the scheme and formation of the Enterprise between United Defendants and MultiPlan to carry out their racketeering and other illegal activities.

218. The Whitepapers are jointly developed over the course of the collaboration between United Defendants and MultiPlan.

The Secret Internal Whitepapers

219. On information and belief, MultiPlan's marketing and sales departments, including Jaqueline Kienzle, Vice President of Sales and Account Management at MultiPlan, and managers of United Defendants' accounts, Susan Mohler and Dale White, exchange with United Defendants these internal non-public Whitepapers. The Whitepapers ae created by the Multiplan marketing department in concert with Multiplan's data engineers.

220. Whitepapers are, on information and belief, secret internal documents that explain, in detail, exactly how the DiP methodology can be implemented to derive any payment price United Defendants or any other payer wants, regardless of what the law actually mandates.

221. On information and belief, executives from United Defendants, including Rebecca Paradise, Vice President of Out of Network Payment Strategies, review, comment, and provide feedback on MultiPlan's Whitepapers in order to structure United Defendants' relationship with

MultiPlan and implement the DiP methodology to underpay claims and violate the law in whatever manner makes the most money for United Defendants and Multiplan.

222. On information and belief, the Whitepapers explain that United Defendants set performance standards which are defined by target prices. MultiPlan uses DiP to derive a price below the target price.

223. On information and belief, the Whitepapers also explain that United Defendants can represent "savings" to its customers (purchasers of health insurance) that are not the actual amounts it paid for those services.

224. As such, these jointly developed Whitepapers provide a partial blueprint of the Enterprise, the vehicle that is being used to carry out fraudulent racketeering acts that directly damage Physician Practice through underpayment of valid, medically necessary claims.

The Network Access Agreement

225. The National Network Access Agreement ("Agreement") is a written contract between United Defendants and MultiPlan that sets out how United Defendants and MultiPlan profit from the proceeds of the DiP-generated underpayments.

226. Although a benign legal contract between businesses on its face, the Agreement is intended to provide cover and a vehicle for the parties to share the ill-gotten gains of the DiP pricing methodology.

Defendants Engage in a Pattern of Criminal Activity and Racketeering Activity

Defendants Engage in Theft

227. Physician Practice provided emergent and/or authorized non-emergent professional anesthesiology services to United Defendants' Members.

228. Physician Practice is entitled to be reimbursed by United Defendants for those professional services at usual and customary rates for those services in the geographic areas in which the services were provided, in accordance with Florida law.

229. Physician Practice's professional services, as well as its claims and rights to reimbursement at usual and customary rates for those services in the geographic areas in which the services were provided, are things of value and constitute property under Florida law. Fla. St. § 812.012(4)(b)-(c), (6)(b).

230. On information and belief, once United Defendants approve a Claim for payment, United Defendants pull funds from the applicable reserve and designate those funds for reimbursement for Physician Practice's claim ("Physician Practice's Designated Funds").

231. However, instead of paying a reasonable rate to Physician Practice, Defendants used Data iSight to fabricate a fraudulent "reasonable rate" as justification for withholding a substantial part of Physician Practice's Designated Funds.

232. For every Claim, Physician Practice was paid substantially less than its charges or a usual and customary rate.

233. Then, based on the Enterprise's system, as discussed herein, on information and belief, United Defendants and MultiPlan pocket the remaining amount of Physician Practice's Designated Funds – the difference between Physician Practice's Designated Funds and the fraudulent "reasonable" amount paid to Physician Practice.

234. Defendants have committed theft by knowingly obtaining and using, and endeavoring to obtain or use, Physician Practice's property with the intent to either temporarily or permanently deprive Physician Practice of its rights to and benefits from the property, including payment of Physician Practice's Claims as required by law.

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235. Defendants have also committed theft by endeavoring to obtain or use Physician Practice's property with the intent to either temporarily or permanently deprive Physician Practice of its rights to and benefits from the property, including payment of Physician Practice's Claims as required by law.

236. Defendants have also committed theft by knowingly obtaining and using, and endeavoring to obtain or use, Physician Practice's property with the intent to temporarily or permanently appropriate that property to Defendants' own use or the use of other persons not entitled to the use of that property.

237. Defendants have also committed theft by endeavoring to obtain or use Physician Practice's property with the intent to temporarily or permanently appropriate that property to Defendants' own use or the use of other persons not entitled to the use of that property.

238. Defendants have also conspired with one another to commit theft, intending to obtain or use Physician Practice's property with the intent to either temporarily or permanently deprive Physician Practice of its rights to and benefits from the property, including payment of their claims as required by law.

239. Defendants have also conspired to commit theft, intending to obtain or use Physician Practice's property with the intent to temporarily or permanently appropriate that property to Defendants' own use or the use of other persons not entitled to the use of that property.

240. In engaging in the above-referenced thefts, endeavoring to commit theft, and conspiring to commit theft, each Defendant possessed a felonious intent to steal from Physician Practice and conspire with others to steal from Physician Practice.

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241. By committing, attempting to commit, and conspiring to commit theft, Defendants have engaged in criminal activity within the meaning of Fla. Stat. § 772.102(1)(a)(20) and racketeering activity within the meaning of Fla. Stat. § 895.02(8)(a)(32).

Violations of the Florida Communications Fraud Act

242. Defendants have engaged in a scheme to defraud pursuant to which they have obtained property from Physician Practice and others. This conduct constitutes organized fraud in violation of Fla. Stat. § 817.034(4)(a)(1) of the Florida Communications Fraud Act.

243. Defendants' scheme to defraud is a systematic, ongoing course of conduct intended to defraud Physician Practice and others.

244. Defendants' scheme to defraud is intended to obtain property from Physician Practice and others by false or fraudulent pretenses, representations, promises, and willful misrepresentations of future acts including but not limited to the United Defendants' pre-authorization of the medically necessary anesthesia services provided by Physician Practice to United Defendants' Members in violation of Fla. Stat. § 817.034(4)(b)(1).

245. Defendants have also attempted to defraud Physician Practice and have obtained property by temporarily or permanently depriving Physician Practice and others of their property, including but not limited to their services, tangible, and intangible personal property, including rights, interests, and claims, as well as other things of value and benefits therefrom.

246. Defendants have conspired to defraud Physician Practice and have obtained property by temporarily or permanently depriving Physician Practice and others of their property, including but not limited to their services, tangible, and intangible personal property, including rights, interests, and claims, as well as other things of value and benefits therefrom.

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247. By committing, attempting to commit, and conspiring to commit organized fraud, Defendants have engaged in criminal activity within the meaning of Fla. Stat. Ann. in violation of Fla. Stat. § 772.102(1)(a)(22), and racketeering activity within the meaning of Fla. Stat. § 895.02(8)(a)(34).

248. By committing, attempting to commit, and conspiring to commit organized fraud, Defendants have engaged in criminal activity within the meaning of Fla. Stat. § 772.102(1)(a)(22), and racketeering activity within the meaning of Fla. Stat. § 895.02(8)(a)(34).

Defendants Engage In Communications Fraud

249. In furtherance of their scheme to defraud, Defendants have transmitted and transferred, and caused others to transmit or transfer, signs, signals, writings, images, sounds, data and intelligence in whole or in part by mail and wire.

250. The Defendants communicated, via wire communications, false and misleading information to Physician Practice and falsely denied they had information requested by the Physician Practice about the basis for the drastically-cut reimbursement rates that Defendants sought to persuade Physician Practice to accept.

251. In addition, the Defendants have furthered this scheme by communicating payment amounts and making reimbursement payments to Physician Practice by means of the United States Postal Service and wire communications at unlawful rates that were far below reasonable rates for the services provided.

252. Through their scheme to defraud, Defendants have obtained property by temporarily or permanently depriving Physician Practice and others of their property, including but not limited to their services, tangible, and intangible personal property, including rights, interests, and claims, as well as other things of value and benefits therefrom.

253. Defendants have also appropriated Physician Practice's property to their own use or to the use of other persons not entitled thereto.

254. Defendants have also attempted to commit communications fraud by engaging in a scheme to defraud that is intended to obtain property from Physician Practice and others.

255. Defendants have also attempted to commit communications fraud by attempting to appropriate Physician Practice's property to their own use or to the use of other persons not entitled thereto.

256. Defendants have also conspired to obtain property by temporarily or permanently depriving Physician Practice and others of their property, including but not limited to their services, tangible, and intangible personal property, rights, interests, and claims, as well as other things of value and benefits therefrom.

257. Defendants have also conspired to appropriate Physician Practice's property to their own use or to the use of other persons not entitled thereto.

258. By committing, attempting to commit, and conspiring to commit communications fraud, Defendants have engaged in criminal activity within the meaning of Fla. Stat. § 772.102(1)(a)(22), and racketeering activity within the meaning of Fla. Stat. § 895.02(8)(a)(34).

Defendants Have Engaged In a Pattern of Criminal Activity and Racketeering Activity

259. Each Defendant has engaged in at least two incidents of criminal activity and racketeering activity that have the same or similar intents, results, accomplices, victims, or methods of commission or that otherwise are interrelated by distinguishing characteristics and are not isolated incidents.

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260. The incidents of criminal activity and racketeering activity engaged in by the Defendants have the same or similar intents, in that they sought to, and did, unlawfully avoid paying Physician Practice as required by law.

261. The incidents of racketeering activity engaged in by the Defendants have the same or similar results, in that they sought to, and did, unlawfully avoid paying Physician Practice as required by law.

262. The incidents of criminal activity and racketeering activity engaged in by the Defendants have the same or similar victims, consisting of Physician Practice and other out-of-network providers whom Defendants have schemed to unlawfully avoid paying based upon false and fraudulent data.

263. The incidents of criminal activity and racketeering activity engaged in by the Defendants are not isolated; rather, those incidents are part of the Defendants' regular way of doing business and are regularly and systematically engaged in by them to avoid paying out-of-network providers, including Physician Practice, as required by law.

264. The last incident of criminal activity and the last incident of racketeering activity occurred within five years after a prior incident.

265. The incidents of criminal activity and racketeering activity do not arise out of a single contract or transaction. The incidents of criminal activity and racketeering activity involve services provided to different persons, on different dates, at different locations, by different physicians.

266. Defendants' conduct poses a continued threat of racketeering and criminal activity, as described below.

267. Defendants have engaged in thousands of acts of racketeering activity and criminal activity directed at Physician Practice and other providers.

268. Defendants have engaged in these acts of racketeering activity and criminal activity over a substantial period of time.

269. The acts of racketeering activity and criminal activity engaged in by Defendants are intended to and have become part of the Defendants' regular way of doing business.

270. The acts of racketeering activity and criminal activity are extremely lucrative for Defendants, and Defendants intend to continue to engage in those acts indefinitely, unless forced to cease by judicial intervention.

271. As a direct and proximate result of Defendants' acts of criminal activity and racketeering activity, Physician Practice has suffered more than approximately $4,800,000 in discrete financial losses, from March 1, 2020 to the present, which damages continue to accrue.

The Enterprise

272. Defendants have formed an ongoing informal organization, with the common purpose of engaging in a fraudulent course of conduct, including to unlawfully avoid paying Physician Practice as required by law.

273. The Enterprise formed by the Defendants has a purpose, which includes engaging in and attempting to engage in acts of criminal activity and racketeering activity intended to unlawfully avoid paying Physician Practice as required by law.

274. The Enterprise provides the vehicle through which the acts of racketeering activity are committed, and the racketeering acts themselves include a specific threat of repetition extending indefinitely into the future.

275. There are relationships among the entities associated with the Enterprise.

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276. The relationships between United Defendants and MultiPlan are sufficient to permit them to pursue the Defendants' unlawful purpose through the Enterprise.

277. The Enterprise functions as a continuing unit. The relationships between United Defendants and MultiPlan continue to the present, and the Defendants continue to jointly pursue their collective unlawful purpose.

278. These relationships include relationships between the United Defendants. The United Defendants form part of a symbiotic whole and each works for the benefit of one another. These entities share logos, resources, services, and revenues.

279. For example, when the United Defendants enter into participating provider agreements in Florida, the United Defendants do so on behalf of themselves and all "Affiliates," which are defined to include "entities controlling, controlled by or under common control" with each other. These participating provider agreements thus cover claims submitted by the participating provider for United HMO, United PPO and UMR, among other of the United Defendants' related entities.

280. Additionally, the United Defendants operate in concert with one another, directing that all claims for reimbursement for medical services be remitted to the same electronic filing portal.

281. As set forth above, the United Defendants also have relationships with MultiPlan. The United Defendants and other United entities have contracts with MultiPlan, coordinate their efforts with MultiPlan, and share with MultiPlan money obtained from Physician Practice and other victims of the scheme.

282. The relationships between the members of the association-in-fact enterprise are sufficient to permit them to pursue their unlawful purpose. The United Defendants cooperate

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closely with MultiPlan to implement the scheme and share the benefits of the scheme with MultiPlan. These relationships continue to the present, and the Enterprise continues to pursue its purpose.

283. Each of the Defendants participates in the operation and management of the Enterprise.

284. Each of the Defendants has agreed to participate in the Enterprise with knowledge of the Enterprise's unlawful goals and purposes to commit acts in furtherance of the Enterprise's common purpose, and to share in the monies obtained through the scheme.

285. Each of the Defendants has committed acts of criminal activity and racketeering activity in furtherance of the Enterprise's common unlawful purpose.

286. Defendants agreed to, and do, act through the Enterprise to manipulate reimbursement rates and control allowed payments to the Physicians.

287. Defendants have received, and continue to receive, financial gains from their scheme to defraud Physician Practice.

288. The purpose and direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to deprive Physician Practice of the payments they are entitled to by statute so that Defendants can retain a portion of the funds allocated to Physician Practice, to the harm of Physician Practice, and to the benefit of the Enterprise.

289. Physician Practice has been and is being harmed in its businesses and property by Defendants' scheme. Physician Practice was deprived of the fair value of its services. Defendants falsely told Physician Practice that Defendants' payments were consistent with an objective calculation of reasonable rates and comparable with rates charged by their competitors. Physician Practice was denied the funds allocated to it for anesthesia services rendered to United's Members.

Physician Practice brings this suit to recover the fair value of its services, to enjoin Defendants from continuing their fraud, and to ensure appropriate damages are levied against Defendants for their racketeering enterprise such that the verdict shall be precautionary for all payors contemplating using the false and fraudulent pricing tool and the illegal retention of providers' property.

290. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

COUNT I
Violation of Florida RICO, Fla. Stat. § 895.03(3)
(as against all Defendants)

291. Physician Practice re-alleges and restates paragraphs 1 through 290 above as if they were fully set forth herein.

292. Physician Practice is a "person" within the meaning of Fla. Stat. § 895.05.

293. Defendants are each a "person" within the meaning of Fla. Stat. § 895.03.

294. As set forth above, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of Fla. Stat. § 895.02(5), comprised of, at least, Defendants.

295. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

296. Defendants had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding Physician Practice and depriving Physician Practice of payment for the services they provided to Defendants' Members at no less than Physician Practice's charges or the usual and customary rate for Physician Practice's services to enable Defendants to retain for themselves

funds allocated to Physician Practice for the anesthesia services it rendered to United Defendants' Members.

297. As set forth above, the Defendants have been, and continue to be, engaged in a scheme to defraud Physician Practice by committing a series of unlawful acts which constitute predicate racketeering acts under Fla. Stat. §§ 895.02 and 895.03.

298. Each Defendant provides benefits to insured Members, processes claims for services provided to Members, purports to determine and recommend a reimbursement rate for such services, and/or issues payments for services, and knowingly and willingly participates in the scheme to defraud Physician Practice.

299. Physician Practice was injured as a direct and proximate result of Defendants' violations of Fla. Stat. § 895.03(3).

300. Physician Practice is entitled to injunctive relief prohibiting Defendants from continuing to manipulate the rates of reimbursement for Physician Practice's out-of-network anesthesiology services and compelling United Defendants to reimburse the Physicians no less than the reimbursement rates to which the Court declares Physician Practice is entitled from United for the anesthesiology services Physician Practice renders to United's Members as out-of-network providers.

301. Physician Practice prays that the Court enter appropriate orders and judgments enjoining Defendants' violations of the provisions of Fla. Stat. Ann. § 895.03 by imposing reasonable restrictions upon the future activities of the Defendants, including, but limited to prohibiting each of them from engaging in the same type of endeavor as the enterprise in which they have engaged in violation of the provisions of § 895.03. Fla. Stat. § 895.05(1)(b).

COUNT II
Conspiracy to Violate Florida RICO, Fla. Stat. § 895.03(4)
(as against all Defendants)

302. Physician Practice re-alleges and restates paragraphs 1 through 290 above as if they were fully set forth herein.

303. Physician Practice is a "person" within the meaning of Fla. Stat. § 895.05.

304. Defendants are each a "person" within the meaning of Fla. Stat. § 895.03.

305. As set forth above, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of Fla. Stat. § 895.02(5), comprised of at least Defendants.

306. Defendants were, and continue to be, associated with the Enterprise and knowingly endeavored and conspired, within the meaning of Fla. Stat. § 895.03(4), to violate Fla. Stat. § 895.03(3) by conducting and participating, directly or indirectly, in the conduct and affairs in the Enterprise through a pattern of racketeering activity within the meaning of Fla. Stat. § 895.02(7).

307. As a direct and proximate result of Defendants' violations of Fla. Stat. § 895.03(4), Physician Practice was injured in its business, suffering financial losses.

308. Physician Practice is entitled to injunctive relief prohibiting Defendants from continuing to conspire to manipulate the rates of reimbursement for Physician Practice's out-of-network anesthesiology services and compelling United to reimburse Physician Practice no less than the reimbursement rates to which the Court declares Physician Practice is entitled from United for the anesthesiology services Physician Practice renders to United's Members as an out-of-network provider.

309. Physician Practice prays that the Court enter appropriate orders and judgments enjoining Defendants' violations of the provisions of Fla. Stat. Ann. § 895.03 by imposing

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reasonable restrictions upon the future activities of the Defendants, including, but limited to prohibiting each of them from engaging in the same type of endeavor as the enterprise in which they have engaged in violation of the provisions of § 895.03. Fla. Stat. § 895.05(1)(b).

COUNT III
Violation of CRCPA, Fla. Stat. § 772.103(3)
(as against all Defendants)

310. Physician Practice re-alleges and restates paragraphs 1 through 290 above as if they were fully set forth herein.

311. Physician Practice is a "person" within the meaning of Fla. Stat. § 772.104.

312. Defendants are each a "person" within the meaning of Fla. Stat. § 772.103.

313. As set forth above, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of Fla. Stat. § 772.102(3), comprised of at least Defendants.

314. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

315. Defendants had, and continue to have, the common and continuing purpose of depriving Physician Practice of the reimbursement to which they are entitled by statute and attempting to defraud Physician Practice.

316. As set forth above, the Defendants have been, and continue to be, engaged in a scheme to defraud Physician Practice by committing a series of unlawful acts which constitute a pattern of criminal activity under Fla. Stat. §§ 772.102 and 772.103, involving multiple instances of theft in violation of Fla. Stat. § 812.014, and multiple instances of communications fraud in violation of Fla. Stat. § 817.034

317. Each Defendant provides benefits to insured Members, processes claims for services provided to Members, purports to determine and recommend a reimbursement rate for such services, and/or issues payments for services, and knowingly and willingly participates in the scheme to defraud Physician Practice and retain funds allocated to Physician Practice for anesthesia services rendered to United Defendants' Members.

318. As a direct and proximate result of Defendants' violations of Fla. Stat. § 772.103(3), Physician Practice was injured in its business, suffering financial losses.

319. Physician Practice is entitled to treble damages from Defendants, jointly and severally, caused by the Defendants' unlawful scheme.

COUNT IV
Conspiracy to Violate CRCPA, Fla. Stat. § 772.103(4)
(as against all Defendants)

320. Physician Practice re-alleges and restates paragraphs 1 through 290 above as if they were fully set forth herein.

321. Physician Practice is a "person" within the meaning of Fla. Stat. § 772.104.

322. Defendants are each a "person" within the meaning of Fla. Stat. § 772.103.

323. As set forth above, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of Fla. Stat. § 772.102(3), comprised of at least Defendants.

324. Defendants were, and continue to be, associated with the Enterprise and knowingly endeavored and conspired, within the meaning of Fla. Stat. § 772.103(4), to violate Fla. Stat. § 772.103(3) by conducting and participating, directly or indirectly, in the conduct and affairs in the Enterprise through a pattern of racketeering activity within the meaning of Fla. Stat. § 895.02(7).

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325. As a direct and proximate result of Defendants' violations of Fla. Stat. § 772.103(4), Physician Practice has been injured in its business, suffering financial losses.

326. Physician Practice is entitled to treble damages from Defendants, jointly and severally, caused by the Defendants' unlawful scheme.

COUNT V
Violation of FDUTPA
(as against MultiPlan)

327. Physician Practice re-alleges and restates paragraphs 1 through 290 above as if they were fully set forth herein.

328. MultiPlan engages in trade or commerce by advertising, soliciting, providing, offering, or distributing its Data iSight service, which MultiPlan, according to MultiPlan, generates "fair" reimbursement rates for out-of-network services in accordance with objective independent data.

329. Physician Practice is a consumer of MultiPlan's services. Insofar as United prices a claim utilizing Data iSight, MultiPlan intends for providers to utilize and rely on its recommended reimbursement rates as fair and reasonable reimbursement rates for out-of-network services based on objective data and neutral analyses. Physician Practice is thus an intended beneficiary of MultiPlan's out-of-network pricing services. Indeed, Data iSight advertises its services as benefiting healthcare providers. For example, in a section of its website titled "Transparency for You, the Provider," MultiPlan describes Data iSight as affording the following benefits to providers: "A key feature of Data iSight is this website, which gives [providers] a better understanding of how these payment amounts are determined. The website makes the process for determining appropriate payment transparent to you so that you may become a more informed healthcare partner, and to assist you with any questions about how this claim was reduced. It also

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provides the information to the health plan payer and the patient so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

330. Furthermore, Physician Practice is a consumer of MultiPlan's rental network services through which MultiPlan serves as a broker between non-participating providers, such as Physician Practice, and health insurance companies, such as United.

331. MultiPlan's conduct is unfair and deceptive under FDUTPA. The reimbursement rates that MultiPlan, through Data iSight, generates and purportedly recommends to United are not, in fact, fair and reasonable reimbursement rates for out-of-network services reflecting the usual and customary charges for such services in the community. Nor are they based on Data iSight's independent determinations of objective data as to the usual and customary reimbursements. Rather, the reimbursement rates that MultiPlan purports to recommend to United through Data iSight are rates at which United has instructed MultiPlan to price such claims. MultiPlan thereby knowingly functions as a conduit through which United endeavors to launder its deficient reimbursements in a façade of reasonableness, objectivity, and legitimacy in order to deceive healthcare providers, such as Physician Practice, into accepting United's out-of-network reimbursements as being reasonable and representative of the usual and customary charges in the market for the services healthcare providers like Physician Practice renders. MultiPlan's conduct is likely to mislead a consumer of its services acting reasonably in the circumstances.

332. Furthermore, contrary to its portrayal, MultiPlan's recommended prices are unfair because MultiPlan is financially incentivized to generate rates that are as low as possible through its contracts with United, rather than rates that accurately reflect the usual and customary charges in the community for the services rendered.

333. MultiPlan's conduct has caused Physician Practice to suffer actual damages. As a direct result of MultiPlan's fraudulent scheme, Physician Practice has received deficient reimbursements from United on all of the Claims at amounts less than Physician Practice is entitled to receive. Furthermore, MultiPlan's conduct has harmed Physician Practice's contractual relationship with MultiPlan in that it has received less in reimbursement for the Claims than it would otherwise receive if those services had been priced pursuant to MultiPlan's rental network rates, which are rates that Physician Practice has accepted through its agreements with MultiPlan.

334. MultiPlan has therefore violated FDUTPA, Fla. Stat. § 501.204(1).

JURY DEMAND

Physician Practice hereby demands a trial by jury of all issues so triable.

PRAYER FOR RELIEF

WHEREFORE, Physician Practice prays that this Court:

(i) enter judgments against Defendants and in favor of Physician Practice as to Counts I and II;

(ii) issue an injunction (a) prohibiting Defendants from utilizing Data iSight, and (b) prohibiting Defendants from continuing to manipulate and conspiring to manipulate the rates of reimbursement for Physician Practice's out-of-network anesthesiology services, including without limitation the utilization of Data iSight;

(iii) enter judgments against Defendants and in favor of Physician Practice pursuant to Counts III and IV in an amount constituting treble damages from Defendants, jointly and severally, caused by Defendants' unlawful scheme to deprive Physician Practice of the reimbursement to which it is entitled under Florida law for the anesthesiology services provided to United Defendants' Members and reasonable attorneys' fees incurred in bringing this action;

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(iv) enter judgment against MultiPlan and in favor of Physician Practice pursuant to Count V, in an amount equal to the amounts Physician Practice's Claims were underpaid and reasonable attorneys' fees incurred in bringing this action;

(v) award Physician Practice prejudgment and postjudgment interest on the amounts overdue on the underpaid claims;

(vi) award Physician Practice its costs;

(vii) grant Physician Practice any and all further relief as more specifically sought in all preceding paragraphs and as the Court deems just and appropriate under the circumstances.

Respectfully submitted:

/s/ Justin C. Fineberg

ALAN D. LASH
Florida Bar No. 510904
alash@lashgoldberg.com
JUSTIN C. FINEBERG
Florida Bar No. 0053716
jfineberg@lashgoldberg.com
JONATHAN E. SIEGELAUB
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Florida Bar No. 0021815
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LASH & GOLDBERG LLP
Weston Corporate Center I
2500 Weston Road. Suite 220
Weston, FL 33331
Tel.: 954-384-2500
Fax: 954-384-2510
Counsel for Plaintiffs

Dated November 2, 2020

Filing # 116022363 E-Filed 11/02/2020 07:46:35 PM

FORM 1.997. CIVIL COVER SHEET

The civil cover sheet and the information contained in it neither replaces nor supplement the filing and service of pleadings or other documents as required by law. This form shall be filed by the plaintiff or petitioner with the Clerk of Court for purpose of reporting uniform data pursuant to section 25.075, Florida Statute. (See instructions for completion.)

---

1. CASE STYLE

In the Circuit Court of the Thirteenth Judicial Circuit for Hillsborough County, Florida

Gulf-to-Bay Anesthesiology Associates, LLC
Plaintiff(s)

Case Number: _____

Division: _____

vs

UnitedHealthcare of Florida, Inc. UnitedHealthca
Defendant(s)

---

2. AMOUNT OF CLAIM

Please indicate the estimated amount of the claim, rounded to the nearest dollar. The estimated amount of the claim is requested for data collection and clerical processing purposes only. The amount of the claim shall not be used for any other purposes.

- ☐ $8,000 or less _____
- ☐ $8,001 - $30,000 _____
- ☐ $30,001 - $50,000 _____
- ☐ $50,001 - $75,000 _____
- ☐ $75,001 - $100,000 _____
- ☑ over $100,000.00 $4,800,000.00

3. TYPE OF CASE (If the case fits more than one type of case, select the most definitive category.) If the most descriptive label is a subcategory (is indented under a broader category), place an X in both the main category and subcategory boxes.

CIRCUIT CIVIL

- ☐ Condominium
- ☐ Contracts and indebtedness
- ☐ Eminent domain
- ☐ Auto negligence
- ☐ Negligence – other
  - ☐ Business governance
  - ☐ Business torts
  - ☐ Environmental/Toxic tort
  - ☐ Third party indemnification
  - ☐ Construction defect
- ☐ Homestead residential foreclosure $50,001 - $249,999
- ☐ Homestead residential foreclosure $250,000 or more
- ☐ Non-homestead residential Foreclosure $0 - $50,000
- ☐ Non-homestead residential Foreclosure $50,001-$249,999
- ☐ Non-homestead residential Foreclosure $250,000 or more
- ☑ Other
  - ☐ Antitrust / trade regulation
  - ☑ Business transactions
  - ☐ Constitutional challenge – statute or ordinance
  - ☐ Constitutional challenge – proposed amendment

- ☐ Mass tort
- ☐ Negligent security
- ☐ Nursing home negligence
- ☐ Premises liability – commercial
- ☐ Premises liability – residential
- ☐ Products liability
- ☐ Real property / Mortgage foreclosure
  - ☐ Commercial foreclosure $0 - $50,000
  - ☐ Commercial foreclosure $50,001 - $249,999
  - ☐ Commercial foreclosure $250,000 or more
  - ☐ Homestead residential foreclosure $0 - $50,000
- ☐ Corporate trusts
- ☐ Discrimination – employment or other
- ☐ Insurance claims
- ☐ Intellectual property
- ☐ Libel / Slander
- ☐ Shareholder derivative action
- ☐ Securities litigation
- ☐ Trade secrets
- ☐ Trust litigation

☑ PLEASE CHECK THIS BOX IF THIS CASE IS APPROPRIATE FOR ASSIGNMENT TO THE COMPLEX BUSINESS LITIGATION DIVISION. PLEASE SEE ATTACHED COMPLEX BUSINESS LITIGATION DIVISION ADDENDUM FORM.

COUNTY CIVIL

- ☐ Small Claims
- ☑ Civil
- ☐ Real property/Mortgage foreclosure
- ☐ Replevins
- ☐ Evictions
  - ☐ Residential Evictions
  - ☐ Non-Residential Evictions
- ☐ Other civil (non-monetary)

4. **REMEDIES SOUGHT** (Check all that apply):
   - ☑ Monetary;
   - ☑ Non-monetary declaratory or injunctive relief;
   - ☐ Punitive

5. **NUMBER OF CAUSES OF ACTION:** 5

   (Specify) 1-Violation of Fld RICO, § 895.03(3); 2-Conspiracy to Violate Fla RICO §895.03(4)
   3- Violation of CRCPA § 772.103(3); 4-Conspiracy Violate CRCPA§ 772.103(4); 5-Violation FDUTPA

6. **IS THIS CASE A CLASS ACTION LAWSUIT?**
   - ☐ Yes
   - ☑ No

7. **HAS NOTICE OF ANY KNOWN RELATED CASE BEEN FILED?**
   - ☑ No
   - ☐ Yes. If "Yes", list all related cases by name, case number and court. _____

8. IS JURY TRIAL DEMANDED IN COMPLAINT?

☑ Yes

☐ No

I CERTIFY that the information I have provided in this cover sheet is accurate to the best of my knowledge and belief, and that I have read and will comply with the requirements of Florida Rule of Judicial Administration 2.425.

Signature /s/ *Justin C. Fineberg* FL Bar Number 0053716

Attorney or Party (Bar Number if attorney)

Justin C. Fineberg 10/30/2020

Type or Print Name Date

COMPLEX BUSINESS LITIGATION DIVISION ADDENDUM

Party or Attorney Filing Action Must Place an "X" in One of the Boxes Below

The categories of cases set out below shall guide the parties and the Court in the designation of cases for the Complex Business Litigation Division ("CBLD").

AMOUNT IN CONTROVERSY GREATER THAN $150,000.00

☐ Non-consumer UCC-related transactions;

☐ Purchases and sales of businesses or the assets of a business, including contract disputes, commercial landlord- tenant claims, and business torts;

☐ Non-consumer sale of goods or services by or to business enterprises;

☐ Non-consumer bank or brokerage accounts, including loan, deposit, cash management, and investment accounts;

☐ Purchase, sale, lease of commercial (real or personal) property or security interests therein;

☐ Commercial surety bonds;

☐ Franchisee / franchisor relationships and liabilities;

☐ Malpractice against professionals, except health care providers, in connection with rendering services relating to a business enterprise;

☑ Business torts, including unfair competition, breach of fiduciary duty, and tortious interference with contracts;

☐ Complex construction litigation, other than consumer home construction disputes, unless a court determines that the home construction dispute is business-related and complex; or

☐ Insurance coverage, bad faith litigation, and third party indemnity actions against insurers arising under policies issued to businesses, such as claims arising under a commercial general liability policy, commercial property policy, or title insurance policy, not including claims where the underlying dispute is a personal injury claim, unless a court determines that the personal injury insurance claim is business-related and complex.

ANY AMOUNT IN CONTROVERSY

☐ Internal affairs or governance, dissolution or liquidation rights, obligations between or among owners (shareholders, partners, members), or liability or indemnity of managers (officers, directors, managers, trustees, or members or partners functioning as managers) of corporations, partnerships, limited partnerships, limited liability companies or partnerships;

☐ Trade secrets and non-compete agreements;

☐ Intellectual property;

☐ Securities or state securities laws;

☐ Antitrust statutes;

☐ Shareholder derivative actions and related class actions; and

☐ Corporate trust affairs or director and officer liability.

NOTE: **A copy of the Civil Cover Sheet and this Addendum must be served with the Complaint for all Complex Business Litigation Division cases. See Administrative Order S-2013-021 for further Complex Business Litigation Division requirements.**

Filing # 116022363 E-Filed 11/02/2020 07:46:35 PM

FORM 1.997. CIVIL COVER SHEET

The civil cover sheet and the information contained in it neither replace nor supplement the filing and service of pleadings or other documents as required by law. This form must be filed by the plaintiff or petitioner with the Clerk of Court for the purpose of reporting uniform data pursuant to section 25.075, Florida Statutes. (See instructions for completion.)

I. CASE STYLE

IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT,
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA

Gulf-to-Bay Anesthesiology Associates, LLC
Plaintiff

Case # _____
Judge _____

vs.
UnitedHealthcare of Florida, Inc., UnitedHealthcare Insurance Co., UMR, Inc., Multiplan, Inc.
Defendant

II. AMOUNT OF CLAIM

Please indicate the estimated amount of the claim, rounded to the nearest dollar. The estimated amount of the claim is requested for data collection and clerical processing purposes only. The amount of the claim shall not be used for any other purpose.

☐ $8,000 or less
☐ $8,001 - $30,000
☐ $30,001- $50,000
☐ $50,001- $75,000
☐ $75,001 - $100,000
☒ over $100,000.00

III. TYPE OF CASE (If the case fits more than one type of case, select the most definitive category.) If the most descriptive label is a subcategory (is indented under a broader category), place an x on both the main category and subcategory lines.

CIRCUIT CIVIL

☐ Condominium
☐ Contracts and indebtedness
☐ Eminent domain
☐ Auto negligence
☐ Negligence—other
- ☐ Business governance
- ☐ Business torts
- ☐ Environmental/Toxic tort
- ☐ Third party indemnification
- ☐ Construction defect
- ☐ Mass tort
- ☐ Negligent security
- ☐ Nursing home negligence
- ☐ Premises liability—commercial
- ☐ Premises liability—residential

☐ Products liability
☐ Real Property/Mortgage foreclosure
- ☐ Commercial foreclosure
- ☐ Homestead residential foreclosure
- ☐ Non-homestead residential foreclosure
- ☐ Other real property actions

☐Professional malpractice
- ☐ Malpractice—business
- ☐ Malpractice—medical
- ☐ Malpractice—other professional

☒ Other
- ☐ Antitrust/Trade regulation
- ☐ Business transactions
- ☐ Constitutional challenge—statute or ordinance
- ☐ Constitutional challenge—proposed amendment
- ☐ Corporate trusts
- ☐ Discrimination—employment or other
- ☐ Insurance claims
- ☐ Intellectual property
- ☐ Libel/Slander
- ☐ Shareholder derivative action
- ☐ Securities litigation
- ☐ Trade secrets
- ☐ Trust litigation

COUNTY CIVIL

☐ Small Claims up to $8,000
☐ Civil
☐ Real property/Mortgage foreclosure

☐ Replevins
☐ Evictions
- ☐ Residential Evictions
- ☐ Non-residential Evictions

☐ Other civil (non-monetary)

COMPLEX BUSINESS COURT

This action is appropriate for assignment to Complex Business Court as delineated and mandated by the Administrative Order. Yes ☒ No ☐

IV. REMEDIES SOUGHT (check all that apply):
☒ Monetary;
☒ Nonmonetary declaratory or injunctive relief;
☐ Punitive

V. NUMBER OF CAUSES OF ACTION: [ ]
(Specify)

5

VI. IS THIS CASE A CLASS ACTION LAWSUIT?
☐ yes
☒ no

VII. HAS NOTICE OF ANY KNOWN RELATED CASE BEEN FILED?
☒ no
☐ yes If "yes," list all related cases by name, case number, and court.

VIII. IS JURY TRIAL DEMANDED IN COMPLAINT?
☒ yes
☐ no

I CERTIFY that the information I have provided in this cover sheet is accurate to the best of my knowledge and belief, and that I have read and will comply with the requirements of Florida Rule of Judicial Administration 2.425.

Signature: s/ Justin C. Fineberg
Attorney or party

Fla. Bar # 53716
(Bar # if attorney)

Justin C. Fineberg
(type or print name)

11/02/2020
Date

Filing # 116290948 E-Filed 11/06/2020 02:11:00 PM

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint to UnitedHealthcare Insurance Co. in the above styled cause upon the Defendant(s):

UNITEDHEALTHCARE INSURANCE CO.
CHIEF FINANCIAL OFFICER
P O BOX 6200 (32314-6200)
200 E. GAINES ST
TALLAHASSEE, FL 32399-0000

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint with the clerk of this court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the court. There are other legal requirements.

20CA008606
DIV. L

You may want to call an attorney right away. If you do not know an attorney, you may call an attorney referral service or a legal aid office (listed in the phone book).

If you choose to file a written response yourself, at the same time you file your written response to the court you must also mail or take a copy of your written response to the "Plaintiff/Plaintiff's Attorney" named below.

ALAN D. LASH
Florida Bar No. 510904
alash@lashgoldberg.com
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jfineberg@lashgoldberg.com
JONATHAN E. SIEGELAUB
Florida Bar No. 1019121
jsiegelaub@lashgoldberg.com
RACHEL H. LEBLANC
Florida Bar No. 0021815
rleblanc@lashgoldberg.com
LASH & GOLDBERG LLP
100 S.E. Second Street
Suite 1200, Miami Tower
Miami, FL 33131-2100
(305) 347-4040
(305) 347-4050 Fax

DATED on this 6th day of November, 2020

(SEAL)

CLERK OF THE COUNTY COURT

By: Elaine Welch
Deputy Clerk

AMERICANS WITH DISABILITIES ACT OF 1990 ADA NOTICE

"If you are a person with a disability who needs any accommodation in order to participate in this proceeding, you are entitled, at no cost to you, to the provision of certain assistance. Please contact the Eleventh Judicial Circuit Court's ADA Coordinator, Lawson E. Thomas Courthouse Center, 175 NW 1st Ave., Suite 2702, Miami, FL 33128, Telephone (305) 349-7175; TDD (305) 349-7174, Fax (305) 349-7355 at least 7 days before your scheduled court appearance, or immediately upon receiving this notification if the time before the scheduled appearance is less than 7 days; if you are hearing or voice impaired, call 711."

Filing # 116290948 E-Filed 11/06/2020 02:11:00 PM

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint to UnitedHealthcare of Florida, Inc. in the above styled cause upon the Defendant(s):

UNITEDHEALTHCARE OF FLORIDA, INC.
c/o CT Corporation System Its Registered Agent
1200 S. Pine Island Road
Plantation, FL 33324

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint with the clerk of this court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the court. There are other legal requirements.

20CA008606
DIV. L

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DATED on this 6th day of November 2020.

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CLERK OF THE COUNTY COURT

By: Elaine Welch
Deputy Clerk

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IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint, to UMR, Inc. in the above styled cause upon the Defendant(s):

UMR, INC.
c/o CT CORPORATION SYSTEM its Registered Agent
1200 SOUTH PINE ISLAND ROAD
PLANTATION, FL 33324

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint with the clerk of this court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the court. There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may call an attorney referral service or a legal aid office (listed in the phone book).

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DATED on this _____ day of November, 2020

(SEAL)

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By:_____
Deputy Clerk

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IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint to UnitedHealthcare of Florida, Inc. in the above styled cause upon the Defendant(s):

UNITEDHEALTHCARE OF FLORIDA, INC.
c/o CT Corporation System Its Registered Agent
1200 S. Pine Island Road
Plantation, FL 33324

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint with the clerk of this court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the court. There are other legal requirements.

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CLERK OF THE COUNTY COURT

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IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint to UnitedHealthcare Insurance Co. in the above styled cause upon the Defendant(s):

UNITEDHEALTHCARE INSURANCE CO.
CHIEF FINANCIAL OFFICER
P O BOX 6200 (32314-6200)
200 E. GAINES ST
TALLAHASSEE, FL 32399-0000

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint with the clerk of this court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the court. There are other legal requirements.

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DATED on this _____ day of November, 2020

(SEAL)

CLERK OF THE COUNTY COURT

By:_____
Deputy Clerk

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IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY
ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC.,
UNITEDHEALTHCARE INSURANCE CO.,
UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint, to UMR, Inc. in the above styled cause upon the Defendant(s):

UMR, INC.
c/o CT CORPORATION SYSTEM its Registered Agent
1200 SOUTH PINE ISLAND ROAD
PLANTATION, FL 33324

IMPORTANT

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JUSTIN C. FINEBERG
Florida Bar No. 0053716
jfineberg@lashgoldberg.com
JONATHAN E. SIEGELAUB
Florida Bar No. 1019121
jsiegelaub@lashgoldberg.com
RACHEL H. LEBLANC
Florida Bar No. 0021815
rleblanc@lashgoldberg.com
LASH & GOLDBERG LLP
100 S.E. Second Street
Suite 1200, Miami Tower
Miami, FL 33131-2100
(305) 347-4040
(305) 347-4050 Fax

DATED on this 6th day of November, 2020

(SEAL)

CLERK OF THE COUNTY COURT

By: Elgin Welch
Deputy Clerk

AMERICANS WITH DISABILITIES ACT OF 1990 ADA NOTICE

"If you are a person with a disability who needs any accommodation in order to participate in this proceeding, you are entitled, at no cost to you, to the provision of certain assistance. Please contact the Eleventh Judicial Circuit Court's ADA Coordinator, Lawson E. Thomas Courthouse Center, 175 NW 1st Ave., Suite 2702, Miami, FL 33128, Telephone (305) 349-7175; TDD (305) 349-7174, Fax (305) 349-7355 at least 7 days before your scheduled court appearance, or immediately upon receiving this notification if the time before the scheduled appearance is less than 7 days; if you are hearing or voice impaired, call 711."

Filing # 116290948 E-Filed 11/06/2020 02:11:00 PM

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

THE STATE OF FLORIDA:

TO EACH SHERIFF OF THE STATE: You are commanded to serve this Summons and a copy of the Complaint to Multiplan, Inc. in the above styled cause upon the Defendant(s):

MULTIPLAN, INC.
c/o CORPORATION SERVICE COMPANY ITS REGISTERED AGENT
1201 HAYS ST
TALLAHASSEE, FL 32301

IMPORTANT

A lawsuit has been filed against you. You have 20 calendar days after this summons is served on you to file a written response to the attached complaint with the clerk of this court. A phone call will not protect you. Your written response, including the case number given above and the names of the parties, must be filed if you want the court to hear your side of the case. If you do not file your response on time, you may lose the case, and your wages, money, and property may thereafter be taken without further warning from the court. There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may call an attorney referral service or a legal aid office (listed in the phone book).

If you choose to file a written response yourself, at the same time you file your written response to the court you must also mail or take a copy of your written response to the "Plaintiff/Plaintiff's Attorney" named below.

ALAN D. LASH
Florida Bar No. 510904
alash@lashgoldberg.com
JUSTIN C. FINEBERG
Florida Bar No. 0053716
jfineberg@lashgoldberg.com
JONATHAN E. SIEGELAUB
Florida Bar No. 1019121
jsiegelaub@lashgoldberg.com
RACHEL H. LEBLANC
Florida Bar No. 0021815
rleblanc@lashgoldberg.com
LASH & GOLDBERG LLP
100 S.E. Second Street
Suite 1200, Miami Tower
Miami, FL 33131-2100
(305) 347-4040
(305) 347-4050 Fax

DATED on this _____ day of November, 2020

(SEAL)

CLERK OF THE COUNTY COURT

By:_____
Deputy Clerk

AMERICANS WITH DISABILITIES ACT OF 1990 ADA NOTICE

"If you are a person with a disability who needs any accommodation in order to participate in this proceeding, you are entitled, at no cost to you, to the provision of certain assistance. Please contact the Eleventh Judicial Circuit Court's ADA Coordinator, Lawson E. Thomas Courthouse Center, 175 NW 1st Ave., Suite 2702, Miami, FL 33128, Telephone (305) 349-7175; TDD (305) 349-7174, Fax (305) 349-7355 at least 7 days before your scheduled court appearance, or immediately upon receiving this notification if the time before the scheduled appearance is less than 7 days; if you are hearing or voice impaired, call 711."

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IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA
CASE NO: 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY
ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC.,
UNITEDHEALTHCARE INSURANCE CO.,
UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

SUMMONS

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1201 HAYS ST
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20CA008606
DIV. L

If you choose to file a written response yourself, at the same time you file your written response to the court you must also mail or take a copy of your written response to the "Plaintiff/Plaintiff's Attorney" named below.

ALAN D. LASH
Florida Bar No. 510904
alash@lashgoldberg.com
JUSTIN C. FINEBERG
Florida Bar No. 0053716
jfineberg@lashgoldberg.com
JONATHAN E. SIEGELAUB
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Suite 1200, Miami Tower
Miami, FL 33131-2100
(305) 347-4040
(305) 347-4050 Fax

DATED on this 6th day of November, 2020

(SEAL)

CLERK OF THE COUNTY COURT

By: Elaine Welch
Deputy Clerk

AMERICANS WITH DISABILITIES ACT OF 1990 ADA NOTICE

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Filing # 117063248 E-Filed 11/20/2020 03:56:48 PM

IN THE CIRCUIT COURT FOR THE
THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY,
FLORIDA

GULF-TO-BAY ANESTHESIOLOGY
ASSOCIATES, LLC,

Plaintiff,

v.

Case No.: 20-CA-008606

UNITED HEALTHCARE OF FLORIDA,
INC., UNITEDHEALTHCARE
INSURANCE CO., UMR, INC., and
MULTIPLAN, INC.,

Defendants.
_____/

NOTICE OF APPEARANCE AS COUNSEL FOR DEFENDANTS UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., UMR, INC., AND DESIGNATION OF PRIMARY AND SECONDARY E-MAIL ADDRESSES

PLEASE TAKE NOTICE that Irene A. Bassel Frick, Esq. and Gera R. Peoples, Esq. of Akerman LLP hereby enter this appearance as counsel on behalf of Defendants, UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., and UMR, INC., (the "United Defendants"), and request that they be copied on all filings relative to this lawsuit.

The undersigned also designates their primary and secondary e-mail addresses in compliance with Rule 1.080 and Florida Rule of Judicial Administration 2.516 and request that copies of all orders, process, pleadings, and other documents filed or served in this matter be served on them at the Primary and Secondary E-mail addresses listed below, with such service E-mail complying with Rule 2.516(b)(1)(E). Where service of hard copies is to be made in addition

to the E-mail service required by new Rule 2.516(b)(1)(A), counsel request that the copies be served upon them at the physical address listed below.

E-Mail Designation

Primary E-mail addresses:	gera.peoples@akerman.com
Secondary E-mail addresses:	magda.cabra@akerman.com
Primary E-mail addresses:	irene.basselfrick@akerman.com
Secondary E-mail addresses:	nicole.emmett@akerman.com

Dated: November 20, 2020.

Respectfully submitted,

/s/ Gera R. Peoples, Esq.
Gera R. Peoples, Esq.
Florida Bar No. 450022
gera.peoples@akerman.com
magda.cabra@akerman.com
AKERMAN LLP
Three Brickell City Centre
98 Southeast Seventh Street, Ste. 1100
Miami, Florida 33131
Telephone: (305) 374-5600

and

/s/ Irene A. Bassel Frick, Esq.
Irene A. Bassel Frick
Florida Bar No.: 0158739
irene.bassel@akerman.com
nicole.emmett@akerman.com
AKERMAN LLP
401 E. Jackson Street
Suite 1700
Tampa, FL 33602-5250
Phone: (813) 223-7333
Facsimile: (813) 223-2837
Attorneys for United Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was filed via the Florida E-Portal system and served via Electronic Mail e-service email on November 20, 2020 on the following:

ALAN D. LASH
alash@lashgoldberg.com
JUSTIN C. FINEBERG
jfineberg@lashgoldberg.com
JONATHAN E. SIEGELAUB
jsiegelaub@lashgolberg.com
RACHEL H. LEBLANC
rleblanc@lashgoldberg.com
LASH & GOLDBERG LLP
Weston Corporate Center I
2500 Weston Road. Suite 220
Weston, FL 33331
Counsel for Plaintiffs

/s/ Gera R. Peoples, Esq.
Attorney

55459665;1

EXHIBIT B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA

CASE NO. _____

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC. UNITED HEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

CONSENT TO REMOVAL BY DEFENDANTS UNITED HEALTHCARE OF FLORIDA, INC., UNITEDHEALTHCARE INSURANCE CO., AND UMR, INC.

Pursuant to 28 U.S.C. § 1446, Defendants United Healthcare of Florida, Inc., United Healthcare Insurance Co., and UMR, Inc., by and through their undersigned counsel, hereby consent to the removal by MultiPlan, Inc. of the matter styled as *Gulf-to-Bay Anesthesiology Associates, LLC v. United Healthcare of Florida, Inc., et al.*, bearing Case No. 20-CA-008606, which was initially filed in the Circuit Court for the Thirteenth Judicial Circuit in and for Hillsborough County, Florida.

Dated this 11th day of December, 2020.

Respectfully submitted,

Irene Bassel Frick

Irene A. Bassel Frick
Florida Bar No.: 0158739
irene.bassel@akerman.com
nicole.emmett@akerman.com
AKERMAN LLP
401 E. Jackson Street
Suite 1700
Tampa, FL 33602-5250

Phone: (813) 223-7333
Facsimile: (813) 223-2837

and

Gera R. Peoples, Esq.
Florida Bar No. 450022
gera.peoples@akerman.com
magda.cabra@akerman.com
AKERMAN LLP
Three Brickell City Centre
98 Southeast Seventh Street, Ste. 1100
Miami, Florida 33131
Telephone: (305) 374-5600
Attorneys for United Healthcare of Florida, Inc., United Healthcare Ins. Co., and UMR, Inc.

Exhibit C

Case Information

Case Number: 20-CA-008606

Uniform Case Number: 292020CA008606A001HC

Gulf-to-Bay Anesthesiology Associates, LLC vs UnitedHealthcare of Florida, Inc.

Icon Keys | Summary | Parties | Events\Documents | Financial | File Location | Related Cases

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From

To

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Select	Document Index	Clock-In Event Date	Event Description	Comment	Image	Certify
	11	11/20/2020	NOTICE OF APPEARANCE			
	6	11/06/2020	REQUEST FOR SUMMONS TO BE ISSUED (E-Filed)			
	7	11/06/2020	REQUEST FOR SUMMONS TO BE ISSUED (E-Filed)			

Select	Document Index	Clock-In Event Date	Event Description	Comment	Image	Certify
⬇	8	11/06/2020	REQUEST FOR SUMMONS TO BE ISSUED (E-Filed)		✓	🛒
⬇	9	11/06/2020	REQUEST FOR SUMMONS TO BE ISSUED (E-Filed)		✓	🛒
⬇	10	11/06/2020	E-FILED SUMMONS ISSUED	X4 - jfineberg@lashgoldberg.com ; yyzquierdo@lashgoldberg.com ; lashgoldberg@gmail.com	✓	🛒
⬇	10	11/06/2020	E-FILED SUMMONS ISSUED	X4 - jfineberg@lashgoldberg.com ; yyzquierdo@lashgoldberg.com ; lashgoldberg@gmail.com	✓	🛒
⬇	10	11/06/2020	E-FILED SUMMONS ISSUED	X4 - jfineberg@lashgoldberg.com ; yyzquierdo@lashgoldberg.com ; lashgoldberg@gmail.com	✓	🛒
⬇	10	11/06/2020	E-FILED SUMMONS ISSUED	X4 - jfineberg@lashgoldberg.com ; yyzquierdo@lashgoldberg.com ; lashgoldberg@gmail.com	✓	🛒
	1	11/02/2020	File Home Location - Electronic			
⬇	2	11/02/2020	CIVIL COVER SHEET		✓	🛒
⬇	3	11/02/2020	CIVIL COVER SHEET		✓	🛒
⬇	4	11/02/2020	COMPLAINT	jfineberg@lashgoldberg.com ; yyzquierdo@lashgoldberg.com ; lashgoldberg@gmail.com	✓	🛒

Select	Document Index	Clock-In Event Date	Event Description	Comment	Image	Certify
	5	11/02/2020	REQUEST FOR DIVISION ASSIGNMENT (E-FILING)			

Showing 1 to 14 of 14 entries

Previous 1 Next

Exit Case Details

p

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA

CASE NO. 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC. UNITED HEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

NOTICE OF FILING OF NOTICE OF REMOVAL

PLEASE TAKE NOTICE that on December 11, 2020, Defendant, MultiPlan, Inc. ("MultiPlan"), filed with the Clerk of the United States District Court for the Middle District of Florida, its Notice of Removal of the above-styled action, a copy of which Notice of Removal is attached hereto as **Exhibit 1**.

By filing its Notice of Removal, MultiPlan effected removal of this action to the United States District Court for the Middle District of Florida.

Pursuant to 28 U.S.C. § 1446(d), this Court is prohibited from proceeding in the above-styled action unless and until the action is remanded.

RESPECTFULLY SUBMITTED on this 11th day of December, 2020.

/s/ Bret M. Feldman
BRET M. FELDMAN, FBN 370370
PHELPS DUNBAR LLP
100 South Ashley Drive, Ste. 2000
Tampa, Florida 33602-5315

(813) 472-7879
(813) 472-7570 (Fax)
Bret.feldman@phelps.com

ATTORNEYS FOR MULTIPLAN, INC.

CERTIFICATE OF SERVICE

I CERTIFY that a copy of the foregoing was electronically served on counsel below and all counsel of record via *Florida Courts E-Filing Portal* on December 11, 2020.

Alan D. Lash
Justin C. Fineberg
Jonathan E. Siegelaub
Rachel H. LeBlanc
Lash & Goldberg LLP
Weston Corporate Center I
2500 Weston Road, Ste. 220
Weston, FL 33331
alash@lashgoldberg.com
jfineberg@lashgoldberg.com
jsiegelaub@lashgoldberg.com
rleblanc@lashgoldberg.com

/s/ Bret M. Feldman
Bret M. Feldman

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA

CASE NO. 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC. UNITED HEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

NOTICE TO COUNSEL OF REMOVAL OF A CIVIL ACTION

TO: Alan D. Lash
Justin C. Fineberg
Jonathan E. Siegelaub
Rachel H. LeBlanc
Lash & Goldberg LLP
Weston Corporate Center I
2500 Weston Road, Ste. 220
Weston, FL 33331

PLEASE TAKE NOTICE that on December 11, 2020, Defendant, MultiPlan, Inc. ("MultiPlan"), has filed its Notice of Removal of a Civil Action, in the office of the Office of the Clerk of the United States District Court for the Middle District of Florida. A copy of the Notice of Removal was attached to the Notice of Filing Notice of Removal in this Court on December 11, 2020.

RESPECTFULLY SUBMITTED on this 11th day of December, 2020.

/s/ Bret M. Feldman
BRET M. FELDMAN, FBN 370370
PHELPS DUNBAR LLP

100 South Ashley Drive, Ste. 2000
Tampa, Florida 33602-5315
(813) 472-7879
(813) 472-7570 (Fax)
Bret.feldman@phelps.com

ATTORNEYS FOR MULTIPLAN, INC.

CERTIFICATE OF SERVICE

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Alan D. Lash
Justin C. Fineberg
Jonathan E. Siegelaub
Rachel H. LeBlanc
Lash & Goldberg LLP
Weston Corporate Center I
2500 Weston Road, Ste. 220
Weston, FL 33331
alash@lashgoldberg.com
jfineberg@lashgoldberg.com
jsiegelaub@lashgoldberg.com
rleblanc@lashgoldberg.com

/s/ Bret M. Feldman
Bret M. Feldman

IN THE CIRCUIT COURT FOR THE THIRTEENTH JUDICIAL CIRCUIT
IN AND FOR HILLSBOROUGH COUNTY, FLORIDA

CASE NO. 20-CA-008606

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

Plaintiff,

v.

UNITED HEALTHCARE OF FLORIDA, INC. UNITED HEALTHCARE INSURANCE CO., UMR, INC., and MULTIPLAN, INC.,

Defendants.

_____/

CERTIFICATION OF NOTICE OF REMOVAL

TO: Pat Frank
Clerk of Court & Comptroller, Hillsborough County
601 E Kennedy Blvd
Tampa, FL 33602

In compliance with 28 U.S.C. § 1446(d) you are hereby notified of the filing of a Notice of Removal of the above-styled cause to the United States District Court for the Middle District of Florida. A copy of the Notice of Removal was attached to the Notice of Filing Notice of Removal which was filed in this Court on December 11, 2020.

/ Bret M. Feldman
BRET M. FELDMAN, FBN 370370
PHELPS DUNBAR LLP
100 South Ashley Drive, Ste. 2000
Tampa, Florida 33602-5315
(813) 472-7879
(813) 472-7570 (Fax)
Bret.feldman@phelps.com

ATTORNEYS FOR MULTIPLAN, INC.

CERTIFICATE OF SERVICE

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Alan D. Lash
Justin C. Fineberg
Jonathan E. Siegelaub
Rachel H. LeBlanc
Lash & Goldberg LLP
Weston Corporate Center I
2500 Weston Road, Ste. 220
Weston, FL 33331
alash@lashgoldberg.com
jfineberg@lashgoldberg.com
jsiegelaub@lashgoldberg.com
rleblanc@lashgoldberg.com

/s/ Bret M. Feldman
Bret M. Feldman

EXHIBIT D

EXHIBIT D(1)

2020.08.04 Claim.TXT

1 FLN/DCC 2021734141923 ID#: SRC IND: 7 VENDOR ID
EN 837 CLAIM FORM - MEDICAL DATE 08/04/20

1 INSUREDS ID NUMBER ID#: HIC# RTE: ATTCH: KEYER: 111111999 DT: 08 04 20	
2 PATIENTS NAME (LFM), REL DOB SEX PAT REL TO INSD 18/SELF B R	4 INSUREDS NAME (LFM) DOB SEX DOB SEX B R
5 PATIENTS ADDRESS, CITY, STATE, ZIP CODE, PHONE PHONE# 0000000000	7 INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE PHONE# 0000000000
8 STAT MARITAL: EMPLOYMENT: STUDENT: DECEASED:	
9 OTHER INSUREDS NAME (LFM) INSURED ID#:	DOB SEX 00000000
	7A EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID EMPLOYMENT STATUS CODE:

| PATIENT RELATIONSHIP TO INSURED: | ID # |

9A OTHER INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE	7B INSUREDS POLICY, GROUP OR FECA# AND NAME
SPEC PRG IND	
000	
PHONE# 0000000000	7C INSURANCE PLAN OR PROGRAM NAME, PAYOR ID AND SPC
9B OTHER INSUREDS POLICY OR GROUP# AND NAME	UNITED HEALTHCARE
87726 CI/COMM INS	PAYOR SEQ # P
SPEC PRG IND	
000	7D IS THERE ANOTHER HEALTH BENEFIT PLAN?
	NO, PATIENT DOES NOT HAVE OTHER INSURANCE

9C INSURANCE PLAN/PROGRAM NAME, PAYOR ID, SPC, FILING IND	7E INSURANCE ADDRESS
CLM FILING IND:	
DESCRIPTION:	

9D EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID	9E OTHER INSURANCE ADDRESS INFORMATION
EMPLOYMENT STATUS CODE:	

ID#

10 IS PATIENTS CONDITION RELATED TO: A EMPLOYMENT? N/NOT EMP REL

B AUTO/OTHER ACCIDENT? NO ACCIDENT

PLACE/ST DATE 000000 HOUR

11 BILLING PROVIDER NAME, ADDRESS, PHONE, ID#S

GULF TO BAY ANESTHESIOLOGY ASSOCIAT

516 VONDERBURG DR

BRANDON FL 335115954

PHONE# 8889526772

TIN# 593411711 EIN/SSN EIN UPIN#

UHC ID NPI 1720039746 MDCD#

11A PAY TO PROVIDER ADDRESS

PAY-TO ADDR-1: PO BOX 637791

PAY-TO ADDR-2:

CITY-1: CINCINNATI ST: OH ZIP CODE: 452637791

COUNTRY:

[redacted]

+----------+----------
|13A CLAIM DELAY REASON CODE:

+----------+----------
|14 DATE OF CURRENT: ILLNESS-FIRST SYMPTOM OR INJURY-ACCIDENT OR PREGNANCY-LMP 000000 | 15 SAME/SIMILAR ILLNESS DATE | 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | TOTAL DISABILITY FROM 000000 TO 000000 | PARTIAL DISABILITY FROM 000000 TO 000000 | SAME SYMPTOM IND: FIRST SYMPTOM IND: | DATE RETURNED TO WORK 000000 | 000000

+----------+----------
|17 REFERRING PHYS (RX ORDERING PHY) LFM NPI | 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICE
| DASTGIR | FAROOQUE 1902053465 | FROM 000000 TO 000000 | SUPERVISING PHYS LFM NPI | | | | | |

+----------+----------
|17A ID# OF REF. PHY. | 20 OUTSIDE LAB? $CHARGE | | |

19 REF PHY UPIN ID & TYPE		REF PHY TAX
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1 THROUGH 12 TO 24E BY LINE)	ICD VERSION 0 (0,9)	22 RESUBMISSION
1 K2970 ORIG REF NO	2	CODE
3	4	
		23 PRIOR AUTHORIZATION NUMBER
5	6	
7	8	
9	10	23A CLIA# (CLAIM LEVEL)
11	12	

24 A DATES OF SERVICE FROM	TO	B PLC/ SV	C TYPE/ SV	D CPT/ HCPCS	MOD 1, 2, 3, 4	E DIAG CODE	F $CHARGES	G DAY/ UNITS	GG EP/ ANES	H EMG/ TIME	I OTHER INS IND	J NEGOTIAT/ RATE IND	K DEDUCTIBLE/ AMOUNT	L PAID AMOUNT
071320	071320	24		00731	QZ	1000	1176.00	00000.0	0010		N		.00	.00

24M LINE INFO			

SERVICE LINE #	LINE ITEM CNTRL NO	SVC NPI	CLIA # QUAL	CLIA# (LINE LEVEL)
001	425288631OZ1			

24H EPSDT IND	CODE1	CODE2	CODE3

SERVICE LINE #	EPSDT IND	FAMILY PLANNING IND
001		

25 FEDERAL TAX ID#	SSN/EIN	26 PATIENTS ACCOUNT#	27 PROV ACCPTS ASGNMT	28 TOT CHARGE	29 TOT PAT PD	30 TOTAL OTHER INSURANCE
593411711	EIN		A/ASSIGNED	1176.00	.00	PD .00ALW .00

31 SIGNATURE OF SERVICING PHYSICIAN/ SUPPLIER (FL)	32 NAME AND ADDRESS OF FACILITY 32B - ENCOUNTER PAID	WHERE SERVICES WERE RENDERED
	DATES:	
TAXONOMY CODE 367500000X		BRANDON SURGERY CENTER NEW

CLAIM LEVEL:	516 VONDERBURG DR
LINE LEVEL:	BRANDON FL 335115954
ST LICENSE# 1215307012	SVC NPI (CLAIM LEVEL):

33 SERVICING PHYSICIAN/SUPPLIER NAME, ADDRESS, PHONE ETC	33B - ORG ID AND RECEIPT DATE
LIGAD	MARK
ORG ID:	PHONE# 0000000000
NABP#	UPIN# NPI 1336531581
MEDICARE#	MEDICAID#

34 PAY-TO PROVIDER NPI: CLINICAL TRIAL#:	CLRNG HOUSE CLAIM ID: K84AVH0AZ901JC

S1 OTHER INSURED2 INFORMATION -	S4 OTHER INSURANCE INFORMATION -
DOB, SEX, SSN: 00000000	CLAIM NUMBER:
PATIENT RELATION TO INSURED:	PAYER RESP SEQ :

```
   ROUTE IND:                                    |
 | ADDR1:                                                    | CLAIM TOTAL OI
PAID AMOUNT:           .00                          |
 | ADDR2:                                                    | CLAIM TOTAL
DEDUCTIBLE AMOUNT:          .00                        |
 | CITY,ST,ZIP:                                              | CLAIM CONTRACTUAL
ADJ:         .00                                 |
 | PHONE:  0000000000                                        | CLAIM INTEREST
AMOUNT PAID:          .00                          |
 |                                                           | CLAIM TOTAL
COINSURANCE AMOUNT:          .00                        |
 | EMPLOYMENT STATUS CODE:                                   |
                                                 |
 | EMPLOYERS/SCHOOL NAME:                                    | REMARK CODE 1,2,3
AND 4:                                           |
 | ADDR:                                                     | CLAIM ADJUSTMENT
INDICATOR:                                        |
 | CITY,ST,ZIP                                               | CLAIM ADJUSTMENT
ORIG. PAYMENT:          .00                       |
 | EMPLOYEE ID:                                              |
                                                 |
 +---------------------------------------------------------+ REMITTANCE ADVICE
REMARK CODE1:                                     |
 |S2 OTHER PAYOR2 INFORMATION -                             | REMITTANCE ADVICE
REMARK CODE2:                                     |
 |                                                          | REMITTANCE ADVICE
REMARK CODE3:                                     |
 | POL/GROUP#:                                              | REMITTANCE ADVICE
REMARK CODE4:                                     |
 |                                               SPEC PRG IND:  000 | REMITTANCE ADVICE
REMARK CODE5:                                      |
 | INSURANCE PLAN/GROUP NAME:
|-------------------------------------------------------------------|
 | PAYOR2 ID AND SPC:  00000                    PAYER RESP SEQ :    |S5 OTHER PAYOR2
PLAN/PROGRAM NAME AND ADDRESS INFORMATION          |
 +-----------------------------------------------------------+
                                                 |
 |S3 MISCELLANEOUS CLAIM INFORMATION -                        |
                                                 |
 |                                                          |
                                                 |
 | CLAIM TAX AMOUNT:           .00                          |
                                                 |
 | PROVIDER DISCOUNT AMOUNT:           .00                  |
                                                 |

+-----------------------------------------------------------+--------------------
-------------------------------------------+
```

HCP LINE PRICING/REPRICING INFORMATION -

ICN: CD90601640

01	02	03	04
PRICE METHOD	REPRICED ALLOWED AMT / 05 RATE	SAVINGS AMOUNT	REFERENCE ID
	.00 / .00	.00	

HCP LINE PRICING/REPRICING INFORMATION CONTINUED

06	07	13	14	15
REFERENCE ID	APPROVED DRG AMT	REJECT CODE	POLICY COMPLIANCE CODE	EXCEPTION CODE
	.00			

2020.08.11 Claim (002).TXT

1 FLN/DCC 2021734141923 ID#: SRC IND: 7 VENDOR ID
EN EMC CLAIM FORM - MEDICAL DATE 08/11/20

|1 INSUREDS ID NUMBER ID#: HIC# RTE:
ATTCH: KEYER: 000000000 DT: 08 11 20|

|2 PATIENTS NAME (LFM) |3 PAT DOB SEX |4
INSUREDS NAME (LFM) DOB SEX |
| | |
| B R | | B
R |

|5 PATIENTS ADDRESS, CITY, STATE, ZIP CODE, PHONE |6 PAT RELATION |7
INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE |
	TO INSURED
	01/SELF
PHONE# 0000000000 +----------+
PHONE# 0000000000
+----------|8 PATIENT STAT
9 OTHER INSUREDS NAME (LFM) DOB SEX	|7A
EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID
	MARITAL:
00000000	
EMPLOYMENT STATUS CODE:
INSURED ID#:	EMPLOYMENT:
PATIENT RELATIONSHIP TO INSURED:	
ID# |
+----------+
|9A OTHER INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE | STUDENT: |7B
INSUREDS POLICY, GROUP OR FECA# AND NAME |
| | |

SPEC PRG IND|

| | | 703997

000 |

| | DECEASED: NO

+----------+

| PHONE# 0000000000 +----------|7C

INSURANCE PLAN OR PROGRAM NAME, PAYOR ID AND SPC |

+----------|10 IS PATIENTS |

|

|9B OTHER INSUREDS POLICY OR GROUP# AND NAME | CONDITION | UNITED

HEALTHCARE 87726 F/COMMERCIAL |

| SPEC PRG IND| RELATED TO:

+----------+

| 000 | |7D IS

THERE ANOTHER HEALTH BENEFIT PLAN? |

+----------+A EMPLOYMENT? |

|

|9C INSURANCE PLAN OR PROGRAM NAME, PAYOR ID AND SPC | |

| |

| |

+----------+

| 00000 |B AUTO/OTHER |11

BILLING PROVIDER NAME, ADDRESS, PHONE, ID#S |

+----------+ ACCIDENT? |

|

|9D EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID | NO ACCIDENT | LIGAD

MARK |

| | |

|

| EMPLOYMENT STATUS CODE: | PLACE/ST |

PARTICIPATNG PHYS: |

| | DATE 000000 |

0000 PHONE# 0000000000 |

| | HOUR 000 | TIN#

593411711 EIN/SSN EIN UPIN# |

| ID# | | MDCR#

MDCD# NPI 1720039746 |

+----------+----------+----------

----------+

[redacted]

| |

| |

| |

[redacted]

+----------+----------+----------

```
-----------------------------------------------+
 |14 DATE OF CURRENT:  ILLNESS-FIRST SYMPTOM OR      |15 SAME/SIMILAR     |16 DATES
PATIENT UNABLE TO WORK IN CURRENT OCCUPATION   |
 |                     INJURY-ACCIDENT OR            |   ILLNESS DATE     |
                                                |
 |    000000           PREGNANCY-LMP                 |                    | TOTAL
DISABILITY      FROM  000000    TO  000000       |
 |                                                   |       000000       | PARTIAL
DISABILITY    FROM  000000    TO  000000       |
 |   SAME SYMPTOM IND:       FIRST SYMPTOM IND:      |                    | DATE
RETURNED TO WORK  000000                          |

+-------------------------------------------------+--------------------+----------
-----------------------------------------------+
 |17 PHYSICIAN (REF/ORD/SUP)       LFM  NPI        Q |17A ID# ?REF PHY? Q |18
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES    |
 |                                                   |                    |
                                                |
 | DASTGIR               FAROOQUE       1902053465   | 1902053465         |   FROM
000000              TO  000000                 |

+-------------------------------------------------------------------------+----------
-----------------------------------------------+
 |19 REF PHY UPIN                 REF PHY TAX ID & TYPE                   |20
OUTSIDE LAB?                    $CHARGE            |
 |ADDL INFO:001431634                                                     |
                                                |

+-------------------------------------------------------------------------+----------
-----------------------------------------------+
 |21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY        ICD VERSION 0   (0,9)|22
MEDICAID RESUBMISSION                            |
 |   (RELATE 1-4 & A-L TO BOX 24 DIAG CODE BY LINE)                        |
                                                |
 | 1|A K2970               2|B                    3|C                   |   CODE
O        ORIGINAL REF. NO.  CD90601640         |
 |                                                                         |
                                                |
 | 4|D                      E                      F
+-------------------------------------------------------+
 |                                                                         |23 PRIOR
AUTHORIZATION NUMBER                          |
 |   G                      H                      I                      |
                                                |
 |   J                      K                      L                      |
                                                |

+-------------------------------------------------------------------------+----------
```

```
+---------------------------------------------+
 |21A  REMARKS:                                |
                                               |

+---------------+----+----+------------------+-----+-----------+-----+----------+
---+----------+-------------+--------------+
 |24     A        |  B |  C |         D          |  E  |      F     | G   |    GG
| H |     I     |      II      |       J       |
 |DATES OF SERVICE|PLC/|TYPE| CPT/        MOD   |DIAG |  $CHARGES  |DAY/
|ANESTHESIA|EMG| OTHER INS |  NEGOTIATED  |   DEDUCTIBLE  |
 | FROM     TO    | SV |/SV | HCPCS   1, 2, 3, 4|CODE |            |UNITS|   TIME
|IND|  ALLOWED  |RATE REDUC IND|     AMOUNT    |

+---------------+----+----+------------------+-----+-----------+-----+----------+
---+----------+-------------+--------------+
 | 071320  071320 | 24 | 07 | 00731  QZ          |A    |    1176.00 |0000 |   0010
| N |        .00|              |            .00|

+---------------+----+----+------------------+-----+-----------+-----+----------+
---+----------+-------------+--------------+
 |24M LINE INFO                  |

 +---------------+--------------+

 |SERVICE LINE #  |CLIA #         |

 +---------------+--------------+

 | 001            |               |

 +---------------+--------------+


+---------------+----+----+------------------+-----+-----------+-----+----------+
---+----------+-------------+--------------+
 |25 FEDERAL TAX ID#  SSN/EIN|26 PATIENTS ACCOUNT#  |27 PROV ACCPTS ASGNMT|28 TOT
CHARGE|29 TOT PAT PD|30 TOTAL OTHER INSURANCE    |
 |                           |                      |                     |
   |            |                          |
 |   593411711          EIN  | 268313080/344        |                     |
1176.00 |         .00 |PD            ALW          |

+---------------------------------+-----------------------------------+----------
-----------------------------------------+
 |                           |                      |27A MEDICARE VOUCHER |
   |            |                          |
 |                           |                      |                     |
   |            |                          |
```

			N/NOT ASSIGNED

30A TOTAL OTHER INSURANCE CONTINUED					
PAT RESP .00	COPAY .00	COINS .00	DEDUCT .00	WRITEOFF .00	

31 SIGNATURE OF SERVICING PHYSICIAN/SUPPLIER (FL)	32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED	33 SERVICING PHYSICIAN/SUPPLIER NAME, ADDRESS, PHONE ETC
		GULF TO BAY ANESTHESIOLOGY
		LIGAD MARK
DEGREES OR CREDENTIALS AN	BRANDON SURGERY CENTER	PO BOX 637791
TAXONOMY		
CORPORATE PROVIDER TYPE		CINCINNATI OH 452637791 PHONE# 8773074554
	NPI	NABP#
UPIN# NPI		
ST LICENSE#		MEDICARE# 1720039746 MEDICAID#

34 PAY-TO PROVIDER NPI:

24CONTINUED			OTHER INSURANCE				
	RENDERING	HCT					
	NPI		PAT RESP	COPAY	COINS	PAID	WRITEOFF	PRIM PD
	1336531581	00	.00	.00	.00	.00	.00	.00

```
+---------------+-----------+----+----------+----------+----------+----------+
----------+----------+
 +-----------------------------------------------------------+

 |S1 OTHER INSURED2 INFORMATION -                            |

 |                                                           |

 | NAME (LFM):                                               |

 | DOB, SEX, ID#:  00000000                                  |

 | PATIENT RELATION TO INSURED:                              |

 | ADDRESS1:                                                 |

 | ADDRESS2:                                                 |

 | CITY, STATE, ZIP CODE:                                    |

 | PHONE:  0000000000                                        |

 |                                                           |

 | EMPLOYMENT STATUS CODE:                                   |

 | EMPLOYERS/SCHOOL NAME:                                    |

 | ADDRESS:                                                  |

 | CITY, STATE, ZIP CODE:                                    |

 | EMPLOYEE ID:                                              |

 +-----------------------------------------------------------+

 |S2 OTHER PAYOR2 INFORMATION -                              |

 |                                                           |

 | INSURED2 POLICY/GROUP#:                                   |

 | POLICY/GROUP NAME:                      SPEC PRG IND:  000 |

 | INSURANCE PLAN/PROGRAM NAME:                              |

 | PAYOR2 ID AND SPC:  00000                                 |
```

```
+-------------------------------------------------------------+
|S3 MISCELLANEOUS CLAIM INFORMATION -                         |
|                                                             |
| CLAIM TAX AMOUNT:         .00                               |
| PROVIDER DISCOUNT AMOUNT:         .00                       |
+-------------------------------------------------------------+

+-------------------------------------------------------------------------------------------
-----------------------------------------+
|SERVICE LINE UPINS -
                                         |

+-------------------------------------------------------------------------------------------
-----------------------------------------+
|01)         02)         03)         04)         05)         06)         07)
 08)         09)         10)                     |

+-------------------------------------------------------------------------------------------
-----------------------------------------+

+-------------------------------------------------------------------------------------------
-----------------------------------------+
|PRICING INFORMATION -
                                         |
| TPO ID:  133068979   TPO REFERENCE#  145936302         REJ MESSAGE IND:
                                         |

+---------------------+-----+----------+------+---------+-----+---------------+----
-----------------------------------------+
|          A          |  B  |    C     |  D   |    E    |  F  |       G       |
                      H                  |
|    AUTHORIZATION    |PRICE| ALLOWED  |CHANGE|PROCEDURE|APPRV|    RESERVED   |
              FREE FORM REMARKS          |
|       NUMBER        |MTHOD|  AMOUNT  | IND  |  CODE   |UNITS|               |
                                         |

+---------------------+-----+----------+------+---------+-----+---------------+----
-----------------------------------------+
|                     |  2  |    255.57|      |         | 000 |               |IS
                                         |
```

2020.08.11 Claim (002).TXT

5A-4360*01*000001-PM-20231-101*E01EPSUHCTOPS

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

UnitedHealthcare

231UTOPPD1025001-04360-01
GULF TO BAY ANESTHESIOLOGY ASS
GULF TO BAY ANESTHESIOLOGY
PO BOX 637791
CINCINNATI OH 45263-7791

DATE:	08/18/20
TIN:	593411711
NPI:	1720039746
PAYEE NAME:	GULF TO BAY ANESTHESIOLOGY ASS
TRACE NUMBER:	TR 64668022
PAYMENT:	$0.00
GROUP NUMBER:	703997
GROUP NAME:	STRYKER

PROVIDER REMITTANCE ADVICE

PLEASE SEE NEXT PAGE FOR MORE INFORMATION

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

GULF TO BAY ANESTHESIOLOGY ASS
GULF TO BAY ANESTHESIOLOGY
PO BOX 637791
CINCINNATI OH 45263

DATE:	08/18/20
TIN:	593411711
NPI:	1720039746
PAYEE NAME:	GULF TO BAY ANESTHESIOLOGY ASS
TRACE NUMBER:	TR 64668022
PAYMENT:	$0.00
GROUP NUMBER:	703997
GROUP NAME:	STRYKER

PATIENT: R B ( )

SUBSCRIBER ID:		**SUBSCRIBER NAME:**	R B	**CLAIM NUMBER:**	CD90601640 0036268004
CLAIM DATE:	07/13/20-07/13/20	**DATE RECEIVED:**	08/04/20	**PRODUCT:**	CHOYC+
REND PROV ID:	1336531581	**REND PROV:**	GULF TO BAY ANESTHESI		

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
268313080/344					$1,176.00				$0.00	$255.57

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
425288631 0Z1	07/13/20 - 07/13/20		00731	QZ		10		$1,176.00	$255.57	$920.43 $255.57	PI PR	242 1	$0.00	IS
CLAIM# CD90601640 0036268004							SUBTOTAL	$1,176.00	$255.57	$1,176.00			$0.00	

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

TOTAL PAYABLE TO PROVIDER	$0.00	

NOTES

PI242 PAYER INITIATED REDUCTIONS - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS .

PR1 PATIENT RESPONSIBILITY - DEDUCTIBLE AMOUNT

IS MEMBER: THIS SERVICE WAS PROVIDED BY AN OUT-OF-NETWORK PROVIDER. WE PAID THE PROVIDER ACCORDING TO YOUR BENEFITS AND DATA PROVIDED BY DATA ISIGHT. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE, PLEASE CALL DATA ISIGHT AT 866-835-4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. IF THE PROVIDER DISAGREES WITH DATA ISIGHT, THE PROVIDER MIGHT BILL YOU FOR THE DIFFERENCE BETWEEN THE AMOUNT BILLED AND THE AMOUNT ALLOWED. WE'VE ASKED THEM NOT TO. PLEASE CONTACT US IF THEY DO. PROVIDER: PLEASE DON'T BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF A MEMBER, OR A NON-NETWORK PROVIDER APPEALING A DECISION ON BEHALF OF A MEMBER, FOLLOW THE PROCESS FOR APPEALS IN THE MEMBER'S BENEFIT PLAN DOCUMENT. DECISIONS ON APPEALS MADE ON BEHALF OF MEMBERS WILL BE COMPLETED IN 30 DAYS OF SUBMISSION OR WITHIN THE TIMEFRAME REQUIRED BY LAW.

EXHIBIT D(2)

2020.03.31 Claim (002).TXT

1 FLN/DCC 2009116749919 ID#: SRC IND: 7 VENDOR ID
EN 837 CLAIM FORM - MEDICAL DATE 03/31/20

1 INSUREDS ID NUMBER ID#: HIC# RTE: ATTCH: KEYER: 111111999 DT: 03 31 20	
2 PATIENTS NAME (LFM), REL DOB SEX PAT REL TO INSD 01/SPOUSE DOB SEX D D 00000000	4 INSUREDS NAME (LFM) S R
5 PATIENTS ADDRESS, CITY, STATE, ZIP CODE, PHONE PHONE# 0000000000	7 INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE PHONE# 0000000000
8 STAT MARITAL: EMPLOYMENT: STUDENT: DECEASED:	
9 OTHER INSUREDS NAME (LFM) DOB SEX INSURED ID#: 00000000	7A EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID EMPLOYMENT STATUS CODE:

| PATIENT RELATIONSHIP TO INSURED: | ID # |

9A OTHER INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE	7B INSUREDS POLICY, GROUP OR FECA# AND NAME
SPEC PRG IND	
000	
PHONE# 0000000000	7C INSURANCE PLAN OR PROGRAM NAME, PAYOR ID AND SPC
9B OTHER INSUREDS POLICY OR GROUP# AND NAME	UNITED HEALTHCARE
87726 CI/COMM INS	PAYOR SEQ # P
SPEC PRG IND	
000	7D IS THERE ANOTHER HEALTH BENEFIT PLAN?
	NO, PATIENT DOES NOT HAVE OTHER INSURANCE

9C INSURANCE PLAN/PROGRAM NAME, PAYOR ID, SPC, FILING IND	7E INSURANCE ADDRESS
CLM FILING IND:	
DESCRIPTION:	

9D EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID	9E OTHER INSURANCE ADDRESS INFORMATION
EMPLOYMENT STATUS CODE:	

ID#

10 IS PATIENTS CONDITION RELATED TO: A EMPLOYMENT? N/NOT EMP REL

B AUTO/OTHER ACCIDENT? NO ACCIDENT

PLACE/ST DATE 000000 HOUR

11 BILLING PROVIDER NAME, ADDRESS, PHONE, ID#S

GULF TO BAY ANESTHESIOLOGY WOLVERIN

52 W UNDERWOOD ST

ORLANDO FL 328061110

PHONE# 8889526772

TIN# 593411711 EIN/SSN EIN UPIN#

UHC ID NPI 1720039746 MDCD#

11A PAY TO PROVIDER ADDRESS

PAY-TO ADDR-1: PO BOX 637791

PAY-TO ADDR-2:

CITY-1: CINCINNATI ST: OH ZIP CODE: 452637791

COUNTRY:

[redacted]

| 1)PROVIDER HAS SIGNED RELEASE ON FILE FOR CLAIM ADJUDI.|

+----------+----------
|13A CLAIM DELAY REASON CODE:

+----------+----------+----------
14 DATE OF CURRENT: ILLNESS-FIRST SYMPTOM OR	15 SAME/SIMILAR	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
INJURY-ACCIDENT OR	ILLNESS DATE
000000 PREGNANCY-LMP		TOTAL DISABILITY FROM 000000 TO 000000
	000000	PARTIAL DISABILITY FROM 000000 TO 000000
SAME SYMPTOM IND: FIRST SYMPTOM IND:		DATE RETURNED TO WORK 000000

+----------+----------+----------
17 REFERRING PHYS (RX ORDERING PHY) LFM NPI	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICE
SMITHMD	
JEFFREY R 1962504357	FROM 000000 TO 000000
SUPERVISING PHYS LFM NPI	

+----------+----------
17A ID# OF REF. PHY.	20 OUTSIDE LAB? $CHARGE

```
 |                                                                    |
                                        |

+-------------------------------------------------------------------+--------------
-----------------------------------------+
 |19 REF PHY UPIN                                                      REF PHY TAX
ID & TYPE                                  |

+-------------------------------------------------------------------------------------
-----------------------------------------+
 |21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY      ICD VERSION 0 (0,9)    |22
RESUBMISSION                                        |
 |   (RELATE ITEMS 1 THROUGH 12 TO 24E BY LINE)                           |
                                        |
 | 1  C50911                          2  I10                              |   CODE
       ORIG REF NO                      |
 |                                                                        |
                                        |
 | 3                                  4
+-----------------------------------------------------+
 |                                                                        |23 PRIOR
AUTHORIZATION NUMBER                        |
 | 5                                  6                                   |
                                        |
 | 7                                  8                                   |
                                        |
 | 9                                  10                                  |23A CLIA#
(CLAIM LEVEL)                           |
 | 11                                 12                                  |
                                        |

+-------------------------------------------------------------------------------------
-----------------------------------------+

+----------------+----+----+-----------------+-----+------------+-------+----+---
+------------+--------+----------+------------+
 |24     A        |  B |  C |         D         |  E  |      F      |   G   | GG | H
|     I      |   II   |    J     |    L       |
 |DATES OF SERVICE|PLC/|TYPE| CPT/        MOD   |DIAG |  $CHARGES   | DAY/
|ANES|EMG| OTHER INS  |NEGOTIAT|DEDUCTIBLE|    PAID    |
 | FROM     TO    | SV |/SV | HCPCS   1, 2, 3, 4|CODE |             | UNITS
|TIME|IND|  ALLOWED   |RATE IND|  AMOUNT  |   AMOUNT   |

+----------------+----+----+-----------------+-----+------------+-------+----+---
+------------+--------+----------+------------+
 | 031120  031120 | 22 |    |00532   QZ P3      |1200 |     2019.60 |00000.0|0078| N
|         .00|        |       .00|         .00|
```

24M LINE INFO			

SERVICE LINE #	LINE ITEM CNTRL NO		CLIA# (LINE LEVEL)
	SVC NPI	CLIA # QUAL	
001	404290002 6Z1		

24H EPSDT IND	CODE1	CODE2	CODE3

SERVICE LINE #	EPSDT IND	FAMILY PLANNING IND
001		

25 FEDERAL TAX ID# SSN/EIN	26 PATIENTS ACCOUNT#	27 PROV ACCPTS ASGNMT	28 TOT CHARGE	29 TOT PAT PD	30 TOTAL OTHER INSURANCE
593411711 EIN		A/ASSIGNED	2019.60	.00 PD	.00 ALW .00

31 SIGNATURE OF SERVICING PHYSICIAN/	32 NAME AND ADDRESS OF FACILITY	32B - ENCOUNTER PAID
SUPPLIER (FL)	WHERE SERVICES WERE RENDERED	DATES:
TAXONOMY CODE 367500000X	ORLANDO REGIONAL MEDICAL CENTE	

CLAIM LEVEL:		
	52 W UNDERWOOD ST	
LINE LEVEL:		
	ORLANDO	FL
ST LICENSE#	SVC NPI (CLAIM LEVEL):	
1184709057		

33 SERVICING PHYSICIAN/SUPPLIER NAME, ADDRESS, PHONE ETC	33B - ORG ID AND RECEIPT DATE	
CO		DELIA
	ORG ID:	
		PHONE#
0000000000	ORG RCPT DATE:	
NABP#	UPIN#	NPI 1508887274
MEDICARE#	MEDICAID#	

34 PAY-TO PROVIDER NPI:	CLRNG HOUSE CLAIM ID: K3VAVH07B20021
CLINICAL TRIAL#:	

S1 OTHER INSURED2 INFORMATION -	S4 OTHER INSURANCE INFORMATION -
DOB, SEX, SSN: 00000000	CLAIM NUMBER:
PATIENT RELATION TO INSURED:	PAYER RESP SEQ :

```
   ROUTE IND:                                          |
 | ADDR1:                                                          | CLAIM TOTAL OI
PAID AMOUNT:           .00                          |
 | ADDR2:                                                          | CLAIM TOTAL
DEDUCTIBLE AMOUNT:          .00                        |
 | CITY,ST,ZIP:                                                    | CLAIM CONTRACTUAL
ADJ:         .00                                     |
 | PHONE:  0000000000                                              | CLAIM INTEREST
AMOUNT PAID:          .00                            |
 |                                                                 | CLAIM TOTAL
COINSURANCE AMOUNT:          .00                       |
 | EMPLOYMENT STATUS CODE:                                         |
                                                     |
 | EMPLOYERS/SCHOOL NAME:                                          | REMARK CODE 1,2,3
AND 4:                                               |
 | ADDR:                                                           | CLAIM ADJUSTMENT
INDICATOR:                                            |
 | CITY,ST,ZIP                                                     | CLAIM ADJUSTMENT
ORIG. PAYMENT:          .00                           |
 | EMPLOYEE ID:                                                    |
                                                     |
 +-----------------------------------------------------------+ REMITTANCE ADVICE
REMARK CODE1:                                        |
 |S2 OTHER PAYOR2 INFORMATION -                                  | REMITTANCE ADVICE
REMARK CODE2:                                        |
 |                                                               | REMITTANCE ADVICE
REMARK CODE3:                                        |
 | POL/GROUP#:                                                   | REMITTANCE ADVICE
REMARK CODE4:                                        |
 |                                                 SPEC PRG IND:  000 | REMITTANCE ADVICE
REMARK CODE5:                                         |
 | INSURANCE PLAN/GROUP NAME:
|-------------------------------------------------------------------|
 | PAYOR2 ID AND SPC:  00000                  PAYER RESP SEQ :    |S5 OTHER PAYOR2
PLAN/PROGRAM NAME AND ADDRESS INFORMATION          |
 +-----------------------------------------------------------+
                                                     |
 |S3 MISCELLANEOUS CLAIM INFORMATION -                           |
                                                     |
 |                                                               |
                                                     |
 | CLAIM TAX AMOUNT:           .00                               |
                                                     |
 | PROVIDER DISCOUNT AMOUNT:           .00                       |
                                                     |

+-----------------------------------------------------------+--------------------
-------------------------------------------+
```

HCP LINE PRICING/REPRICING INFORMATION -
ICN: CA29607150

01 PRICE METHOD	02 REPRICED ALLOWED AMT	03 SAVINGS AMOUNT	04 REFERENCE ID	05 RATE
	.00	.00		.00

HCP LINE PRICING/REPRICING INFORMATION CONTINUED

06 REFERENCE ID	07 APPROVED DRG AMT	13 REJECT CODE	14 POLICY COMPLIANCE CODE	15 EXCEPTION CODE
	.00			

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
P.O. BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

GULF TO BAY ANESTHESIOLOGY ASS
GULF TO BAY ANESTHESIOLOGY
PO BOX 637791
CINCINNATI OH 45263

PAYMENT DATE:	04/14/20
TIN:	593411711
NPI:	1720039746
PAYEE NAME:	GULF TO BAY ANESTHESIOLOGY ASS
PAYMENT NUMBER:	TR 56670510
PAYMENT AMOUNT:	$120,689.81
GROUP NUMBER:	718352
GROUP NAME:	AUTOMOTIVE SERVICES NETWORK

PATIENT: D D (

SUBSCRIBER ID:		**SUBSCRIBER NAME:**	M S	**CLAIM NUMBER:**	CA29607150 0073313429
CLAIM DATE:	03/11/20-03/11/20	**DATE RECEIVED:**	03/31/20	**PRODUCT:**	CHOYC
REND PROV ID:	1508887274	**REND PROV:**	GULF TO BAY ANESTHESI		

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
261406078/344					$2,019.60				$0.00	$2,019.60

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
4042900026Z1	03/11/20 - 03/11/20		00532	QZ/ P3		93		$2,019.60		$2,019.60	PR	242	$0.00	NI, QF
CLAIM# CA29607150 0073313429							SUBTOTAL	$2,019.60		$2,019.60			$0.00	

NOTES

PR242 PATIENT RESPONSIBILITY - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS .

NI PAYMENT FOR THIS SERVICE IS DENIED. BENEFITS ARE ONLY AVAILABLE WHEN YOU RECEIVE SERVICES FROM A PROVIDER IN YOUR PLAN'S NETWORK.

QF FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE THE ADDITIONAL ANESTHESIA MINUTES FOR A PHYSICAL STATUS MODIFIER.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF A MEMBER, OR A NON-NETWORK PROVIDER APPEALING A DECISION ON BEHALF OF A MEMBER, FOLLOW THE PROCESS FOR APPEALS IN THE MEMBER'S BENEFIT PLAN DOCUMENT. DECISIONS ON APPEALS MADE ON BEHALF OF MEMBERS WILL BE COMPLETED IN 30 DAYS OF SUBMISSION OR WITHIN THE TIMEFRAME REQUIRED BY LAW.

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
P.O. BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

GULF TO BAY ANESTHESIOLOGY ASS
GULF TO BAY ANESTHESIOLOGY
PO BOX 637791
CINCINNATI OH 45263

PAYMENT DATE:	11/17/20
TIN:	593411711
NPI:	1720039746
PAYEE NAME:	GULF TO BAY ANESTHESIOLOGY ASS
PAYMENT NUMBER:	TR 71107654
PAYMENT AMOUNT:	$124,853.01
GROUP NUMBER:	718352
GROUP NAME:	AUTOMOTIVE SERVICES NETWORK

PATIENT: D D ( )

SUBSCRIBER ID:		**SUBSCRIBER NAME:**	M S	**CLAIM NUMBER:**	CA29607150 0077196283
CLAIM DATE:	03/11/20-03/11/20	**DATE RECEIVED:**	03/31/20	**PRODUCT:**	CHOYC
REND PROV ID:	1508887274	**REND PROV:**	GULF TO BAY ANESTHESI		

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
261406078/344					$2,019.60				$505.12	

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
404290002 6Z1	03/11/20 - 03/11/20		00532	QZ/ P3		93		$2,019.60	$505.12	$1,514.48	CO	242	$505.12	IS, QF
CLAIM# CA29607150 0077196283							SUBTOTAL	$2,019.60	$505.12	$1,514.48			$505.12	22, MA67

NOTES

CO242 CONTRACTUAL OBLIGATIONS - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS .

22 WE HAVE RECEIVED MORE INFORMATION AND REPROCESSED THIS CLAIM.

IS MEMBER: THIS SERVICE WAS PROVIDED BY AN OUT-OF-NETWORK PROVIDER. WE PAID THE PROVIDER ACCORDING TO YOUR BENEFITS AND DATA PROVIDED BY DATA ISIGHT. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE, PLEASE CALL DATA ISIGHT AT 866-835-4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. IF THE PROVIDER DISAGREES WITH DATA ISIGHT, THE PROVIDER MIGHT BILL YOU FOR THE DIFFERENCE BETWEEN THE AMOUNT BILLED AND THE AMOUNT ALLOWED. WE'VE ASKED THEM NOT TO. PLEASE CONTACT US IF THEY DO. PROVIDER: PLEASE DON'T BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE.

QF FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE THE ADDITIONAL ANESTHESIA MINUTES FOR A PHYSICAL STATUS MODIFIER.

MA67 CORRECTION TO A PRIOR CLAIM.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF A MEMBER, OR A NON-NETWORK PROVIDER APPEALING A DECISION ON BEHALF OF A MEMBER, FOLLOW THE PROCESS FOR APPEALS IN THE MEMBER'S BENEFIT PLAN DOCUMENT. DECISIONS ON APPEALS MADE ON BEHALF OF MEMBERS WILL BE COMPLETED IN 30 DAYS OF SUBMISSION OR WITHIN THE TIMEFRAME REQUIRED BY LAW.

EXHIBIT D(3)

2020.02.20 Claim (002).TXT

1 FLN/DCC 2005196921922 ID#: SRC IND: 7 VENDOR ID
EN 837 CLAIM FORM - MEDICAL DATE 02/20/20

|1 INSUREDS ID NUMBER ID#: HIC# RTE:
ATTCH: KEYER: 111111999 DT: 02 20 20|

|2 PATIENTS NAME (LFM), REL DOB SEX |4 INSUREDS NAME (LFM)
| PAT REL TO INSD 01/SPOUSE DOB SEX | M
| M J | K
00000000 |

|5 PATIENTS ADDRESS, CITY, STATE, ZIP CODE, PHONE |7 INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE
| |
| |
| |
| |
| |
PHONE# 0000000000 | PHONE# 0000000000 |

|8 STAT MARITAL: EMPLOYMENT: STUDENT:
DECEASED: |
|
|

|9 OTHER INSUREDS NAME (LFM) DOB SEX |7A EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID |
| |
| |
| | EMPLOYMENT STATUS CODE: |
| |
| |
| INSURED ID#: 00000000 |

| PATIENT RELATIONSHIP TO INSURED: | ID # |

9A OTHER INSUREDS ADDRESS, CITY, STATE, ZIP CODE, PHONE	7B INSUREDS POLICY, GROUP OR FECA# AND NAME
	SPEC PRG IND
	917078
	000
PHONE# 0000000000	7C INSURANCE PLAN OR PROGRAM NAME, PAYOR ID AND SPC
9B OTHER INSUREDS POLICY OR GROUP# AND NAME	UNITED HEALTHCARE
87726 CI/COMM INS	PAYOR SEQ # P
SPEC PRG IND	
000	7D IS THERE ANOTHER HEALTH BENEFIT PLAN?
	NO, PATIENT DOES NOT HAVE OTHER INSURANCE

9C INSURANCE PLAN/PROGRAM NAME, PAYOR ID, SPC, FILING IND	7E INSURANCE ADDRESS
CLM FILING IND:	
DESCRIPTION:	

9D EMPLOYERS NAME OR SCHOOL NAME, ADDRESS, EMPLOYEE ID	9E OTHER INSURANCE ADDRESS INFORMATION
EMPLOYMENT STATUS CODE:	

	ID#	

10 IS PATIENTS CONDITION RELATED TO:	A EMPLOYMENT? N/NOT EMP REL
	B AUTO/OTHER ACCIDENT? NO ACCIDENT
PLACE/ST DATE 000000 HOUR	

11 BILLING PROVIDER NAME, ADDRESS, PHONE, ID#S

GULF TO BAY ANESTHESIOLOGY ASSOCIAT		
14000 FIVAY RD		
HUDSON	FL	346677103
PHONE# 8889526772		
TIN# 593411711	EIN/SSN EIN	UPIN#
UHC ID	NPI 1720039746	MDCD#

11A PAY TO PROVIDER ADDRESS

PAY-TO ADDR-1:	PO BOX 637791		
PAY-TO ADDR-2:			
CITY-1: CINCINNATI		ST: OH	ZIP CODE: 452637791
COUNTRY:			

[redacted]

+----------+----------+
|13A CLAIM DELAY REASON CODE:
|

+----------+----------+----------+
|14 DATE OF CURRENT: ILLNESS-FIRST SYMPTOM OR INJURY-ACCIDENT OR PREGNANCY-LMP
|15 SAME/SIMILAR ILLNESS DATE
|16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
| 000000
| TOTAL DISABILITY FROM 000000 TO 000000
| 000000
| PARTIAL DISABILITY FROM 000000 TO 000000
| SAME SYMPTOM IND: FIRST SYMPTOM IND:
| DATE RETURNED TO WORK 000000

+----------+----------+----------+
|17 REFERRING PHYS (RX ORDERING PHY) LFM NPI
|18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICE
| WAHLMD
| MICHAEL J 1114017142
| FROM 012020 TO 000000
| SUPERVISING PHYS LFM NPI

+----------+----------+----------+
|17A ID# OF REF. PHY.
|20 OUTSIDE LAB? $CHARGE

```
 |                                                                    |
                                        |

+-------------------------------------------------------------------+--------------
-----------------------------------------+
 |19 REF PHY UPIN                                                      REF PHY TAX
ID & TYPE                                  |

+-------------------------------------------------------------------------------
-----------------------------------------+
 |21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY      ICD VERSION 0 (0,9)    |22
RESUBMISSION                                        |
 |   (RELATE ITEMS 1 THROUGH 12 TO 24E BY LINE)                           |
                                        |
 | 1  I714                          2  I350                              |   CODE
       ORIG REF NO                      |
 |                                                                        |
                                        |
 | 3  Z8673                         4
+-----------------------------------------------------+
 |                                                                        |23 PRIOR
AUTHORIZATION NUMBER                        |
 | 5                                6                                     |
                                        |
 | 7                                8                                     |
                                        |
 | 9                                10                                    |23A CLIA#
(CLAIM LEVEL)                           |
 | 11                               12                                    |
                                        |

+-------------------------------------------------------------------------------
-----------------------------------------+

+---------------+----+----+-----------------+-----+------------+-------+----+---
+-----------+--------+----------+------------+
 |24     A        |  B |  C |         D         |  E  |      F      |   G   | GG | H
|     I      |   II   |    J     |    L       |
 |DATES OF SERVICE|PLC/|TYPE| CPT/        MOD   |DIAG |  $CHARGES   | DAY/
|ANES|EMG| OTHER INS  |NEGOTIAT|DEDUCTIBLE|    PAID    |
 | FROM     TO    | SV |/SV | HCPCS   1, 2, 3, 4|CODE |             | UNITS
|TIME|IND|  ALLOWED   |RATE IND|  AMOUNT  |   AMOUNT   |

+---------------+----+----+-----------------+-----+------------+-------+----+---
+-----------+--------+----------+------------+
 | 012020  012020 | 21 |    |00562   AA P4      |1230 |    11088.00 |00000.0|0506| N
|         .00|        |       .00|         .00|
 | 012020  012020 | 21 |    |93503              |1230 |     1723.00 |00001.0|0000| N
```

```
|         .00|        |       .00|         .00|
 | 012020  012020 | 21 |    |36556              |1230 |     1428.00 |00001.0|0000| N
|         .00|        |       .00|         .00|
 | 012020  012020 | 21 |    |93313              |1230 |      713.00 |00001.0|0000| N
|         .00|        |       .00|         .00|
 | 012020  012020 | 21 |    |36620              |1230 |      571.00 |00001.0|0000| N
|         .00|        |       .00|         .00|
```

```
+----------------+----+----+-------------------+-----+------------+-------+----+---
+------------+--------+----------+------------+
 |24M LINE INFO                                |
```

```
+---------------+-------------------------------+-----------------------------------
-----------------+---------------------------+
 |SERVICE LINE # | LINE ITEM CNTRL NO            | CLIA# (LINE LEVEL)
                 | SVC NPI    | CLIA # QUAL    |
```

```
+---------------+-------------------------------+-----------------------------------
-----------------+---------------------------+
 | 001           |396484099IZ1                   |
                 |             |                 |
 | 002           |396484099IZ2                   |
                 |             |                 |
 | 003           |396484099IZ3                   |
                 |             |                 |
 | 004           |396484099IZ4                   |
                 |             |                 |
 | 005           |396484099IZ5                   |
                 |             |                 |
```

```
+---------------+-------------------------------+-----------------------------------
-----------------+---------------------------+
 |24H EPSDT IND    CODE1     CODE2     CODE3     |

 +---------------+-----------+-------------------+

 |SERVICE LINE # | EPSDT IND |FAMILY PLANNING IND|

 +---------------+-----------+-------------------+

 | 001           |           |                   |

 | 002           |           |                   |

 | 003           |           |                   |

 | 004           |           |                   |
```

```
| 005              |            |                    |

+----------------+-----------+-------------------+


+---------------------------+--------+------------+---------------------+----------
--+-------------+---------------------------+
|25 FEDERAL TAX ID#  SSN/EIN|26 PATIENTS ACCOUNT# |27 PROV ACCPTS ASGNMT|28 TOT
CHARGE|29 TOT PAT PD|30 TOTAL OTHER INSURANCE     |
|                           |                     |                     |
 |             |                              |
|   593411711          EIN  |                     |    A/ASSIGNED       |
15523.00|          .00|PD         .00ALW         .00|

+---------------------------+--------+------------+---------------------+----------
--+-------------+---------------------------+
|31 SIGNATURE OF SERVICING PHYSICIAN/|32 NAME AND ADDRESS OF FACILITY
                      | 32B - ENCOUNTER PAID |
|   SUPPLIER (FL)                    |   WHERE SERVICES WERE RENDERED
                      |       DATES:         |
|                                    |
                      |                      |
|   TAXONOMY CODE     207L00000X     |   REGIONAL MEDICAL CENTER BAYONE
                      | CLAIM LEVEL:         |
|                                    |   14000 FIVAY RD
                      |                      |
|                                    |
                      |  LINE LEVEL:         |
|                                    |   HUDSON                          FL
346677103                    |                      |
|   ST LICENSE#                      |             SVC NPI (CLAIM LEVEL):
1992759419                  |                      |

+------------------------------------+---------------------------------------------
----------------------+----------------------+
|33 SERVICING PHYSICIAN/SUPPLIER NAME, ADDRESS, PHONE ETC
                      | 33B - ORG ID AND     |
|
                      |       RECEIPT DATE   |
|   KONDA                                                                ANGELINA
                      |                      |
|
                      | ORG ID:              |
|
                      |                      |
|                                                                            PHONE#
0000000000                   | ORG RCPT DATE:       |
```

NABP#	UPIN#	NPI 1871524413
MEDICARE#	MEDICAID#	

34 PAY-TO PROVIDER NPI:	CLRNG HOUSE CLAIM ID: K2KAVH0JES02AP
CLINICAL TRIAL#:	

S1 OTHER INSURED2 INFORMATION -	S4 OTHER INSURANCE INFORMATION -
DOB, SEX, SSN: 00000000	CLAIM NUMBER:
PATIENT RELATION TO INSURED:	PAYER RESP SEQ :
ROUTE IND:	
ADDR1:	CLAIM TOTAL OI PAID AMOUNT: .00
ADDR2:	CLAIM TOTAL DEDUCTIBLE AMOUNT: .00
CITY,ST,ZIP:	CLAIM CONTRACTUAL ADJ: .00
PHONE: 0000000000	CLAIM INTEREST AMOUNT PAID: .00
	CLAIM TOTAL COINSURANCE AMOUNT: .00
EMPLOYMENT STATUS CODE:	
EMPLOYERS/SCHOOL NAME:	REMARK CODE 1,2,3 AND 4:
ADDR:	CLAIM ADJUSTMENT INDICATOR:
CITY,ST,ZIP	CLAIM ADJUSTMENT ORIG. PAYMENT: .00
EMPLOYEE ID:	
	REMITTANCE ADVICE REMARK CODE1:
S2 OTHER PAYOR2 INFORMATION -	REMITTANCE ADVICE

REMARK CODE2:
| REMITTANCE ADVICE
REMARK CODE3:
| POL/GROUP#:
| REMITTANCE ADVICE
REMARK CODE4:
SPEC PRG IND: 000 | REMITTANCE ADVICE
REMARK CODE5:
| INSURANCE PLAN/GROUP NAME:

| PAYOR2 ID AND SPC: 00000 PAYER RESP SEQ : |S5 OTHER PAYOR2 PLAN/PROGRAM NAME AND ADDRESS INFORMATION

|S3 MISCELLANEOUS CLAIM INFORMATION -

| CLAIM TAX AMOUNT: .00

| PROVIDER DISCOUNT AMOUNT: .00

|HCP LINE PRICING/REPRICING INFORMATION -

|ICN: AY40762398

01	02	03	04	05
PRICE METHOD	REPRICED ALLOWED AMT	SAVINGS AMOUNT	REFERENCE ID	RATE
	.00	.00		.00

HCP LINE PRICING/REPRICING INFORMATION CONTINUED					
06		07	13	14	15
REFERENCE ID		APPROVED DRG AMT	REJECT CODE	POLICY COMPLIANCE CODE	EXCEPTION CODE
		.00			

United HealthCare Services, Inc.
CHICO SERVICE CENTER
PO BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

GULF TO BAY ANESTHESIOLOGY ASS
GULF TO BAY ANESTHESIOLOGY
PO BOX 637791
CINCINNATI OH 45263

PAYMENT DATE:	03/03/20
TIN:	593411711
NPI:	1720039746
PAYEE NAME:	GULF TO BAY ANESTHESIOLOGY ASS
PAYMENT NUMBER:	TR 53864400
PAYMENT AMOUNT:	$87,587.69
GROUP NUMBER:	917078
GROUP NAME:	MACY'S

PATIENT: J M ( )

SUBSCRIBER ID:		**SUBSCRIBER NAME:**	K M	**CLAIM NUMBER:**	AY40762398 0122988026
CLAIM DATE:	01/20/20-01/20/20	**DATE RECEIVED:**	02/20/20	**PRODUCT:**	CHOYC+
REND PROV ID:	1871524413	**REND PROV:**	GULF TO BAY ANESTHESI		

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
258404609/344					$15,523.00				$2,854.50	$2,141.00

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
396484099 1Z2	01/20/20 - 01/20/20		93503			1		$1,723.00	$174.76	$1,548.24	CO	242	$174.76	IS
396484099 1Z3	01/20/20 - 01/20/20		36556			1		$1,428.00		$1,428.00	PR	234	$0.00	I4, M80
396484099 1Z4	01/20/20 - 01/20/20		93313			1		$713.00		$713.00	PR	234	$0.00	I4, M80
396484099 1Z5	01/20/20 - 01/20/20		36620			1		$571.00	$75.97	$495.03	CO	242	$75.97	IS
396484099 1Z1	01/20/20 - 01/20/20		00562	AA/ P4		536		$11,088.00	$2,603.77	$8,484.23	CO	242	$2,603.77	IS, QF
CLAIM# AY40762398 0122988026							SUBTOTAL	$15,523.00	$2,854.50	$12,668.50			$2,854.50	QF, N634

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

NOTES

CO242 CONTRACTUAL OBLIGATIONS - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS .

PR234 PATIENT RESPONSIBILITY - THIS PROCEDURE IS NOT PAID SEPARATELY.

I4 THIS SERVICE OR SUPPLY IS DENIED. IT IS CONSIDERED PART OF ANOTHER SERVICE PERFORMED ON THE SAME DAY, OR IT IS NOT ALLOWED AS A SEPARATE CHARGE.

IS MEMBER: THIS SERVICE WAS PROVIDED BY AN OUT-OF-NETWORK PROVIDER. WE PAID THE PROVIDER ACCORDING TO YOUR BENEFITS AND DATA PROVIDED BY DATA ISIGHT. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE, PLEASE CALL DATA ISIGHT AT 866-835-4022 OR VISIT DATAISIGHT.COM. DATA ISIGHT WILL WORK WITH THE PROVIDER ON YOUR BEHALF. IF THE PROVIDER DISAGREES WITH DATA ISIGHT, THE PROVIDER MIGHT BILL YOU FOR THE DIFFERENCE BETWEEN THE AMOUNT BILLED AND THE AMOUNT ALLOWED. WE'VE ASKED THEM NOT TO. CONTACT US IF THEY DO. PROVIDER: DON'T BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE.

QF FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/ INCLUDE THE ADDITIONAL ANESTHESIA MINUTES FOR A PHYSICAL STATUS MODIFIER.

STD - PRA

UnitedHealthcare®

PROVIDER REMITTANCE ADVICE

PAYMENT DATE:	03/03/20
TIN:	593411711
NPI:	1720039746
PAYEE NAME:	GULF TO BAY ANESTHESIOLOGY ASS
PAYMENT NUMBER:	TR 53864400
PAYMENT AMOUNT:	$87,587.69
GROUP NUMBER:	917078
GROUP NAME:	MACY'S

NOTES

M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.
N634	THE ALLOWANCE IS CALCULATED BASED ON ANESTHESIA TIME UNITS.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF A MEMBER, OR A NON-NETWORK PROVIDER APPEALING A DECISION ON BEHALF OF A MEMBER, FOLLOW THE PROCESS FOR APPEALS IN THE MEMBER'S BENEFIT PLAN DOCUMENT. DECISIONS ON APPEALS MADE ON BEHALF OF MEMBERS WILL BE COMPLETED IN 30 DAYS OF SUBMISSION OR WITHIN THE TIMEFRAME REQUIRED BY LAW.

EXHIBIT 8

PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C. & Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: 2:19-cv-00832-JAD-VCF

FIRST AMENDED COMPLAINT

Jury Trial Demanded

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") as and

for their First Amended Complaint against defendants UnitedHealth Group, Inc. ("UHG"), and its subsidiaries and/or affiliates United Healthcare Insurance Company ("UHCIC") United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); Oxford Benefit Management, Inc. ("Oxford" together with UHG, UHC Services and UMR, the "UHC Affiliates" and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra Health"); Sierra Health-Care Options, Inc. ("Sierra Options" and together with Sierra Health, the "Sierra Affiliates"); Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants") hereby complain and allege as follows:

NATURE OF THIS ACTION

1. This action arises out of a dispute concerning the rate at which Defendants reimburse the Health Care Providers for the emergency medicine services they have already provided, and continue to provide, to patients covered under the health plans underwritten, operated, and/or administered by Defendants (the "Health Plans") (Health Plan beneficiaries for whom the Health Care Providers performed covered services that were not reimbursed correctly shall be referred to as "Patients" or "Members").[1] Collectively, Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their third party payment rates to defraud the Health Care Providers, to deny them reasonable payment for their services which the law requires, and to coerce or extort the Health Care Providers into contracts that only provide for manipulated rates. Defendants have reaped millions of dollars from their illegal, coercive, unfair, fraudulent conduct and will reap millions more if their conduct is not stopped.

2. Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their payment rates to defraud the Health Care Providers and deny them reasonable payment for services, which the law requires.

[1] The Health Care Providers do not assert any causes of action with respect to any Patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). The Health Care Providers also do not assert any claims relating to Defendants' managed Medicaid business or with respect to the right to payment under any ERISA plan. Finally, the Health Care Providers do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members. Thus, there is – and was – no basis to remove this lawsuit to federal court under federal question jurisdiction.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

PARTIES

3. Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") is a professional emergency medicine services group practice that staffs the emergency departments at ER at Aliante; ER at The Lakes; Mountainview Hospital; Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus; Dignity Health – St. Rose Dominican Hospitals, San Martin Campus; Dignity Health – St. Rose Dominican Hospitals, Siena Campus; Southern Hills Hospital and Medical Center; and Sunrise Hospital and Medical Center located throughout Clark County, Nevada. Fremont is part of the TeamHealth Holdings, Inc. ("TeamHealth") organization.

4. Plaintiff Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians") is a professional emergency medicine services group practice that staffs the emergency department at Banner Churchill Community Hospital in Fallon, Nevada.

5. Plaintiff Crum, Stefanko And Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") is a professional emergency medicine services group practice that staffs the emergency department at Northeastern Nevada Regional Hospital in Elko, Nevada.

6. Defendant UnitedHealth Group, Inc. ("UHG") is the largest single health carrier in the United States and is a Delaware corporation with its principal place of business in Minnesota. UHG is a publicly-traded holding company that is dependent upon monies (including dividends and administrative expense reimbursements) from its subsidiaries and affiliates which include all of the other Defendant entities named herein.

7. Defendant United HealthCare Insurance Company ("UHCIC") is a Connecticut corporation with its principal place of business in Connecticut. UHCIC is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, United HealthCare Insurance Company is a licensed Nevada health and life insurance company.

8. Defendant United HealthCare Services, Inc. dba UnitedHealthcare ("UHC Services") is a Minnesota corporation with its principal place of business in Connecticut and affiliate of UHCIC. UHC Services is responsible for administering and/or paying for certain

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emergency medical services at issue in the litigation. On information and belief, United HealthCare Services, Inc. is a licensed Nevada health insurance company.

9. Defendant UMR, Inc. dba United Medical Resources ("UMR") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. UMR is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, UMR is a licensed Nevada health insurance company.

10. Defendant Oxford Health Plans, Inc. ("Oxford") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. Oxford is responsible for administering and/or paying for certain emergency medical services at issue in the litigation.

11. Defendant Sierra Health and Life Insurance Company, Inc. is a Nevada corporation and affiliate of UHCIC. Sierra Health is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Health is a licensed Nevada health insurance company.

12. Defendant Sierra Health-Care Options, Inc. ("Sierra Options") is a Nevada corporation and affiliate of UHCIC. Sierra Options is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Options is a licensed Nevada health insurance company.

13. Defendant Health Plan of Nevada, Inc. ("HPN") is a Nevada corporation and affiliate of UHCIC. HPN is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, HPN is a licensed Nevada Health Maintenance Organization ("HMO").

14. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions, circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of Does 1-10 and Roes Entities 11-20 are unknown to the Health Care Providers, who sues those defendants by such fictitious names. The Health Care Providers will seek leave of this Court to amend this Complaint to insert the proper names of the defendant

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Doe and Roe Entities when such names and capacities become known to the Health Care Providers.

JURISDICTION AND VENUE

15. The amount in controversy exceeds the sum of fifteen thousand dollars ($15,000.00), exclusive of interest, attorneys' fees and costs.

16. The Eighth Judicial District Court, Clark County, has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. The Health Care Providers contest this Court's subject matter jurisdiction over the matters alleged herein and have moved to remand. *See* Motion to Remand (ECF No. 5). The Health Care Providers do not waive their continued objection to Defendants' removal based on alleged preemption under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Venue is proper in Clark County, Nevada.

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

17. The Health Care Providers are professional practice groups of emergency medicine physicians and healthcare providers that provides emergency medicine services 24 hours per day, 7 days per week to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by the Health Care Providers. The Health Care Providers provide emergency department services throughout the State of Nevada.

18. The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. The Health Care Providers fulfill this obligation for the hospitals which they staff. In this role, the Health Care Providers' physicians provide emergency medicine services to all patients, regardless of insurance coverage or ability to pay, including to Patients with insurance coverage issued, administered and/or underwritten by Defendants.

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19. Upon information and belief, Defendants operate as an HMO under NRS Chapter 695C, and is an insurer under NRS Chapters 679A, 689A (Individual Health Insurance), 689B (Group and Blanket Health Insurance), 689C (Health Insurance for Small Employers) and 695G (Managed Care Organization). Defendants provide, either directly or through arrangements with providers such as hospitals and the Health Care Providers, healthcare benefits to its members.

20. There is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation; the Health Care Providers are therefore designated as a "non-participating" or "out-of-network" provider for all of the claims at issue. An implied-in-fact agreement exists between the Health Care Providers and Defendants, however.

21. Because federal and state law requires that emergency services be provided to individuals by the Health Care Providers without regard to insurance status or ability to pay, the law protects emergency service providers -- like Fremont here -- from predatory conduct by payors, including the kind of conduct in which Defendants have engaged leading to this dispute. If the law did not do so, emergency service providers would be at the mercy of such payors. the Health Care Providers would be forced to accept payment at any rate or no rate at all dictated by insurers under threat of receiving no payment, and then the Health Care Providers would be forced to transfer the financial burden of care in whole or in part onto Patients. The Health Care Providers are protected by law, which requires that for the claims at issue, the insurer must reimburse the Health Care Providers at a reasonable rate or the usual and customary rate for services they provide.

22. The Health Care Providers regularly provide emergency services to Defendants' Patients.

23. Defendants are contractually and legally responsible for ensuring that Patients receive emergency services without obtaining prior approval and without regard to the "in network" or "out-of-network" status of the emergency services provider.

24. The uhc.com website state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are

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> provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

25. Relevant to this action:

a. From July 1, 2017 through the present, Fremont has provided emergency medicine services to Defendants' Members as an out-of-network provider of emergency services as follows: ER at Aliante (approximately July 2017-present); ER at The Lakes (approximately July 2017-present); Mountainview Hospital (approximately July 2017-present); Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus (approximately July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, San Martin Campus approximately (July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present).

b. At all times relevant hereto, Team Physicians and Ruby Crest have provided emergency medicine services to Defendants' Members as out-of-network providers of emergency services at Banner Churchill Community Hospital in Fallon, Nevada and Northeastern Nevada Regional Hospital in Elko, Nevada, respectively.

26. Defendants have generally adjudicated and paid claims with dates of service through July 31, 2019. As the claims continue to accrue, so do the Health Care Providers' damages. For each of the claims for which the Health Care Providers seek damages, Defendants have already determined the claim was covered and payable.

The Relationship Between the Health Care Providers and Defendants

27. Defendants provide health insurance to their members (*i.e.*, their insureds).

28. In exchange for premiums, fees, and/or other compensation, Defendants are responsible for paying for health care services rendered to members covered by their health plans.

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29. In addition, Defendants provide services to their Members, such as building participating provider networks and negotiating rates with providers who join their networks.

30. Defendants offer a range of health insurance plans. Plans generally fall into one of two categories.

31. "Fully Funded" plans are plans in which Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums.

32. "Employer Funded" plans are plans in which Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

33. Defendants provide coverage for emergency medical services under both types of plans.

34. Defendants are contractually and legally responsible for ensuring that their members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

35. Defendants highlight such coverage in marketing their insurance products.

36. For example, on the "patient protections" section of Defendants' website, uhc.com, Defendants state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

37. Payors typically demand a lower payment rate from contracted participating providers.

38. In return, payors offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

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39. For all claims at issue in this lawsuit, the Health Care Providers were non-participating providers, meaning they did not have an express contract with Defendants to accept or be bound by Defendants' reimbursement policies or in-network rates.

40. Specifically, the reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) at rates below the billed charges and a reasonable payment for the services rendered, (d) as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to herein as the "Non-Participating Claims."

41. The Non-Participating Claims involve only commercial and Exchange Products operated, insured, or administered by the insurance company Defendants. They do not involve Medicare Advantage or Medicaid products.

42. Further, the Non-Participating Claims at issue do not involve coverage determinations under any health plan that may be subject to the federal Employee Retirement Income Security Act of 1974, or claims for benefits based on assignment of benefits.[2]

43. Those counts concern the *rate* of payment to which the Health Care Providers are entitled, not whether a *right* to receive payment exists.

44. Defendants bear responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

45. Defendants understand and expressly acknowledge that their members will seek emergency treatment from non-participating providers and that Defendants are obligated to pay for those services.

…

…

[2] The Health Care Providers understand, in any event, that Defendants do not require or rely upon assignments from their members in order to pay claims for services provided by the Health Care Providers to their members.

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The Reasonable Rate for Non-Participating Emergency Services is Well-Established

46. Defendants have traditionally allowed payment at 75-90% of billed charges for the Health Care Providers' emergency services.

47. Defendants have done so largely through the use of rental networks, which establish a reasonable rate for out-of-network provider services through arms-length negotiations between the rental network and providers on the one hand, and the rental network and health insurance companies on the other.

48. Rental networks act as "brokers" between non-participating providers and health insurance companies.

49. A rental network will secure a contract with a provider to discount its out-of-network charges.

50. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

51. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

52. For many years, the Health Care Providers' respective contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from the Health Care Providers' billed charges for claims adjudicated through the rental network agreement.

53. In practice, nearly all of the Health Care Providers' non-participating provider claims submitted under Employer Funded plans from 2008 to 2017 were paid at between 75-90% of billed charges, including the Non-Participating Claims submitted to Defendants.

54. This longstanding history establishes that a reasonable reimbursement rate for the Health Care Providers' Non-Participating Claims for emergency services is 75-90% of the Health Care Providers' billed charge.

55. Beginning in approximately January 2019, Defendants have further slashed their reimbursement rate for Non-Participating Claims to less than 60%, and to as low as 12% of the

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charges billed for professional services, rates that are well-below reasonable reimbursement rates.

56. Defendants' drastic payment cuts are entirely inconsistent with the established rate and history between the parties.

Defendants Paid the Health Care Providers Unreasonable Rates

57. Defendants arbitrarily began manipulating the rate of payment for claims submitted by the Health Care Providers. Defendants drastically reduced the rates at which they paid the Health Care Providers for emergency services for some claims, but not others. Instead of paying a usual and customary rate of the charges billed by the Health Care Providers, Defendants paid some of the claims for emergency services rendered by the Health Care Providers at far below the usual and customary rates. Yet, Defendants paid other substantially identical claims (e.g. claims billed with the same Current Procedural Terminology (CPT) Code, as maintained by American Medical Association) submitted by the Health Care Providers at higher rates and in some instances at 100% of the billed charge.

a. For example, on October 10, 2017, Defendants' Member #1, presented to the emergency department at Southern Hills Hospital and was treated by Fremont's providers. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants allowed and paid $223.00, which is just 17% of the charges billed. By contrast, on October 9, 2017, Defendants' Member #2 presented to the emergency department at St. Rose Dominican Hospitals, Siena Campus. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants paid $1,295.00, 100% of the charges billed.

b. By way of further example, between January 9 and 31, 2019, Defendants' Members #3, #4, #5 all presented to emergency departments staffed by Fremont's providers. In each instance the professional services were billed with CPT Code 99285 and Defendants paid nearly all or 100% of the billed charges. By contrast, on February 26, 2019, Defendants' Members #6, #7 and #8 all presented to emergency departments staffed by Fremont. In each instance the professional services were billed with CPT Code 99285 in the amount of $1,360.00 and Defendants only paid $185.00, a mere 13.6% of the billed charges in each instance.

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c. Further, Fremont's providers treated Member #9 on March 3, 2019. The professional services were billed at $971.00 (CPT 99284) and Defendants allowed $217.53, which is 22% of billed charges.

d. The Health Care Providers do not assert any of the foregoing claims pursuant to, or in reliance on, any assignment of benefit by Defendants' Members. Upon information and belief, Defendants do not require or rely upon assignment of benefits from their Members in order to pay claims for services provided by the Health Care Providers.

58. Defendants generally paid lower reimbursement rates for services provided to Members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to Members of employer funded plans or those plans under which they provide administrator services only.

59. The Health Care Providers have continued to provide emergency medicine treatment, as required by law, to Patients covered by Defendants' plans who seek care at the emergency departments where they provide coverage.

60. Defendants bear responsibility for paying for emergency medical care provided to their Members regardless of whether the treating physician is an in-network or out-of-network provider.

61. Defendants expressly acknowledge that their Members will seek emergency treatment from non-participating providers and that they are obligated to pay for those services.

62. In emergency situations, individuals go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the opportunity to determine in advance which hospitals and physicians are in-network under their health plan. Defendants are obligated to reimburse the Health Care Providers at the usual and customary rate for emergency services the Health Care Providers provided to their Patients, or alternatively for the reasonable value of the services provided.

63. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from the Health Care Providers' physicians: treatment of

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conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

64. As alleged herein, the Health Care Providers provided treatment on an out-of-network basis for emergency services to thousands of Patients who were Members in Defendants' Health Plans. The total underpayment amount for these related claims is in excess of $15,000.00 and continues to grow. Defendants have likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

65. Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to the Health Care Providers. Defendants implemented this program to coerce, influence and leverage business discussions with the Health Care Providers to become a participating provider at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

66. Defendants failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims as legally required.

67. The Health Care Providers contested the unsatisfactory rate of payment received from Defendants in connection with the claims that are the subject of this action.

68. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

69. The Health Care Providers bring this action to compel Defendants to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the emergency services that it provided and will continue to provide Patients and to stop Defendants from profiting from their manipulation of payment rate data.

Defendants' Prior Manipulation of Reimbursement Rates

70. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own Members.

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71. In 2009, defendant UnitedHealth Group, Inc. was investigated by the New York Attorney General for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

72. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

73. Defendant UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

74. In a press release announcing the settlement, the New York Attorney General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

75. Also in 2009, for the same conduct, defendants UnitedHealth Group, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid $350 million to settle class action claims alleging that they underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

76. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers.

77. For example, the State of Connecticut uses FAIR Health's database to determine reimbursement for non-participating providers' emergency services under the state's consumer protection law.

78. Defendants tout the use of FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website.

79. As stated on Defendants' website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for non-participating provider claims, the relevant United

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Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging.

80. While Defendants give the appearance of remitting reimbursement to non-participating providers that meet usual and customary rates and/or the reasonable value of services based on geography that is measured from independent benchmark services such as the FAIR Health database, Defendants have found other ways to manipulate the reimbursement rate downward from a usual and customary or reasonable rate in order to maximize profits at the expense of the Health Care Providers.

81. During the relevant time, Defendants imposed significant cuts to the Health Care Providers' reimbursement rate for out-of-network claims under Defendants' fully funded plans, without rationale or justification.

82. Defendants pay claims under fully funded plans out of their own pool of funds, so every dollar that is not paid to the Health Care Providers is a dollar retained by Defendants for their own use.

83. Defendants' detrimental approach to payments for members in fully funded plans continues today, Defendants have made payments to the Health Care Providers at rates as low as 20% of billed charges.

84. Team Physicians' providers treated Member #10 on March 15, 2019 and the professional services (CPT 99285) were billed in the amount of $1,138.00, but Defendants allowed $435.20 which is just 38% of the billed charges.

85. In another example, Team Physicians' providers treated Member #11 on February 9, 2019 and the professional services (CPT 99285) were billed in the amount of $1,084.00, but Defendants allowed $609.28 which is just 56% of the billed charges.

86. Further, Fremont's providers treated Member #12 on April 17, 2019 and the professional services were billed in the amount of $1,428.00 (CPT 99285), but defendants allowed $435.20 which is 30% of the billed charges.

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87. Fremont also treated Member #13 on March 25, 2019 and the professional services were billed in the amount of $973.00, but defendants allowed $214.51 which is 22% of the billed charges.

88. As a result of these deep cuts in payments for services provided to Members of fully funded plans, Defendants have not paid the Health Care Providers a reasonable rate for those services since early 2019.

89. In so doing, Defendants have illegally retained those funds.

Defendants' Current Schemes

90. In 2017, Defendants also attempted to pay less than a reasonable rate on their employer funded plans, further exacerbating the financial damages to the Health Care Providers.

91. From late 2017 to 2018, over the course of multiple meetings in person, by phone, and by email correspondence, the Health Care Providers' representatives tried to negotiate with Defendants to become participating, in-network providers.

92. As part of these negotiations, the Health Care Providers' representatives met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

93. Around December 2017, Mr. Rosenthal told the Health Care Providers' representatives that Defendants intended to implement a new benchmark pricing program specifically for their employer funded plans to decrease the rate at which such claims were to be paid.

94. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically reimbursed providers – a drastic and unjustified discount from what Defendants have been paying the Health Care Providers on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market.

95. Defendants' proposed rate was neither reasonable nor fair.

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96. In May 2018, Mr. Rosenthal escalated his threats, making clear during a meeting that, if the Health Care Providers did not agree to contract for the drastically reduced rates, Defendants would implement benchmark pricing that would reduce the Health Care Providers' non-participating reimbursement by 33%.

97. Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare Inc. and part of the Office of the Chief Executive of Defendant UnitedHealth Group, Inc., said that, by April 2019, Defendants would cut the Health Care Providers' non-participating reimbursement by 50%.

98. Asked why Defendants were forcing such dramatic cuts on the Health Care Providers' reimbursement, Mr. Schumacher said simply "because we can."

99. Defendants made good on their threats and knowingly engaged in a fraudulent scheme to slash reimbursement rates paid to the Health Care Providers for non-participating claims submitted under their employer funded plans to levels at, or even below, what they had threatened in 2018.

100. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third party, Data iSight, to process the Health Care Providers' claims and to determine reasonable reimbursement rates.

101. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since as early as June 1, 2016 with some of the Health Care Providers to secure reasonable rates from payors for the Health Care Providers' non-participating emergency services. The Health Care Providers have no contract with Data iSight, and the Non-

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Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement.

102. Since January 2019, Defendants have engaged in a scheme and conspired with Data iSight to impose arbitrary and unreasonable payment rates on the Health Care Providers under the guise of utilizing an independent, objective database purportedly created by Data iSight to dictate the rates imposed by Defendants.

103. Defendants also continued to advance this scheme on the negotiation front.

104. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants planned to cut the Health Care Providers' rates over three years to just 42% of the average and reasonable rate of reimbursement that the Health Care Providers had received in 2018 if the Health Care Providers did not formally contract with them at the rate dictated by Defendants.

105. Mr. Schumacher additionally advised that leadership across the Defendant entities were aware and supportive of the drastic cuts and provided no objective basis for them.

106. The next day, Angie Nierman, a Vice President of Networks at UnitedHealth Group, Inc., sent a written proposal reflecting Mr. Schumacher's stated cuts.

107. In addition to denying the Health Care Providers what is owed to them for the Non-Participating Claims, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

108. As further evidence of Defendants' scheme to use their market power to the detriment of the Health Care Providers and other emergency provider groups that are part of the TeamHealth organization, in August 2019, UHG advised at least one Florida medical surgical facility (the "Florida Facility") that Defendants will not continue negotiating an in-network agreement unless the Florida Facility identifies an in-network anesthesia provider. The current out-of-network anesthesia provider is part of the TeamHealth organization. Defendants' threats to discontinue contract negotiations prompted the Florida Facility's Chief Operating Officer to send TeamHealth a "Letter of Concern" on August 14, 2019. Defendants' threats and leverage are aimed at intentionally interfering with existing contracts and with a goal of reducing TeamHealth's market participation.

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109. Additionally, Defendants first threatened, and then, on or about July 9, 2019, globally terminated all existing in-network contracts with medical providers that are part of the TeamHealth organization, including the Health Care Providers, in an effort to widen the scale of the scheme to deprive the Health Care Providers of reasonable reimbursement rates through its manipulation of reimbursement rate data.

Defendants' Fraudulent Schemes to Deprive the Health Care Providers of Reasonable Reimbursement Violates Nevada's Civil Racketeering Statute

110. Each Defendant, UnitedHealth Group, Inc., United Healthcare Insurance Company, United Health Care Services Inc., UMR, Inc., Oxford Benefit Management, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada, Inc. (collectively "Defendants") violated NRS 207.350 *et seq.* by committing the following crimes related to racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) and that the Defendants devised, conducted, and participated in with unnamed third parties, including, but not limited to, Data iSight.

111. The Enterprise, as defined in NRS 207.380 consists of the Defendants, non-parties Data iSight and other entities that develop software used in reimbursement determinations used by the Defendants (the "Enterprise"). The participants of the Enterprise are associated, upon information and belief, by virtue of contractual agreement(s) and/or other arrangement(s) wherein they have agreed to undertake a common goal of reducing payments to the Health Care Providers for the benefit of the Enterprise. The Enterprise participants communicate routinely through telephonic and electronic means as they unilaterally impose reimbursement rates based on their manipulated "data" but which is nothing more than a transparent attempt to impose artificially reduced reimbursement rates that the Defendants threatened during business-to-business negotiations.

112. The Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight, through a pattern of unlawful activity.

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113. As part of this scheme, the Defendants prepared to, and did knowingly and unlawfully, reduce the Health Care Providers' reimbursement rates for the non-participating claims to amounts significantly below the reasonable rate for services rendered to Defendants' Members, to the detriment of the Health Care Providers and to the benefit and financial gain of Defendants and Data iSight.

114. To carry out the scheme and in furtherance of the conspiracy, Defendants and Data iSight engaged in conduct violative of NRS 207.400.

115. Since January 2019, the Enterprise worked together to manipulate and artificially lower non-participating provider reimbursement data that coincides and matches the earlier threats made by UHG in an effort to avoid paying the Health Care Providers for the usual and customary fee or rate and/or for the reasonable value of the services provided to Defendants' Members for emergency medicine services. The unilateral reduction in reimbursement rates is not founded on actual statistically sound data, and is not in line with reimbursement rates that can be found through sites such as the FAIR Health database, a recognized source for such reimbursement rates. Each time the Defendants direct payment using manipulated reimbursement rates and issue the Health Care Providers a remittance, the Defendants further their scheme or artifice to defraud Fremont because the Defendants retain the difference between the amount paid based on the artificially reduced reimbursement rate and the amount paid that should be paid based on the usual and customary fee or rate and/or the reasonable value of services provided, to the detriment of the Health Care Providers who have already performed the services being billed. Further, the Health Care Providers' representatives have contacted Data iSight and have been informed that acceptable reimbursement rates are actually influenced and/or determined by Defendants, not Data iSight.

116. As a result of the scheme, Defendants have injured the Health Care Providers in their business or property by a pattern of unlawful activity by reason of their violation of NRS 207.400(1)(a)- (d), (1)(f), (1)(i)-(j). *See* NRS 207.470.

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Defendants' and Data iSight's Activities Constitute Racketeering Activity

117. Defendants and Data iSight committed, and continue to commit, crimes related to racketeering pursuant to NRS 207.360 that have the same or similar pattern, intents, results, accomplices, victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents in violation of NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) such that they have engaged in racketeering activity as defined by NRS 207.400 and which poses a continued threat of unlawful activity such that they constitute a criminal syndicate under NRS 207.370.

118. Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to the Health Care Providers for the emergency services that the Health Care Providers provided to Defendants' Members, for the financial gain of the Defendants and Data iSight.

119. The racketeering activity has happened on more than two occasions that have happened within five years of each other. In fact, the Defendants have processed and submitted a substantial number of artificially reduced payments to the Health Care Providers since January 2019 in furtherance of Defendants' unlawful conduct.

120. As a direct and proximate result of those activities, the Health Care Providers have suffered millions of dollars in discrete and direct financial loss that stem from the Defendants' knowing retention of payment that is founded on a scheme to manipulate payment rates and payment data to their benefit.

The Enterprise and Scheme

121. The Enterprise is comprised of Defendants and third-party entities, to include Data iSight, that developed software used in reimbursement determinations by Defendants.

122. Defendants and Data iSight agreed to, and do, manipulate reimbursement rates and control allowed payments to the Health Care Providers through acts of the Enterprise.

123. The Defendants and Data iSight conceal their scheme by hiding behind written agreements and/or other arrangements, and false statements.

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124. Since at least January 1, 2019, the Defendants, by virtue of their engagement and use of Data iSight, have falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates.

125. In reality, Data iSight is used as a cover for Defendants to justify paying reimbursement to the Health Care Providers at rates that are far less than the reasonable payment rate that the Health Care Providers have historically received and are entitled to under the law. The reimbursement rates purportedly collected and employed by Data iSight are nothing more than an instrumentality for the Defendants' unilateral decision to stop paying the Health Care Providers the usual and customary fee and/or the reasonable value of the services provided.

126. This scheme is concealed through the use of false statements on Data iSight's website and in Defendants' and Data iSight's communications with providers, including the Health Care Providers' representatives.

127. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between Defendants and Data iSight.

The Enterprise's False Statements: Transparency

128. By the end of June 2019, an increasingly significant amount of non-participating claims submitted to Defendants were being processed for payment by Data iSight.

129. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

130. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

131. This concealment was designed by the Enterprise to, and does, prevent the Health Care Providers from receiving a reasonable payment for the services it provides.

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132. For claims whose reimbursement is determined by Data iSight, non-participating providers receive a Provider Remittance Advice form ("Remittance") from Defendants with "IS" or "1J" in the "Remark/Notes" column.

133. Over the past six months, an ever-increasing number of non-participating claims have been processed by Data iSight with drastically reduced payment amounts.

134. Yet Defendants and Data iSight do not state, on the face of the Remittance, or anywhere else, any reason for the dramatic cut.

135. Instead, the Remittances contain a note to call a toll-free number if there are questions about the claim.

136. In July 2019, a representative of Team Physicians contacted Data iSight via that number to discuss three separate claims with CPT Code 99285 (emergency department visit, problem of highest severity) which had been billed at $1,084.00, but for which Data iSight had allowed two claims at $435.20 (40% of billed charges) and one at $609.28 (56% of billed charges). After Team Physicians' representative spoke with Data iSight's intake representative, a Data iSight representative, Kimberly (Last Name Unknown) ("LNU") ("Kimberly"), called back and she asked if Team Physicians wanted a proposal for one of the inquired-upon claims. Team Physicians' representative indicated that he was interested in learning more and asked what reimbursement rate would be offered. Kimberly stated, "I have to look at a couple of things and decide." Thereafter, Kimberly sent the Team Physicians' representative a proposed Letter of Agreement (prepared July 31, 2019) (ICN: 48218522) offering to increase the allowed amount from $609.28 to $758.80 – increasing the amount to 70% of billed charges instead of 56% – as payment in full and an agreement not to balance bill Defendants' Member or Member's family. All it took was one call and a request for a more reasonable payment and almost immediately Defendant United Healthcare Services increased the amount it would pay, although still not to the level that the Health Care Providers consider to be reasonable.

137. Medical providers that are part of the TeamHealth organization have experienced this same trend across the country with Data iSight. In one instance, in July 2019, a representative of another provider, Emergency Group of Arizona Professional Corporation (the

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"AZ Provider"), contacted Data iSight via that number to discuss a claim with CPT Code 99284 (emergency department visit, problem of high severity) which had been billed at $1,190.00, but for which Data iSight had allowed and paid $295.28, just 24.8% of billed charges.

138. After the AZ Provider's representative spoke with Data iSight's intake representative, a Data iSight representative, Michele Ware ("Ware"), called back and claimed the billed charges were paid based on a percentage of the Medicare fee schedule. The AZ Provider's representative challenged the reasonableness of the $295.28 payment. After learning that the AZ Provider had not yet billed Defendants' Member for the difference, Ware stated "ok – so you're willing negotiate" and offered to pay 80% of billed charges. In response, the AZ Provider's representative asked for payment of 85% of billed charges – $1,011.50 – to which Ware promptly agreed. Immediately thereafter, Ware sent a written agreement for the AZ Provider's representative to review and sign, confirming payment of $1,011.50 as payment in full and an agreement not to balance bill Defendants Services' Member or Member's family.

139. In another instance, when asked to provide the basis for the dramatic cut in payment for the claims, a Data iSight representative by the name of Phina LNU, did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

140. Instead, the representative simply stated that the rates were developed by Data iSight and Defendants. When the Health Care Providers' representative continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that "it is just an amount that is recommended and sent over to United [HealthCare]." When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

141. Further attempts to understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight executives have also been futile.

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142. Data iSight and the Defendants know that the rates that Data iSight have allowed for the Health Care Providers' claims in 2019 are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

143. Defendants know this because when a provider challenges the payment, Data iSight and Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the Health Care Providers persist long enough in the process.

144. This process to contest the unreasonable payment takes weeks to conclude for the Health Care Providers and is impracticable to follow for every claim – a fact that Defendants and Data iSight understand.

145. For example, as evidence of this fraudulent practice, the Health Care Providers' representatives contested the allowed amounts on the claim discussed above in paragraph 136.

146. Eventually, Data iSight, offered to allow payment of at least one claim at 70% of the billed charges.

147. Absent providers taking the time to chase every claim, Data iSight and Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

148. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until the Health Care Providers challenge its determinations continually harms the Health Care Providers, in that, even if they eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens them with excessive administrative time and expense and deprives the Health Care Providers of their right to prompt payment.

The Enterprise's False Statements: Representations that Payment Rates Are "Defensible and Market Tested"

149. The Enterprise's claim to "transparency" is not its only fraudulent representation.

150. The Enterprise, through Data iSight, also falsely represents, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

151. Claims processed by Data iSight contain the following note:

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> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835- 4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

152. This note is intended to, and does, mislead the Health Care Providers to believe that the reimbursement calculations are tied to external, objective data.

153. Further, in its provider portal, Data iSight describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

154. Data iSight's parent company, MultiPlan, similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and notes that it has been "[v]alidated by statisticians as effective and fair."

155. These statements are false.

156. Data iSight's rates are not data-driven: they match the rate threatened by Defendants in 2018 and are whatever Defendants want, and direct Data iSight, to allow.

157. For example, the Health Care Providers submitted claims for Members but received reimbursement in very different allowed amounts:

a. Member #14 was treated on May 9, 2019. Fremont billed Defendants $973.00 for procedure code 99284, and Defendants allowed $875.70 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by Defendants to Fremont for non-participating provider services.

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b. But, for Member #15, who was treated on May 24, 2019, Defendants, through Data iSight, allowed only $295.28 for billed charges of $1,019.00, which is only 29% of the billed charges.

c. Further, at just one site, Defendants allowed and paid Team Physicians at varying amounts for the same procedure code (99285) (Members ##16a-16e):

i. Date of Service ("DOS"): January 4, 2019; Charge $1084.00; Allowed $609.28 (56% of Charge and reimbursed using Data iSight);

ii. DOS: January 15, 2019; Charge $1084.00; Allowed $294.60 (27% of Charge);

iii. DOS: January 24, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight);

iv. DOS: January 29, 2019; Charge $1084.00; Allowed $328.39 (30% of Charge); and

v. DOS: February 7, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight).

158. This lock-step reduction, consistent with Defendants' 2018 threats to drastically reduce rates even further if the Health Care Providers failed to agree to their proposed contractual rates, spans a significant number of the Health Care Providers' claims for payment for services to Defendants' Members.

159. From the above examples, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable reimbursement rate, as its rates are not consistent, defensible, or reasonable.

160. Rather, Defendants, in complicity with Data iSight, increasingly reimburse the Health Care Providers at entirely unreasonable rates, in retaliation for the Health Care Providers' objections to their reimbursement scheme, and completely contrary to their false assertions designed to mislead the Health Care Providers and similar providers into believing that they will receive payment at reasonable rates.

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161. This reimbursement is dictated by Defendants, to the financial detriment of the Health Care Providers.

The Enterprise's False Statements: Geographic Adjustment

162. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

163. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

164. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

165. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with Defendants to cut uniformly out-of-network provider payments across geographic locations.

166. For example, Member WY was treated in Wyoming on January 21, 2019. The provider billed Defendants $779 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

167. Four days later, on January 25, 2019, Member AZ in Arizona and billed Defendants $1,212.00 for CPT Code 99284 and Defendants, via Data iSight, allowed exactly $413.39.

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168. On the same date, Member NH was treated on the other side of the country in New Hampshire. The provider billed Defendants $1,047 for procedure 99284, and Defendants, via Data iSight, again allowed $413.39.

169. On February 8, 2019, Member OK was treated in Oklahoma. The provider billed Defendants $990 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

170. Two days later, Members KS and NM were treated in Kansas and New Mexico, respectively. The providers billed Defendants $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, Defendants, via Data iSight, allowed exactly $413.39.

171. One month later, Member CA was treated in California and Member NV was treated in Nevada. The CA provider billed Defendants $937.00 for procedure code 99284. Defendants, via Data iSight, yet again allowed exactly $413.39. A Health Care Provider billed Defendants $763.00 for procedure code 99284 and, via Data iSight, Defendants again allowed exactly $413.39.

172. Two months later, on May 20, 2019, a provider treated Member PA in Pennsylvania and billed Defendants $1,094 for procedure code 99284, and Defendants, via Data iSight, allowed exactly $413.39.

Patient	Location	Date of Service	Billed Amount	CPT Code	Allowed Amount – "DataiSight™ Reprice"
WY	Wyoming	1/21/19	$779 .00	99284	$413.39
AZ	Arizona	1/25/19	$1,212.00	99284	$413.39
NH	New Hampshire	1/25/19	$1047.00	99284	$413.39
OK	Oklahoma	2/8/19	$990.00	99284	$413.39
KS	Kansas	2/10/19	$778.00	99284	$413.39
NM	New Mexico	2/10/19	$895.00	99284	$413.39
CA	California	3/25/19	$937.00	99284	$413.39
NV	Nevada	3/30/19	$763.00	99284	$413.39
PA	Pennsylvania	5/20/19	$1,094.00	99284	$413.39

173. Defendants falsely claim on their website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

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174. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed $413.39:

Location	CPT Code	80th Percentile of Fair Health Benchmark
Wyoming	99284	$1,105.00
New Hampshire	99284	$753.00
Oklahoma	99284	$1,076.00
Kansas	99284	$997.00
New Mexico	99284	$1,353.00
California	99284	$795.00
Pennsylvania	99284	$859.00
Arizona	99284	$1,265.00
Nevada	99284	$927.00

The Enterprise's Predicate Acts

175. To perpetuate the scheme and conceal it from the Health Care Providers, in or around 2018, Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

176. Under those contracts, Data iSight would handle claims determinations for services rendered to Defendants' Members under pre-agreed thresholds set by Defendants.

177. By no later than 2019, Defendants and Data iSight then coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including the Health Care Providers, in furtherance of the scheme.

178. These statements include Data iSight and its parent company posting that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

179. Data iSight communicated to the Health Care Providers' representatives by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United [HealthCare]."

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180. Finally, after weeks of pressure, Data iSight informed the Health Care Providers' representative by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

181. In short, the Enterprise perpetuated its scheme by communicating threats regarding reimbursement cuts to the Health Care Providers in late 2017 and 2018.

182. Then, after making good on those threats, the Enterprise communicated false and misleading information to the Health Care Providers and falsely denied that it had information requested by the Health Care Providers about the basis for the drastically-cut and unreasonable reimbursement rates that Defendants sought to impose.

183. In addition, since at least January 1, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to the Health Care Providers at rates that were far below usual and customary rates and/or reasonable rates for the services provided.

184. For example, Defendants sent Fremont, a Remittance for emergency services provided to Members under multiple procedure codes, including the following for CPT Codes 99284 and 99285:

d. Member #17 was treated on May 14, 2019 at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

e. Member #18 was treated on May 18, 2019, at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

f. Yet, Member #19 was treated on March 25, 2019, at a billed charge of $973.00 (CPT Code 99285), for which Defendants, via MultiPlan, allowed $875.00 which is 90% of billed charges. This a reasonable rate, in line with the reasonable rates historically paid by Defendants to Fremont for non-participating provider services.

g. Further, for professional services provided by Team Physicians between January and June 2019, Defendants allowed and approved payments ranging from $294.60 (27% of billed charges in the amount of $1,084.00) up to 100%, or $1,084.00.

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185. Defendants and Data iSight expected that those unreasonable payments would be accepted in full satisfaction of the Health Care Providers' claims.

186. Defendants and Data iSight have received, and continue to receive, financial gains from their scheme to defraud the Health Care Providers.

187. For the services that the Health Care Providers provided to Defendants' Members in 2019, only 13% of the non-participating claims have, to date, been reimbursed at reasonable rates, resulting in millions of dollars in financial loss to the Health Care Providers.

188. The purpose of, and the direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse the Health Care Providers at unreasonable rates, to the harm of the Health Care Providers, and to the benefit of the Enterprise.

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

189. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

190. At all material times, the Health Care Providers were obligated under federal and Nevada law to provide emergency medicine services to all patients presenting at the emergency departments they staff, including Defendants' Patients.

191. At all material times, Defendants were obligated to provide coverage for emergency medicine services to all of its Members.

192. At all material times, Defendants knew that the Health Care Providers were non-participating emergency medicine groups that provided emergency medicine services to Patients.

193. From July 1, 2017 to the present, Fremont has undertaken to provide emergency medicine services to UH Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients. And from prior to May 2015 to the present, Team Physicians and Ruby Crest have undertaken to provide emergency medicine services to UH

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Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients.

194. From approximately March 1, 2019 to the present Fremont has undertaken to provide emergency medicine services to the Sierra Affiliates' and HPN's Patients, and Sierra Affiliates and HPN have undertaken to pay for such services provided to their Patients. And from prior to May 2015 to the present, Team Physicians and Ruby Crest have undertaken to provide emergency medicine services to Sierra Affiliates' and HPN's Patients, and Sierra Affiliates and HPN have undertaken to pay for such services provided to their Patients.

195. At all material times, Defendants were aware that the Health Care Providers were entitled to and expected to be paid at rates in accordance with the standards established under Nevada law.

196. At all material times, Defendants have received the Health Care Providers' bills for the emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' Patients, and Defendants have consistently adjudicated and paid, and continue to adjudicate and pay, the Health Care Providers directly for the non-participating claims, albeit at amounts less than usual and customary.

197. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by the Health Care Providers to Defendants' Patients, the parties implicitly agreed, and the Health Care Providers had a reasonable expectation and understanding, that Defendants would reimburse the Health Care Providers for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates Defendants pay for other substantially identical claims also submitted by the Health Care Providers.

198. Under Nevada common law, including the doctrine of quantum meruit, the Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at rates, at a minimum, equivalent to the reasonable value of the professional emergency medical services provided by the Health Care Providers.

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199. Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to the Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at rates, at a minimum, equivalent to the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services provided by the Health Care Providers.

200. In breach of its implied contract with the Health Care Providers, Defendants have and continue to unreasonably and systemically adjudicate the non-participating claims at rates substantially below both the usual and customary fees in the geographic area and the reasonable value of the professional emergency medical services provided by the Health Care Providers to the Defendants' Patients.

201. The Health Care Providers have performed all obligations under the implied contract with the Defendants concerning emergency medical services to be performed for Patients.

202. At all material times, all conditions precedent have occurred that were necessary for Defendants to perform their obligations under their implied contract to pay the Health Care Providers for the non-participating claims, at a minimum, based upon the "usual and customary fees in that locality" or the reasonable value of the Health Care Providers' professional emergency medicine services

203. The Health Care Providers did not agree that the lower reimbursement rates paid by Defendants were reasonable or sufficient to compensate the Health Care Providers for the emergency medical services provided to Patients.

204. The Health Care Providers have suffered damages in an amount equal to the difference between the amounts paid by Defendants and the usual and customary fees professional emergency medicine services in the same locality, that remain unpaid by Defendants through the date of trial, plus the Health Care Providers' loss of use of that money; or in an amount equal to the difference between the amounts paid by Defendants and the reasonable value of their professional emergency medicine services, that remain unpaid by the Defendants through the date of trial, plus the Health Care Providers' loss of use of that money.

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205. As a result of the Defendants' breach of the implied contract to pay the Health Care Providers for the non-participating claims at the rates required by Nevada law, the Health Care Providers have suffered injury and is entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

206. The Health Care Providers have been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

SECOND CLAIM FOR RELIEF

(Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing)

207. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

208. The Health Care Providers and Defendants had a valid implied-in-fact contract as alleged herein.

209. A special element of reliance or trust between the Health Care Providers and the Defendants, such that, Defendants were in a superior or entrusted position of knowledge.

210. That the Health Care Providers performed all or substantially all of their obligations pursuant to the implied-in-fact contract.

211. By paying substantially low rates that did not reasonably compensate the Health Care Providers the usual and customary rate or alternatively for the reasonable value of the services provide, Defendants performed in a manner that was unfaithful to the purpose of the implied-in-fact contract, or deliberately contravened the intention and sprit of the contract.

212. That Defendants' conduct was a substantial factor in causing damage to Fremont.

213. As a result of Defendants' tortious breach of the implied covenant of good faith and fair dealing, the Health Care Providers have suffered injury and is entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

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214. The acts and omissions of Defendants as alleged herein were attended by circumstances of malice, oppression and/or fraud, thereby justifying an award of punitive or exemplary damages in an amount to be proven at trial.

215. The Health Care Providers have been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

216. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

217. The Health Care Providers rendered valuable emergency services to the Patients.

218. Defendants received the benefit of having their healthcare obligations to their plan members discharged and their members received the benefit of the emergency care provided to them by the Health Care Providers.

219. As insurers or plan administrators, Defendants were reasonably notified that emergency medicine service providers such as the Health Care Providers would expect to be paid by Defendants for the emergency services provided to Patients.

220. Defendants accepted and retained the benefit of the services provided by the Health Care Providers at the request of the members of its Health Plans, knowing that the Health Care Providers expected to be paid a usual and customary fee based on locality, or alternatively for the reasonable value of services provided, for the medically necessary, covered emergency medicine services it performed for Defendants' Patients.

221. Defendants have received a benefit from the Health Care Providers' provision of services to its Patients and the resulting discharge of their healthcare obligations owed to their Patients.

222. Under the circumstances set forth above, it is unjust and inequitable for Defendants to retain the benefit they received without paying the value of that benefit; i.e., by paying the Health Care Providers at usual and customary rates, or alternatively for the reasonable value of services provided, for the claims that are the subject of this action and for all

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emergency medicine services that the Health Care Providers will continue to provide to Defendants' Members.

223. The Health Care Providers seek compensatory damages in an amount which will continue to accrue through the date of trial as a result of Defendants' continuing unjust enrichment.

224. As a result of the Defendants' actions, the Health Care Providers have been damaged in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

225. The Health Care Providers sue for the damages caused by the Defendants' conduct and is entitled to recover the difference between the amount the Defendants' paid for emergency care the Health Care Providers rendered to its members and the reasonable value of the service that the Health Care Providers rendered to Defendants by discharging their obligations to their plan members.

226. As a direct result of the Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FOURTH CLAIM FOR RELIEF

(Violation of NRS 686A.020 and 686A.310)

227. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

228. The Nevada Insurance Code prohibits an insurer from engaging in an unfair settlement practices. NRS 686A.020, 686A.310.

229. One prohibited unfair claim settlement practice is "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e).

230. As detailed above, Defendants have failed to comply with NRS 686A.310(1)(e) by failing to pay the Health Care Providers' medical professionals the usual and customary rate

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for emergency care provided to Defendants' members. By failing to pay the Health Care Providers' medical professionals the usual and customary rate Defendants have violated NRS 686A.310(1)(e) and committed an unfair settlement practice.

231. The Health Care Providers are therefore entitled to recover the difference between the amount Defendants paid for emergency care the Health Care Providers rendered to their members and the usual and customary rate, plus court costs and attorneys' fees.

232. The Health Care Providers are entitled to damages in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

233. Defendants have acted in bad faith regarding their obligation to pay the usual and customary fee; therefore, the Health Care Providers are entitled to recover punitive damages against Defendants.

234. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FIFTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations)

235. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

236. The Nevada Insurance Code requires an HMO, MCO or other health insurer to pay a healthcare provider's claim within 30 days of receipt of a claim. NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO), NAC 686A.675 (all insurers) (collectively, the "NV Prompt Pay Laws"). Thus, for all submitted claims, Defendants were obligated to pay the Health Care Providers the usual and customary rate within 30 days of receipt of the claim.

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237. Despite this obligation, as alleged herein, Defendants have failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of the submission of the claim. Indeed, Defendants failed to reimburse the Health Care Providers at the usual and customary rate at all. Because Defendants have failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of submission of the claims as the Nevada Insurance Code requires, Defendants are liable to the Health Care Providers for statutory penalties.

238. For all claims payable by plans that Defendants insure wherein it failed to pay at the usual and customary fee within 30 days, Defendants are liable to the Health Care Providers for penalties as provided for in the Nevada Insurance Code.

239. Additionally, Defendants have violated NV Prompt Pay Laws, by among things, only paying part of the subject claims that have been approved and are fully payable.

240. The Health Care Providers seek penalties payable to it for late-paid and partially paid claims under the NV Prompt Pay Laws.

241. The Health Care Providers are entitled to damages in an amount in excess of $15,000.00 to be determined at trial, including for its loss of the use of the money and its attorneys' fees.

242. Under the Nevada Insurance Code and NV Prompt Pay Laws, the Health Care Providers are also entitled to recover their reasonable attorneys' fees and costs.

SIXTH CLAIM FOR RELIEF

(Consumer Fraud & Deceptive Trade Practices Acts)

243. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

244. The Nevada Deceptive Trade Practices Act (DTPA) prohibits the UH Parties from engaging in "deceptive trade practices," including but not limited to (1) knowingly making a false representation in a transaction; (2) violating "a state or federal statute or regulation relating to the sale or lease of goods or services"; (3) using "coercion, duress or intimidation in a

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transaction"; and (4) knowingly misrepresent the "legal rights, obligations or remedies of a party to a transaction." NRS 598.0915(15), 598.0923(3), 598.0923(4), NRS 598.092(8), respectively.

245. The Nevada Consumer Fraud Statute provides that a legal action "may be brought by any person who is a victim of consumer fraud." NRS 41.600(1). "Consumer fraud" includes a deceptive trade practice as defined by the DTPA.

246. Defendants have violated the DTPA and the Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services; and (b) engaging in systematic efforts to delay adjudication and payment of the Health Care Providers' claims for its services provided to UH Parties' members in violation of their legal obligations

247. As a result of Defendants' violations of the DTPA and the Consumer Fraud Statute, the Health Care Providers are entitled to damages in an amount in excess of $15,000.00 to be determined at trial.

248. Due to the willful and knowing engagement in deceptive trade practices, the Health Care Providers are entitled to recover treble damages and all profits derived from the knowing and willful violation.

249. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

SEVENTH CLAIM FOR RELIEF

(Declaratory Judgment)

250. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

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251. This is a claim for declaratory judgment and actual damages pursuant to NRS 30.010 *et seq.*

252. As explained above, pursuant to federal and Nevada law, Defendants are required to cover and pay the Health Care Providers for the medically necessary, covered emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' members.

253. Under Nevada law, Defendants are required to pay the Health Care Providers the usual and customary rate for that emergency care. Instead of reimbursing the Health Care Providers at the usual and customary rate or for the reasonable value of the professional medical services, Defendants have reimbursed them at reduced rates with no relation to the usual and customary rate.

254. Beginning in or about July 2017, Fremont became out-of-network with the UH Parties; and Team Physicians and Ruby Crest have never been in-network with the UH Parties. Since then, the UH Parties have demonstrated their refusal to timely settle insurance claims submitted by the Health Care Providers and have failed to pay the usual and customary rate based on this locality in violation of UH Parties' obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

255. Beginning in or about March 2019, Fremont became out-of-network with the Sierra Affiliates and HPN and Physicians and Ruby Crest have never been in-network with the Sierra Affiliates or HPN. Upon information and belief, the Sierra Affiliates and HPN are failing to timely settle insurance claims submitted by the Health Care Providers and to pay the usual and customary rate based on this locality in violation of the Sierra Affiliates' and HPN's obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

256. An actual, justiciable controversy therefore exists between the parties regarding the rate of payment for the Health Care Providers' emergency care that is the usual and customary rate that Defendants are obligated to pay.

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257. Pursuant to NRS 30.040 and 30.050, the Health Care Providers therefore request a declaration establishing the usual and customary rates that they are entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the UH Parties are required to pay to the Health Care Providers at a usual and customary rate for claims submitted thereafter.

258. Pursuant to NRS 30.040 and 30.050, Team Physicians and Ruby Crest therefore request a declaration establishing the usual and customary rates that they are entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the Sierra Affiliates and HPN are required to pay to Team Physicians and Ruby Crest at a usual and customary rate for claims submitted thereafter.

259. Pursuant to NRS 30.040 and 30.050, Fremont therefore request a declaration establishing the usual and customary rates that Fremont is entitled to receive for claims between March 1, 2019 and trial, as well as a declaration that the Sierra Affiliates and HPN are required to pay to Fremont at a usual and customary rate for claims submitted thereafter.

260. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

EIGHTH CLAIM FOR RELIEF

(Violation of NRS 207.350 *et seq.*)

261. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

262. Nevada RICO allows a private cause of action for racketeering. NRS 207.470 provides in pertinent part that:

> Any person who is injured in his or her business or property by reason of any violation of NRS 207.400 has a cause of action against a person causing such injury for three times the actual damages sustained. An injured person may also recover attorney's fees in the trial and appellate courts and costs of investigation and litigation reasonably incurred.

263. This claim arises under NRS 207.400(b), (c), (d) and (j).

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264. The Defendants committed the following crimes of racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude).

265. The Defendants engaged in racketeering enterprises as defined by NRS 207.380 involving their fraudulent misrepresentations to the Health Care Providers, and failing to pay and retaining significant sums of money that should have been paid to them for emergency medicine services provided to the Defendants' Members, but instead were directed to themselves and/or Data iSight.

266. As set forth above, since at least January 2019, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of NRS 207.380, comprised of at least Defendants and Data iSight, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce and/or committed preparatory acts in furtherance thereof.

267. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

268. Defendants and Data iSight had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding the Health Care Providers and preventing them from obtaining reasonable payment for the services they provided to Defendants' Members, in retaliation for the Health Care Providers' lawful refusal to agree to Defendants' massively discounted and unreasonable proposed contractual rates.

269. Since at least January 2019, the Defendants, have been and continue to be, engaged in preparations and implementation of a scheme to defraud the Health Care Providers by committing a series of unlawful acts designed to obtain a financial benefit by means of false or fraudulent pretenses, representations, promises or material omissions which constitute predicate unlawful activity under NRS 207.390 involving multiple instances of obtaining possession of money or property valued at $650 or more; multiple transactions involving fraud or deceit in course of enterprise or occupation and involuntary servitude in violation of NRS

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200.463. The Defendants have engaged in more than two related and continuous acts amounting to racketeering activity in violation of NRS 207.400(1)(a)-(d), (1)(f), (1)(h)-(i) pursuant to a scheme or artifice to defraud and to which the Defendants have committed for financial benefit and gain to the detriment of the Health Care Providers. The Defendants, on more than two occasions, have schemed with Data iSight to artificially and, without foundation, substantially decrease non-participating provider reimbursement rates while continuing to represent that the reimbursement rates are based on legitimate cost data or paid data.

270. The foregoing acts establish racketeering activity and are related to each other in that they further the joint goal of unfairly and illegally retaining financial benefit to the detriment of the Health Care Providers. In each of the examples provided herein, the acts alleged to establish a pattern of unlawful activity are related because they have the same or similar pattern, intents, results, accomplices, victims or methods of commission, or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.

271. Each Defendant provides benefits to insured members, processes claims for services provided to members, and/or issues payments for services and knows and willingly participates in the scheme to defraud the Health Care Providers.

272. As a direct and proximate result of Defendants' violations of NRS 207.360(28), (35) and (36), the Health Care Providers have sustained a reasonably foreseeable injury in their business or property by a pattern of racketeering activity, suffering substantial financial losses, in an amount to be proven at trial, in violation of NRS 207.470.

273. Pursuant to NRS 207.470, the Health Care Providers are entitled to damages for three times the actual damages sustained, recovery of attorneys' fees in the trial and appellate courts and costs of investigation and litigation reasonably incurred.

REQUEST FOR RELIEF

WHEREFORE, the Health Care Providers request the following relief:

A. For awards of general and special damages in amounts in excess of $15,000.00, the exact amounts of which will be proven at trial;

B. Judgment in their favor on the First Amended Complaint;

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C. Awards of actual, consequential, general, and special damages in an amount in excess of $15,000.00, the exact amounts of which will be proven at trial;

D. An award of punitive damages, the exact amount of which will be proven at trial;

E. A declaratory judgment that Defendants' failure to pay the Health Care Providers a usual and customary fee or rate for this locality or alternatively, for the reasonable value of their services violates the Nevada law, breaches the parties' implied-in-fact contract, is a tortious breach of the implied covenant of good faith and fair dealing, and violates Nevada common law;

F. An order permanently enjoining Defendants from paying rates that do not represent usual and customary fees or rates for this locality or alternatively, that do not compensate the Health Care Providers for the reasonable value of their services; and enjoining Defendants and enjoining Defendants from engaging in acts or omissions that are violative of Nevada law;

G. Judgment against the Defendants and in favor of the Health Care Providers pursuant to the Eighth Claim for Relief in an amount constituting treble damages resulting from Defendants' underpayments to the Health Care Providers for the reasonable value of the emergency services provided to Defendants' Members and reasonable attorneys' fees and costs incurred in bringing this action;

H. The Health Care Providers costs and reasonable attorneys' fees pursuant to NRS 207.470;

I. Reasonable attorneys' fees and court costs;

J. Pre-judgment and post-judgment interest at the highest rates permitted by law; and

K. Such other and further relief as the Court may deem just and proper.

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JURY DEMAND

The Health Care Providers hereby demand trial by jury on all issues so triable.

DATED this 7th day of January, 2020.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 7th day of January, 2020, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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/s/ *Marianne Carter*
An employee of McDonald Carano LLP

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EXHIBIT 9

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

EMERGENCY SERVICES OF OKLAHOMA, PC, OKLAHOMA EMERGENCY SERVICES, PC, SOUTH CENTRAL EMERGENCY SERVICES, PC, and EMERGENCY PHYSICIANS OF MID-AMERICA, P.C.,	)	
Plaintiffs,	)	
vs.	)	No. CJ-2019-487
UNITED HEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES, INC., and UNITED HEALTHCARE OF OKLAHOMA, INC.,	)	
Defendants.	)	

PLAINTIFFS' ORIGINAL PETITION

COME NOW Plaintiffs Emergency Services of Oklahoma, P.C., Oklahoma Emergency Services, P.C., South Central Emergency Services, P.C., and Emergency Physicians of Mid-America, P.C., by and through the undersigned counsel, and file this Original Petition against Defendants United HealthCare Insurance Company, United HealthCare Services, Inc., and United HealthCare of Oklahoma, Inc. (collectively, "Defendants" or the "Insurance Companies") and allege as follows:

INTRODUCTION

1. Plaintiffs Emergency Services of Oklahoma, P.C., Oklahoma Emergency Services, P.C., South Central Emergency Services, P.C., and Emergency Physicians of Mid-America, P.C. (collectively, "Plaintiffs" or the "Plaintiff Doctors") are four groups of physicians who provide emergency care to thousands of citizens of Oklahoma. Unlike most other physicians, who generally have the ability to choose the patients that they treat, these doctors do not. By necessity and under compulsion of federal law, Plaintiff Doctors are obligated to treat all patients who require emergency services. In recognition of the nature and critical importance of these services, Oklahoma law requires health insurers to compensate emergency medicine physicians at reasonable rates, whether or not the doctors are part of the insurers' preferred provider networks. Reasonable compensation is essential to permit Plaintiff Doctors to continue to provide high-quality emergency services and to attract and retain physicians who are willing to work long hours under great stress in order to perform life-saving medical services in otherwise underserved areas of Oklahoma.

2. The Insurance Companies historically have compensated Plaintiff Doctors at more reasonable rates, as required under Oklahoma law. In recent years, however, the Insurance Companies began slashing the rates at which they paid Plaintiff Doctors for their emergency services. The Insurance Companies began paying some of the claims for emergency services rendered by Plaintiff Doctors at rates that are substantially below the historic levels for the same services and significantly below the rates at which the Insurance Companies continued to pay other substantially identical claims.

3. One explanation for this disparity is that the Insurance Companies are reimbursing Plaintiff Doctors for services provided to members of the plans they fully underwrite at

significantly lower rates than they are reimbursing Plaintiff Doctors for services provided to members of the employer-funded plans for which the Insurance Companies only provide administrative services.

4. This action seeks damages for the Insurance Companies' violations of Oklahoma law and to compel the Insurance Companies to abide by Oklahoma law with respect to payment of future claims.

PARTIES

5. Plaintiff Emergency Services of Oklahoma, P.C. is a professional emergency medicine services group practice that staffs the emergency departments at Norman Regional Hospital in Norman, AllianceHealth Deaconess Hospital in Oklahoma City, AllianceHealth Ponca City in Ponca City, Alliance Health Woodward in Woodward, Integris Canadian Valley Hospital in Yukon, Integris Grove General Hospital in Grove, Integris Southwest Medical Center in Oklahoma City, Heart Hospital North Campus in Oklahoma City, Oklahoma Heart Hospital South Campus in Oklahoma City, and St. Mary's Regional Medical Center in Enid.

6. Plaintiff Oklahoma Emergency Services, P.C. is a professional emergency medicine services group practice that staffs the emergency departments at Comanche County Memorial Hospital in Lawton and McBride Clinic Orthopedic Hospital in Oklahoma City.

7. Plaintiff South Central Emergency Services, P.C. is a professional emergency medicine services group practice that staffs the emergency departments at Duncan Regional Hospital in Duncan, Integris Baptist Regional Health in Miami, Integris Health Edmond in Edmond, and Stillwater Medical Center in Stillwater.

8. Plaintiff Emergency Physicians of Mid-America, P.C. is a professional emergency medicine services group practice that staffs the emergency departments at McAlester Regional

Health Center in McAlester, St. Anthony Healthplex East in Oklahoma City, St. Anthony Healthplex Mustang Medical Center in Mustang, St. Anthony Healthplex North Medical Center in Oklahoma City, St. Anthony Healthplex South in Oklahoma City, St. Anthony Hospital in Oklahoma City, and St. Anthony Shawnee Hospital in Shawnee.

9. Defendant United HealthCare Insurance Company is a Connecticut corporation with its principal place of business in Connecticut. United HealthCare Insurance Company is responsible for paying for certain of the emergency medical services at issue in this Petition. On information and belief, United HealthCare Insurance Company is a licensed Oklahoma health insurance company.

10. Defendant United HealthCare Services, Inc., is a Minnesota corporation with its principal place of business in Connecticut. United HealthCare Services, Inc. is responsible for paying for certain of the emergency medical services at issue in this Petition. On information and belief, United HealthCare Services, Inc., is a licensed Oklahoma health insurance company.

11. Defendant United HealthCare of Oklahoma, Inc., is an Oklahoma corporation with a principal place of business in Tulsa, Oklahoma. United HealthCare of Oklahoma, Inc., is responsible for paying for certain of the emergency medical services at issue in this Petition. On information and belief, United HealthCare of Oklahoma, Inc., is a licensed Oklahoma health insurance company.

JURISDICTION & VENUE

12. Jurisdiction is proper pursuant to Okla. Stat. tit. 12, § 2004(F).

13. Venue is proper pursuant to Okla. Stat. tit. 12, § 137 because a significant number of the services that form the basis of the Plaintiff Doctors' claims were performed in Cleveland County.

14. The Insurance Companies are subject to personal jurisdiction in this state because they have entered into contracts to provide insurance to Oklahoma residents and conduct business in this State.

15. Pursuant to Okla. Stat. tit. 12, § 2008, Plaintiff Doctors assert they seek damages in excess of the amount required for diversity jurisdiction pursuant to 28 U.S.C. § 1332.

FACTS

The Plaintiffs Provide Necessary Emergency Care

16. This is an action for damages stemming from the Insurance Companies' failure to properly reimburse Plaintiff Doctors for emergency services provided to members of the Insurance Companies' health plans.[1]

17. Plaintiff Doctors are emergency medicine physicians who staff emergency departments 24 hours a day, 7 days a week. Plaintiff Doctors provide emergency department coverage at 23 emergency departments in Oklahoma.

[1] Plaintiff Doctors do not assert any cause of action with respect to any patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). Thus, there is no basis to remove this lawsuit to federal court under federal question jurisdiction. Plaintiff Doctors also do not assert any claims relating to the Insurance Companies' Managed Medicare business. As explained below, upon entry of an appearance by counsel for the Insurance Companies, Plaintiff Doctors will serve, via encrypted transmission, a list of the individual healthcare claims at issue in this litigation. To the extent that list contains any healthcare claims relating to Managed Medicare, FEHBA, or Managed Medicaid business, Plaintiff Doctors will remove them upon notice by the Insurance Companies.

18. As providers of emergency medical care, Plaintiff Doctors have made a commitment to providing emergency medical services to all patients, regardless of insurance coverage or ability to pay, including to patients with insurance coverage issued or underwritten by the Insurance Companies.

19. This philosophy is reflected in the federal Emergency Medical Treatment and Labor Act ("EMTALA"), which requires emergency room physicians to evaluate, stabilize, and treat all patients, regardless of their insurance status or ability to pay. *See* EMTALA, 42 U.S.C. § 1395dd.

20. EMTALA is one of the central sources of patient protection in the United States healthcare system.

21. However, EMTALA also places a financial burden on emergency medicine physicians, many of whom also adhere to grueling schedules and live in or commute to far-flung locations in order to ensure patients' access to emergency care.

22. Emergency medicine physicians represent 4% of physicians in this country but provide 67% of unreimbursed care.

23. On average, an Emergency medicine physician provides almost $140,000 of charity care every year, and a third of emergency physicians provide more than 30 hours of charity care each week.

24. Almost 1 in 5 emergency patients has no ability to pay, and 3 out of 4 emergency room visits are reimbursed below cost.

25. In recognition of the challenges unique to the practice of emergency medicine, Oklahoma law affords emergency medicine physicians certain protections.

26. Plaintiff Doctors' claims fall into two categories: (1) claims subject to Oklahoma law governing health maintenance organizations ("HMOs"), and (2) other claims not subject to

Oklahoma law governing HMOs. For the purposes of this Petition, these claims are collectively referred to as the "Non-Participating Claims" and sometimes are separately referred to as the "Non-Participating HMO Claims" and "Other Non-Participating Claims."

27. For the Non-Participating HMO claims, Oklahoma law requires the Insurance Companies to reimburse Plaintiffs doctors, at a minimum, at the "prevailing charges" in the geographic area where Plaintiff Doctors provide their services. *See* Okla. Stat. tit. 36, § 6571(A)(2); Okla. Admin. Code 365:40-5-123(e)(l).

28. For the Other Non-Participating Claims, Oklahoma law requires the Insurance Companies to reimburse Plaintiff Doctors at rates, at a minimum, equivalent to the reasonable value of Plaintiff Doctors' services.

29. These guarantees are imperative to ensuring that emergency medicine physicians remain able to offer high quality services to Oklahoma residents. They account for the expenses associated with emergency medicine physicians' education and continued training and incentivize emergency medicine physicians to move to underserved areas, ensuring that emergency medical services are available across the state.

The Insurance Companies Underpaid the Plaintiffs for Emergency Services

30. The Insurance Companies are national managed care organizations that underwrite, operate and administer Health Plans, including HMOs, in Oklahoma.

31. In exchange for premiums and/or fees or other compensation, the Insurance Companies pay for health care services rendered to their members, including the emergency medicine services Plaintiff Doctors have provided and continue to provide to the Insurance Companies' members.

32. In spite of the essential role emergency medicine physicians such as Plaintiff Doctors play in the United States healthcare system, the Insurance Companies have refused to offer sustainable provider contracts to Plaintiff Doctors.

33. Because there is no contract between the Insurance Companies and any of Plaintiff Doctors for the healthcare claims at issue in this litigation, Plaintiff Doctors are designated as "non-participating" or "out-of-network" for all of the claims at issue in this litigation.

34. Because Plaintiff Doctors did not participate in the Insurance Companies' provider network, there was no agreed rate. The Insurance Companies are therefore obligated to reimburse Plaintiff Doctors at the "prevailing charges" in the geographic area where Plaintiff Doctors provide their services or at rates, at a minimum, equivalent to the reasonable value of Plaintiff Doctors' services.

35. Oklahoma law requires that, for the Non-Participating HMO Claims, the Insurance Companies are required to give notice to providers such as Plaintiffs that they "shall bill" the Insurance Companies "directly" for reimbursement claims arising from Plaintiffs' treatment of the Insurance Companies' members.

36. At all material times, the Plaintiffs have billed the Insurance Companies directly for their Non- Participating Claims arising from Plaintiffs' treatment of the Insurance Companies' members.

37. The Insurance Companies have received and accepted Plaintiffs' bills for the emergency medicine services Plaintiffs have provided and continue to provide to the Insurance Companies' members. The Insurance Companies have consistently adjudicated and paid, and continue to adjudicate and pay, the Plaintiffs directly for the Non-Participating Claims, albeit at amounts less than that required by Oklahoma law.

38. By assuming responsibility for paying for the emergency medical services provided to the Insurance Companies' patients, the Insurance Companies are both obligated under Oklahoma law, and have impliedly agreed, to reimburse Plaintiffs at rates in accordance with the standards established by Oklahoma law.

39. Despite not participating in the Insurance Companies' provider network for the time at issue, Plaintiff Doctors regularly provide emergency services to the Insurance Companies' health plan enrollees.

40. From January 2016 to September 2018, Plaintiff Doctors have provided emergency medical services to thousands of the Insurance Companies' health plan enrollees.

41. The Insurance Companies' members have received a wide variety of emergency services (in some instances, life-saving services) from Plaintiff Doctors, including treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric distress and obstetrical distress

42. In recent years, the Insurance Companies have continuously decreased their reimbursements to Plaintiff Doctors for services provided to certain of their members.

43. These new reimbursement levels were significantly less than the rates called for by Oklahoma law.

44. From January 2016 to September 2018, Plaintiff Doctors have identified more than 7,000 emergency service claims that the Insurance Companies paid at unacceptably low rates.

45. The total underpayment amount for these claims is in excess of $3.8 million.

46. As stated in ¶ 42, the Insurance Companies are reimbursing Plaintiff Doctors at unacceptably low rates for services provided to some of their members. They continue to reimburse Plaintiff Doctors at more reasonable rates for services provided to other of their members. The

result is that the Insurance Companies are reimbursing Plaintiff Doctors at drastically different rates for essentially the same services, provided at the same facility, to different members.

47. Upon information and belief, the Insurance Companies generally are paying the lower reimbursement rates for services provided to their fully insured members and the higher reimbursement rates for services provided to members of their administrative services only or self-insured plans.

48. Put differently, when their own money is at stake, rather than the money of one of their employer clients, the Insurance Companies pay the lower rate.

49. For each of the healthcare claims at issue, the Insurance Companies determined the claim to be payable; however, they paid at an arbitrarily reduced rate. Thus, the claims at issue involve no questions of whether the claim is payable; rather, they involve only the issue of whether the Insurance Companies paid the claim at the rate required by Oklahoma law. (They did not.)

50. Okla. Stat. tit. 36, § 6571 (A)(2) requires that "any insurer which . . . makes a determination or contracts with a third party who makes the determination of average area charges or customary and reasonable charges for health care services, procedures or supplies; and . . . based on such determination, authorizes payment in an amount which is less than the amount charged by the health care provider for such services, procedures or supplies . . . shall, upon the request of a health care provider, furnish the name, mailing address and telephone number of the party making the determination to the health care provider." Okla. Stat. tit. 36, § 6571 (A)(2).

51. Okla. Admin. Code 365:40-5-123(e)(2) requires that "[i]f an HMO uses reasonable and customary charge determinations to authorize settlements, it shall: . . . [f]urnish or arrange to furnish the rationale and data sources for a determination, within ten (10) days after receipt of a provider's request for this information and for no more than a nominal copying fee."

52. On February 4, 2019, Plaintiff Doctors sent a letter to the Insurance Companies formally requesting that the Insurance Companies provide Plaintiffs with the rationale and data sources for their determination of the rates they pay. Despite their obligation under Oklahoma law, pursuant to Okla. Stat. tit. 36, § 6571(A)(2) and Okla. Admin. Code 365:40-5-123(e)(2), to provide precisely that information to a provider within 10 days upon request, the Insurance Companies have failed to do so.

53. In withholding from the Plaintiff Doctors what rationale, if any, they hav for the arbitrarily low rates they have and continue to pay the Plaintiff Doctors for their Non-Participating Claims, and the identity of the decision maker, the Insurance Companies are violating their express statutory and regulatory obligations under Oklahoma law.

54. The Insurance Companies have failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

55. Plaintiff Doctors bring this action to collect damages due to the Insurance Companies' failure to comply with Oklahoma law and to compel the Insurance Companies to pay them the rates required by Oklahoma law for the emergency services that Plaintiff Doctors provided to their members.

56. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

COUNT I

Violation of Oklahoma Clean Claim Reimbursement Laws

57. Plaintiff Doctors re-allege and restate the preceding paragraphs as if they were fully set forth herein.

58. The Insurance Companies, which include, an Oklahoma-licensed HMO, must comply with the requirements of Oklahoma law with respect to the Insurance Companies'

reimbursement of clean claims submitted by health care providers, including the Plaintiff Doctors, as set forth in Oklahoma's prompt pay law, Title 36 of the Oklahoma statutes, and the regulations promulgated thereunder ("Clean Claim Reimbursement Laws"). *See* Okla. Stat. tit. 36, § 1219; Okla. Stat. tit 36, § 6571; Okla. Admin. Code 365:40-5-120 *et seq.*

59. Oklahoma law affords the Plaintiff Doctors a private right of action against the Insurance Companies for disputes arising from violations of the Clean Claim Reimbursement Laws, and further permits a prevailing provider to recover simple interest at the rate of percent (10%) per year and reasonable attorney's fees. Okla. Stat. tit. 36, § 1219(F)-(G).

60. Oklahoma's Clean Claim Reimbursement Laws require that the Insurance Companies provide the Plaintiff Doctors with notice that they shall bill the Insurance Companies directly for the Non-Participating HMO Claims. Okla. Admin. Code 365:40-5-123(c)(2).

61. Oklahoma's Clean Claim Reimbursement Laws require that the Insurance Companies, in authorizing payment of "reasonable and customary charges" to Plaintiff Doctors for the Non-Participating HMO Claims, must base such determinations on "prevailing charges" in the geographic area where the services were provided, and provide the data and rationale for those determinations to Plaintiff Doctors, upon request. Okla. Admin. Code 365:40-5-123(e)(l)(2).

62. On information and belief, based upon their own determination of "reasonable and customary charges," the Insurance Companies authorized payment to Plaintiff Doctors for the Non-Participating HMO Claims at amounts less than the amounts charged by Plaintiff Doctors for their services.

63. From January 2016 through September 2018, the Insurance Companies have paid, and continue to pay, Plaintiff Doctors for the Non-Participating HMO Claims at amounts substantially less than the "prevailing charges" in Plaintiff Doctors' respective geographic areas.

64. Despite Plaintiff Doctors' request for the information used for the Insurance Companies' determinations of the rates they have paid Plaintiff Doctors on the Non-Participating HMO Claims, the Insurance Companies have failed and refused to provide Plaintiff Doctors with the data and information required by Oklahoma's Clean Claim Reimbursement Laws.

65. The Insurance Companies' failure and refusal to reimburse Plaintiff Doctors for their Non- Participating HMO Claims at rates, at a minimum, equivalent to the "prevailing charges" in the geographic area where the services are provided, and the Insurance Companies' failure and refusal to furnish to Plaintiff Doctors the information supporting the Insurance Companies' rates of reimbursement both constitute violations of their obligations under Oklahoma's Clean Claim Reimbursement Laws.

66. As a result of the Insurance Companies' violations of Oklahoma's Clean Claim Reimbursement Laws, Plaintiff Doctors have suffered injury and are entitled to monetary damages from the Insurance Companies to compensate them for that injury in an amount equal to the difference between the amounts allowed as payable by the Insurance Companies and the prevailing charges for professional emergency medicine services in the same geographic area, plus interest at the statutory rate and attorney's fees.

COUNT II

Breach of Implied-in-Fact Contract

67. Plaintiff Doctors re-allege and restate the preceding paragraphs as if they were fully set forth herein.

68. At all material times, Plaintiff Doctors were obligated under federal law to provide emergency medicine services to all patients presenting at the emergency departments they staff, including the Insurance Companies' members.

69. At all material times, the Insurance Companies knew that Plaintiff Doctors were non-participating emergency medicine groups that provided emergency medicine services to their members.

70. From January 2016 to September 2018, Plaintiff Doctors have undertaken to provide emergency medicine services to the Insurance Companies' members, and the Insurance Companies have undertaken to pay for such services provided to the Insurance Companies' members.

71. Oklahoma law requires that, for the Non-Participating HMO Claims, the Insurance Companies shall give notice to non-participating providers such as Plaintiff Doctors that they "shall bill" the Insurance Companies "directly" for reimbursement claims arising from Plaintiff Doctors' treatment of the Insurance Companies' members. Okla. Admin. Code 365:40-5-123(c)(2).

72. At all material times, the Insurance Companies were aware that Plaintiff Doctors were entitled to and expected to be paid at rates in accordance with the standards established under Oklahoma law.

73. At all material times, Plaintiff Doctors have "directly" billed the Insurance Companies for the Non-Participating Claims[2] arising from the emergency medical services Plaintiff Doctors render to the Insurance Companies' members, based on the Insurance Companies' implied agreement to reimburse Plaintiff Doctors for those services at rates that complied with Oklahoma law.

[2] A list of the specific healthcare claims that the Insurance Companies have underpaid will be provided to the Insurance Companies by secure encrypted transmission upon entry of an appearance. The Insurance Companies' systemic underpayment of Plaintiff Doctors' claims is ongoing, and the doctors reserve the right to add additional healthcare claims as those claims are identified or accrue.

74. At all material times, the Insurance Companies have received Plaintiff Doctors' bills for the emergency medicine services Plaintiff Doctors have provided and continue to provide to the Insurance Companies' members.

75. The Insurance Companies have consistently adjudicated and paid, and continue to adjudicate and pay, the Plaintiff Doctors directly for the Non-Participating Claims, albeit at amounts less than that required by Oklahoma law.

76. At all material times, Plaintiff Doctors were not parties to participation agreements with the Insurance Companies and did not agree to accept discounted rates from the Insurance Companies or to be bound by the Insurance Companies' reimbursement policies or rate schedules with respect to any of the Non-Participating Claims for emergency medical services Plaintiff Doctors rendered to the Insurance Companies' members.

77. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by Plaintiff Doctors to the Insurance Companies' members, the parties implicitly agreed, and Plaintiff Doctors had a reasonable expectation and understanding, that the Insurance Companies would reimburse Plaintiff Doctors for Non-Participating Claims at rates in accordance with the standards established under Oklahoma law.

78. Under Okla. Stat. tit. 36, § 6571(A)(2) and Okla. Admin. Code 365:40-5-123(e)(l), the Insurance Companies, in issuing payment on the Non-Participating HMO Claims to Plaintiff Doctors in an amount less than Plaintiff Doctors' charges for their services rendered to the Insurance Companies' members, represented to Plaintiff Doctors and agreed that the rates the Insurance Companies would pay were, at a minimum, equivalent to the "prevailing charges" for emergency medicine services in the geographic area where they were provided.

79. Under Oklahoma common law, including the doctrine of *quantum meruit,* the Insurance Companies, by undertaking responsibility for payment to Plaintiff Doctors for the services rendered to the Insurance Companies' members, impliedly agreed to reimburse Plaintiff Doctors at rates, at a minimum, equivalent to the reasonable value of the professional emergency medical services provided by Plaintiff Doctors.

80. In breach of their implied contract with Plaintiff Doctors, the Insurance Companies have and continue to systemically adjudicate the Non-Participating Claims at rates substantially below both the prevailing charges in the geographic area and the reasonable value of the professional emergency medical services provided by Plaintiff Doctors to the Insurance Companies' members.

81. Each of Plaintiff Doctors has performed all obligations under its implied contract with the Insurance Companies concerning emergency medical services to be performed for members.

82. At all material times, all conditions precedent have occurred that were necessary for the Insurance Companies to perform their obligations under their implied contract to pay Plaintiff Doctors for the Non-Participating HMO Claims, at a minimum, based upon the "prevailing charges" in the geographic area, and to pay Plaintiff Doctors at rates, at a minimum, equivalent to the reasonable value of their services for the Other Non-Participating Claims.

83. Plaintiff Doctors did not agree that the lower reimbursement rates paid by the Insurance Companies were reasonable or sufficient to compensate Plaintiff Doctors for the emergency medical services provided to Patients.

84. As a result of the Insurance Companies' breach of the implied contract to pay Plaintiff Doctors for the Non-Participating Claims at the rates required by Oklahoma law, Plaintiff

Doctors have suffered injury and are entitled to monetary damages from the Insurance Companies to compensate them for that injury.

85. For the Non-Participating HMO Claims, Plaintiff Doctors have suffered damages in an amount equal to the difference between the amounts allowed as payable by the Insurance Companies and the lesser of Plaintiff Doctors' charges and the prevailing charges for professional emergency medicine services in the same geographic area, plus the Plaintiff Doctors' loss of use of that money.

86. For the Other Non-Participating Claims, Plaintiff Doctors have suffered damages in an amount equal to the difference between the amounts allowed as payable by the Insurance Companies and the lesser of Plaintiff Doctors' charges and the reasonable value of their professional emergency medicine services, plus Plaintiff Doctors' loss of use of that money.

COUNT III

Unjust Enrichment/Breach of Implied-in-Law Contract

87. Plaintiff Doctors re-allege and restate the preceding paragraphs as if they were fully set forth herein.

88. Plaintiff Doctors conferred a benefit upon the Insurance Companies by providing valuable emergency medicine services to the Insurance Companies' members for which the Insurance Companies were responsible for payment. In exchange for premiums and other forms of compensation, the Insurance Companies owe the Insurance Companies' members an obligation to pay Plaintiff Doctors for the covered medical services the members receive from Plaintiff Doctors. The Insurance Companies derive a benefit from Plaintiff Doctors' provision of emergency medicine services to their members, because it is through Plaintiff Doctors' provision of those services that the Insurance Companies fulfill their obligations to their members.

89. There is no dispute that all of the emergency medicine services at issue in the Non-Participating Claims were covered, because the Insurance Companies already adjudicated and allowed them as payable, albeit at an amount less than required by Oklahoma law.

90. The Insurance Companies voluntarily accepted, retained and enjoyed, and continue to accept, retain and enjoy, the benefits conferred upon it by Plaintiff Doctors, knowing that Plaintiff Doctors expected to be paid for the Non-Participating Claims at rates in accordance with the standards established under Oklahoma law.

91. The Insurance Companies have been unjustly enriched by their failure and refusal to pay Plaintiff Doctors for the Non-Participating Claims at rates in accordance with the standards established under Oklahoma law for the emergency medicine services Plaintiff Doctors provided to the Insurance Companies' members. The Insurance Companies have unjustly enriched themselves by withholding from Plaintiff Doctors monies that, consistent with the standards established under Oklahoma law, the Insurance Companies should have paid to Plaintiff Doctors.

92. Under the circumstances set forth above, it is unjust and inequitable for the Insurance Companies to retain the benefit they received without paying the value of that benefit; *i.e.,* by paying Plaintiff Doctors for the Non-Participating HMO Claims based upon the "prevailing charges" in the geographic area and for the Other Non-Participating Claims based upon *quantum meruit,* or the reasonable value of the emergency medicine services Plaintiff Doctors provided.

93. Plaintiff Doctors seek compensatory damages, as permitted by Oklahoma law, in an amount which will continue to accrue through the date of trial as a result of the Insurance Companies' continuing unjust enrichment, equal to the difference between the amount the Insurance Companies adjudicated as payable for the emergency medicine services Plaintiff

Doctors provided to the Insurance Companies' members and the rates due in accordance with the standards established under Oklahoma law.

COUNT IV

Declaratory Relief - Okla. Stat. tit. 12, § 1651

94. Plaintiff Doctors re-allege and restate the preceding paragraphs as if they were fully set forth herein.

95. This is an action for declaratory and actual damages pursuant to Okla. Stat. tit. 12, § 1651.

96. A bona fide and justiciable controversy exists that involves Plaintiff Doctors' substantial legal interests.

97. All adverse parties are presently before the Court.

98. A judicial declaration is necessary and appropriate to clarify the parties' respective rights and obligations concerning the rate of payment for Plaintiff Doctors' services, and no adequate remedy at law is available

99. To prevent the need for a separate action enforcing Plaintiff Doctors' rights, Plaintiff Doctors seek a declaration from this Court stating that: (1) the Insurance Companies must pay Plaintiff Doctors going forward for their Non-Participating HMO Claims for the emergency medicine services their professionals render to the Insurance Companies' members at the prevailing charges for similar services in the same geographic area; and, (2) the Insurance Companies must pay Plaintiff Doctors going forward for their Other Non-Participating Claims for the emergency medicine services their professionals render to the Insurance Companies' members at the lesser of their billed charges and the reasonable value of Plaintiff's services.

RELIEF REQUESTED & PRAYER

WHEREFORE, Plaintiffs pray that this Court enter judgment for Plaintiffs and against the Insurance Companies as follows:

For the Non-Participating HMO Claims for emergency medicine services rendered to Patients, enter judgments against the Insurance Companies and for each Plaintiff pursuant to Counts I, II and III in an amount representing the difference between the amounts allowed as payable by the Insurance Companies and the prevailing charges for similar services in the same geographic area, as determined by the finder of fact, plus interest;

For the Other Non-Participating Claims for emergency medicine services rendered to Patients, enter judgments against the Insurance Companies and for each Plaintiff pursuant to Counts II and III in an amount representing the difference between the amounts allowed as payable by the Insurance Companies and the reasonable value of the Plaintiff's services, as determined by the finder of fact, plus interest;

Decree pursuant to Count IV that: (1) the Insurance Companies must pay Plaintiffs going forward for their Non-Participating HMO Claims for the emergency medicine services their professionals render to the Insurance Companies' members at the lesser of Plaintiffs' billed charges and the prevailing charges for similar services in the same geographic area; and, (2) the Insurance Companies must pay Plaintiffs going forward for their Other Non-Participating Claims for the emergency medicine services their professionals render to the Insurance Companies' members at the lesser of Plaintiffs' billed charges and the reasonable value of Plaintiff's services; and Award attorney's fees, costs, interest and all other relief as this Court deems just and proper.

DEMAND FOR JURY TRIAL

Plaintiffs demand a trial by jury of all issues so triable.

Respectfully Submitted,

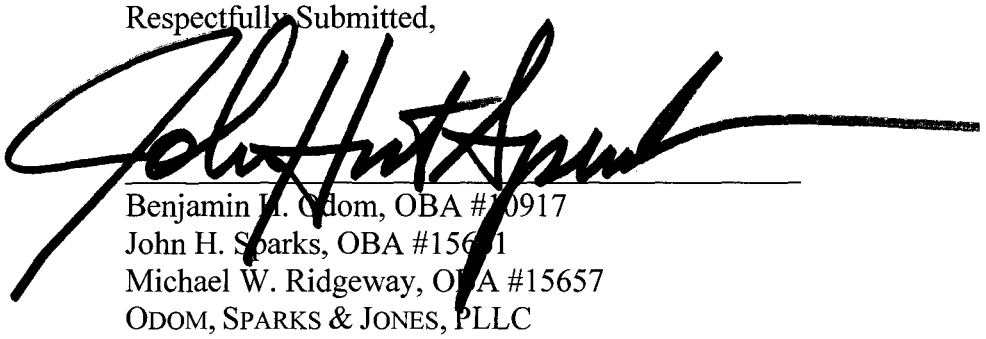

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EXHIBIT 10

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

EMERGENCY PHYSICIAN SERVICES OF NEW YORK, BUFFALO EMERGENCY ASSOCIATES, EXIGENCE MEDICAL OF BINGHAMTON, and EMERGENCY CARE SERVICES OF NEW YORK, *Plaintiffs,* v. UNITEDHEALTH GROUP, INC., UNITED HEALTHCARE SERVICES, INC.; UMR, INC.; UNITEDHEALTHCARE SERVICE LLC; UNITEDHEALTHCARE INSURANCE COMPANY; OXFORD HEALTH PLANS LLC; *Defendants*.	Case No: 1:20-cv-09183-AJN-SN AMENDED COMPLAINT

AMENDED COMPLAINT

Introduction[1]

1. This case is brought in the context of a global coronavirus pandemic, which has infected more than 78 million people and killed 927,000 in the United States.[2] The State of New York has been especially hard hit: 4.8 million people have been infected and 66,000 have been killed.[3]

2. Plaintiffs are hospital-based emergency care providers who practice medicine throughout the State of New York. As emergency care providers, Plaintiffs are essential workers who have risked their lives every day on the front lines of the pandemic.

3. Plaintiffs are also legally obligated to treat all patients who present at their emergency departments, no matter the patients' insurance status or ability to pay for their care.

4. Defendant UnitedHealth Group, Inc. ("UHG") and its subsidiaries comprise the largest commercial health insurer in the United States, reporting $6.7 billion in profits for the second quarter of 2020, a 97% increase from the same period in 2019.[4] They insure 80 million people and control a significant percentage of the commercial healthcare marketplace.

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[1] Plaintiffs amend the Complaint pursuant to the Order dated February 23, 2022, attached as Exhibit A.

[2] *See, e.g.*, *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. Times, https://www.nytimes.com/interactive/2021/us/covid-cases.html (last visited Feb. 17, 2022).

[3] *Id.*

[4] Jocelyn Grzeszczak, *U.S.' Largest Health Insurer Reports $6.7B In Profits Amid COVID, As N.Y. Cuts State Rates*, Newsweek (Aug. 14, 2020, 2:37 PM), https://www.newsweek.com/us-largest-health-insurer-reports-67b-profits-amid-covid-ny-cuts-state-rates-1525210.

5. As described in detail below, Defendants designed and implemented a scheme to unjustly enrich themselves by paying Plaintiffs less than the reasonable value of the emergency care provided and retaining the benefits obtained as a result thereof.

Parties

A. Plaintiffs

6. Plaintiffs Emergency Physicians of New York PC, Buffalo Emergency Associates LLP, Exigence Medical of Binghamton PLLC, and Emergency Care Services of New York PC are groups of emergency care providers who staff the emergency rooms of nineteen hospitals in seventeen municipalities across the State of New York. Each Plaintiff has a principal place of business in New York and regularly provides emergency medical care to United's members.

B. Defendants

7. Defendant UnitedHealth Group is a corporation organized under the laws of the State of Delaware with its principal place of business at 9900 Bren Road East, Minnetonka, Minnesota 55343.

8. Defendant United HealthCare Services, Inc. is a corporation organized under the laws of the State of Minnesota, with its principal place of business in the State of Minnesota. United HealthCare Services, Inc. is responsible for paying for emergency medical services provided by Plaintiffs to one or more of United's members.

9. Defendant UMR, Inc. is a corporation organized under the laws of the State of Delaware, with is principal place of business in the State of Wisconsin. UMR, Inc. is responsible for paying for emergency medical services provided by Plaintiffs to one or more of United's members.

10. Defendant UnitedHealthcare Service LLC is a limited liability company organized under the laws of the State of Delaware. UnitedHealth Group wholly-owns and is the sole member of UnitedHealthcare Service LLC. UnitedHealthcare Service LLC is responsible for paying for emergency medical services provided by Plaintiffs to one or more of United's members.

11. Defendant UnitedHealthcare Insurance Company is a corporation organized under the laws of the State of Connecticut, with its principal place of business in the State of Connecticut. UnitedHealthcare Insurance Company is responsible for paying for emergency medical services provided by Plaintiffs to one or more of United's members.

12. Defendant Oxford Health Plans LLC is a limited liability company organized under the laws of the State of Delaware. UnitedHealthcare Insurance Company wholly-owns and is the sole member of Oxford Health Plans LLC. Oxford Health Plans LLC is responsible for paying for emergency medical services provided by Plaintiffs to one or more of United's members.

Jurisdiction & Venue

13. This Court has subject matter jurisdiction over this case pursuant to 28 U.S.C. § 1332 and 28 U.S.C. § 1367. The amount in controversy exceeds $75,000.

14. This Court has personal jurisdiction over the Defendants.

15. Venue is proper in this District pursuant to 28 U.S.C. § 1391 because a substantial part of the events or omissions giving rise to the claims occurred in this District.

Factual Allegations

A. Defendant UHG Owns, Controls and Directs the Subsidiary Defendants and Is the Ultimate Beneficiary of the Alleged Unjust Enrichment.

16. Defendant UHG is the parent corporation of more than 1,200 companies, including Defendants United HealthCare Services, Inc.; UMR, Inc.; UnitedHealthcare Service LLC;

UnitedHealthcare Insurance Company; and Oxford Health Plans LLC (collectively, the "Subsidiary Defendants" and all Defendants are referred to herein as "United" or "Defendants").

17. The Subsidiary Defendants are not independent. They act in concert under the direction and control of Defendant UHG.

18. As described more fully below, Defendant UHG designed and implemented a scheme to unjustly enrich itself and its subsidiaries by controlling and directing the Subsidiary Defendants to pay Plaintiffs at rates below the reasonable value of the emergency care provided. Defendant UHG did so in order to generate additional and substantial fees (beyond the per month per member fees they collected from their self-insured clients) based upon an alleged "savings" calculated by the difference between the amount that would otherwise be owed (often defined as Plaintiff's billed charges in the Administrative Service Agreements between the Subsidiary Defendants and their self-insured clients) and the amount allowed or paid on the claims at issue in this dispute. In short, the less United paid providers, the more money UHG and the Subsidiary Defendants made.

B. Plaintiffs Provided Emergency Care to United's Members and United Paid Money on Every Claim Submitted by Plaintiffs, Albeit at an Amount Substantially Less Than the Reasonable Value of the Services.

19. During the period beginning in January 2018 and ending in July 2021, Plaintiffs provided emergency care to more than 7,500 patients ("United's Members") covered by commercial insurance plans sold and/or administered by United (the "Disputed Claims").[5]

[5] Because Plaintiffs continue to provide emergency medical services to United's Members, the Disputed Claims are continuing to accrue.

20. None of the Disputed Claims relate to or involve any Medicare Advantage or managed Medicaid products.

21. Before rendering emergency care, Plaintiffs did not, and could not, verify the United member's insurance status or ability to pay because federal and state law obligate Plaintiffs to treat all patients that arrive at the emergency rooms they staff.

22. For example, under the federal Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. §§ 1395dd(a)-(b), (d), and (h), hospitals and physicians who staff hospital emergency rooms have a duty to "provide for an appropriate medical screening examination" when an individual comes to the emergency department. If "the individual has an emergency medical condition," they are required to "stabilize the medical condition" without inquiry into "the individual's method of payment or insurance status." *Id*.

23. Hospitals are subject to civil liability for a violation of EMTALA's mandates, 42 U.S.C. § 1395dd(d)(2)(A), and "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital" who negligently violates EMTALA is subject to civil monetary penalties of up to $50,000 per violation. 42 U.S.C. § 1395dd(d)(1)(B).

24. New York law goes even further than EMTALA and imposes criminal liability on emergency room physicians who fail to satisfy its requirements. New York Public Health Law § 2805-b(2)(b) provides that "[a]ny licensed medical practitioner who refuses to treat a person arriving at a general hospital to receive emergency medical treatment . . . shall be guilty of a

misdemeanor and subject to a term of imprisonment not to exceed one year and a fine not to exceed one thousand dollars."[6]

25. At some point, typically after Plaintiffs provided the emergency care to the United members, the hospital obtained the patient's insurance and demographic information and then sent that information to Plaintiffs.

26. Thereafter, based on the insurance information obtained from the hospitals and the emergency care provided to United's Members, Plaintiffs submitted claims through a common United portal.

27. After receiving the claims, United processed, determined an allowed amount, approved for payment, and made a payment on each of the claims at issue in this case. Although they paid an amount on each and every claim at issue, the payment made was substantially less than the reasonable value of the emergency care provided by Plaintiffs.

C. Plaintiffs and United Did Not Have a Written Agreement That Established an Amount That Would Be Paid for the Emergency Care Provided.

28. All of the emergency care Plaintiffs provided to United's Members was provided on an out-of-network basis—meaning Plaintiffs and Defendants did not have a written agreement establishing a rate of payment for the care provided.

29. Consequently, Plaintiffs were dependent on United to conduct business honestly and pay Plaintiffs the reasonable value of the emergency care provided to United's Members as

[6] Emergency room doctors are often also obligated to provide emergency medical care under their contractual arrangements with the hospitals. Hospitals subject to EMTALA are permitted to contract for emergency services, provided they comply with certain regulatory requirements. 42 C.F.R. § 482.12.

required under New York law. *See New York City Health & Hosps. Corp. v. Wellcare of New York, Inc.*, 937 N.Y.S.2d 540, 545 (N.Y. Sup. Ct. 2011); N.Y. Fin. Serv. Law § 605(a).

30. Given the nature of these relationships, an equitable obligation arises to account for the benefit provided by Plaintiffs to United.

31. In the absence of such an obligation, United would enrich themselves unjustly at the expense of Plaintiffs and their local communities. This obligation requires that United pay Plaintiffs the reasonable value of the services rendered.

32. Thus, United is obligated to pay Plaintiffs for the reasonable value of the services they provided.

D. United Takes Unfair Advantage of New York's Laws Protecting Patients.

33. Receiving payment from United for the reasonable value of their services was essential because, unlike other situations involving out-of-network providers, New York law shields United's Members from liability for Plaintiffs' Disputed Claims. *See, e.g.*, N.Y. Fin. Serv. Law §§ 602(b)(2), 605(a)(1), 606; N.Y. Ins. Law § 3241(c).[7]

34. These statutes and regulations ensure that United's members incur no liability for out-of-network emergency services greater than the member's in-network co-payments,

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[7] These statutes and regulations provide that United "shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider network." N.Y. Fin. Serv. Law § 605(a)(1); *see also* N.Y. Fin. Serv. Law § 602(b)(2); N.Y. Ins. Law § 3241(c). Whenever United fails to pay the Plaintiffs' full charges for a given claim for emergency services, United must provide its patients with notice, which explains to the patients, *inter alia*, that the patient "shall incur no greater out-of-pocket costs for the services than the insured would have incurred with a participating physician" and which "direct[s] the insured to contact the health care plan in the event that the non-participating physician bills the insured for the out-of-network service." N.Y. Comp. Codes. R. & Regs. tit. 23 § 400.5(a)(3).

coinsurance, and deductibles, and thereby effectively remove the patient entirely from payer-provider reimbursement disputes in New York. As such, any effort by Plaintiffs to seek to collect the balance of an underpaid claim from United's members directly would be an exercise in futility, as United must ensure that the patient is not liable for any balance, must notify the patient of this fact, and must instruct the patient to direct any attempts to collect the balance bill to United on any claims that United had already previously adjudicated and underpaid.

35. The structure provides United with an opportunity to retain a substantial benefit because it eliminates member abrasion and complaints that often occur when United directs healthcare providers to seek the balance of their bills from its members.

36. It also turbo charges United's incentive to generate "shared savings" fees by paying less than the amount that would otherwise be owed and the amount ultimately allowed or paid for out-of-network emergency care like that provided by Plaintiffs.

E. United's First Foray Into Artificially Suppressing Reimbursement Rates: Ingenix

37. United's current scheme to deprive healthcare providers the reasonable value of their services can be traced to an earlier scheme operated through a wholly-owned United subsidiary formerly known as "Ingenix."

38. An investigation into Ingenix by the New York Attorney General discovered that Ingenix's reimbursement system was "fraudulent" and "conflict-ridden."[8]

[8] Press Release, *Attorney General Cuomo Announces Historic Nationwide Reform Of Consumer Reimbursement System For Out-Of-Network Health Care Charges*, Office of the N.Y. Att'y Gen. (Oct. 27, 2009), https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-reform-consumer.

39. The "Ingenix" scheme led to a settlement that, among other provisions, established a "new, independent database, not controlled by any insurer, to be used for determining fair and accurate reimbursement rates."[9] The new independent database is operated by FAIR Health.

40. Under the terms of the settlement, Defendant UHG paid $50 million to fund the FAIR Health database, which contains "reliable information about healthcare costs because each year health insurers around the country send [it] over 2 billion healthcare claim records, which are added to FAIR Health's database of more than 36 billion claim records."[10] No providers submit pricing information, only insurers do so. New York, Connecticut and many other states use the FAIR Health database as a guidepost for healthcare consumer protection.[11]

41. The Ingenix scheme also led United to pay $350 million to settle a class action. The settlement agreement dictated that United "shall use [FAIR Health] as the basis for determining Allowed Amounts for Covered Out-Of-Network Services or Supplies" to the extent those plans or arrangements require payment based upon the "usual customary and reasonable" charges or similar language (including but not limited to "reasonable and customary," "average," or "prevailing" charges) for such services and supplies.[12]

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[9] *In Re UnitedHealth Group Inc.*, Investigation No. 2008-161, Assurance of Discontinuance Under Executive Law § 63(15), 3.

[10] FAIR Health Consumer, About FAIR Health, https://www.fairhealthconsumer.org/#about (last visited Feb. 17, 2022).

[11] *Id*.

[12] Settlement Agreement Between United Healthcare Corporation, et. al. and Settling Plaintiffs (January 14, 2009), 14, https://www.sec.gov/Archives/edgar/data/731766/000119312509025587/dex992.htm.

42. When the settlement with the Attorney General's Office was announced, Thomas L. Strickland, at the time the Executive Vice President and Chief Legal Officer of Defendant UnitedHealth Group, stated: "We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy . . . We are pleased that a not-for-profit entity will play this important role for the marketplace."[13]

43. Since its establishment, United has publicly asserted to courts that FAIR Health "analyzes and groups medical procedures by codes, the geographical area where the procedures were performed, and the amount charged by the providers. This database is often used by private health insurers to calculate the 'usual and customary' fee for specific procedures and inform the amounts that they will be willing to pay to out-of-network providers." *UnitedHealthcare Servs., Inc. v. Asprinio*, 16 N.Y.S.3d 139, 145 (N.Y. Sup. Ct. 2015).

44. United has represented that where payment for out-of-network services is to be made at the usual and customary rate, United "most commonly refer[s] to a schedule of charges created by FAIR Health, Inc. ('FAIR Health') to determine the amount of the payment."

45. United's legal obligations to use FAIR Health and pay out-of-network claims at a rate predicated upon the usual, customary and reasonable charges terminated in or about 2015.

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[13] Press Release, *Attorney General Cuomo Announces Historic Nationwide Health Insurance Reform; Ends Practice Of Manipulating Rates To Overcharge Patients By Hundreds Of Millions Of Dollars*, Office of the N.Y. Att'y Gen. (Jan. 13, 2009), https://ag.ny.gov/press-release/2009/attorney-general-cuomo-announces-historic-nationwide-health-insurance-reform-ends.

F. United's Current Scheme to Suppress Reimbursement Rates

a. "Shared Savings" Programs

46. After its obligation to use the FAIR Health databased ended, United began using and implementing a variety of methods to suppress reimbursement rates and generate additional fees above and beyond the per member per month fees it receives for administering employers' self-funded insurance plans. These programs go by a variety of names, all of which United generically refers to as "shared savings" programs. Most of these programs are implemented by United itself, although United also uses a similar program known as Data iSight, which is operated by MultiPlan, Inc.

47. Under these "shared savings" programs—which are typically documented in Administrative Services Agreements between United and its self-insured clients—United takes a percentage of the difference between the amount that would have otherwise been payable to the out-of-network provider and the amount allowed or paid by United to adjudicate the claim.

48. On information and belief, United's administrative services agreements—including the agreements with client in New York and applicable to the Disputed Claims—contain the following provision (with the fees varying by client) regarding shared savings fees:

> You will pay a fee equal to thirty-five percent (35%) of the "Savings Obtained" as a result of the Shared Savings Program described in Section 12. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.

49. United routinely calculates the "Savings Obtained" as difference between the provider's billed charge and the amount allowed by United.

50. By way of example, if an emergency care provided charged $1,250 for the service, and United adjudicated the claim and allowed the provider $250 dollars, the "savings" obtained

would be the difference between those two amounts, or $1,000. United charges its clients a fee on that $1,000, typically between 30% and 50% of the "savings." In this example, and assuming a 40% fee, United would have generated a fee greater than it paid the provider for the emergency provider (i.e. 40% x $1,000 = $400, compared to the $250 allowed or paid to the provider). This is on top of the per-member-per-month fee that United is charging its self-insured clients.

51. The volume of claims processed under these programs generates hundreds of millions of dollars annually for United. And all of these "shared savings" fees are generated by providing the same service for which United is already being compensated on a per member per month basis—namely, the receipt, processing and adjudication of claims.

52. The shared savings fee revenues were material and important to United. United evaluated and analyzed the impact of the shared savings program in internal communications, internal presentations, external documents exchanged with MultiPlan, budgets, and financial statements.

b. Benchmark Pricing Scheme Using Data iSight

53. More recently, United and MultiPlan implemented a new shared-savings program purporting to utilize MultiPlan's Data iSight tool. At no time material to this action did Plaintiffs negotiate with United, MultiPlan or Data iSight or agree to accept a discounted rate for its services, or to be bound by United's, MultiPlan's or Data iSight's undisclosed payment policies, pricing methodologies or rate schedules with respect to any of the Disputed Claims.

54. Notwithstanding the absence of any such agreement, United and MultiPlan have unilaterally applied an unlawful discount to the rates they have paid Plaintiffs for emergency services rendered to United's Members, under the guise of using Data iSight.

55. United and Data iSight represent that the Data iSight methodology is defensible, transparent, objective and geographically adjusted. However, these representations are false.

56. United and MultiPlan's methodologies do not use externally validated data and are sometimes not even consistent amongst themselves. None of United's payments at issue in this case are defensible, transparent, objective or geographically adjusted.

57. For example, payments for claims from providers in different geographic locations show that claims purportedly repriced using Data iSight do not adjust for geographic differences but, instead, ***uniformly*** price out-of-network provider payments across geographic locations to pay the ***identical rates***.

58. Moreover, the payments for claims repriced under the guise of Data iSight are not transparent.

59. Rather, United opted to use Data iSight pricing because it knew, based on MultiPlan's marketing and on meetings between United and Data iSight, that the payment rates Data iSight would produce would be artificially low. Moreover, as part of the Data iSight "methodology," MultiPlan gave United the ability to override any methodology and actually dictate the reimbursement rate. Thus, while United was publicly representing that the payment rates were the result of the Data iSight methodology, that representation was false.

60. The details of United's relationship with MultiPlan, use of Data iSight, United's requested overrides, and other aspects of the benchmark pricing scheme are documented in internal communications, internal presentations, external documents exchanged with MultiPlan, presentations by MultiPlan, budgets, and financial statements.

61. United's unlawful conduct gives rise to the following causes of action.

Causes of Action

Count I: Unjust Enrichment under New York Law (as against all Defendants)

62. Plaintiffs incorporate by reference the facts set forth above as though fully set forth herein.

63. For the Disputed Claims, United has failed to pay Plaintiffs for the reasonable value of the services.

64. Plaintiffs are entitled to be reimbursed the reasonable value of the emergency care provided to United's Members. In adjudicating the Disputed Claims, the Subsidiary Defendants failed to reimburse Plaintiffs the reasonable value of emergency care provided to those Members. That failure benefited the Subsidiary Defendants in several ways, including by allowing the Subsidiary Defendants to generate additional administrative fees and reimbursements that they would not have generated had they paid Plaintiffs the reasonable value of the emergency care provided to United's Members.

65. As the owner of the Subsidiary Defendants, Defendant UHG benefited from the Subsidiary Defendants' failure to reimburse Plaintiffs the reasonable value of the services provided. In particular, UHG received dividends and administrative fees and reimbursements generated by the Subsidiary Defendants' adjudication of medical claims, including the claims arising out of the emergency care Plaintiffs provided to more than 7,500 United Members. Because the benefits UHG received were at the Plaintiffs' expense, equity and good conscience require restitution of said benefits to Plaintiffs.

66. In particular, Defendant UHG should be required to disgorge all benefits received as a result of the Subsidiary Defendants' failure to pay Plaintiffs the reasonable value of the services provided and remit such sums, including interest, to Plaintiffs.

67. In total, United therefore has been enriched by the amount of the difference between (i) the reasonable value of Plaintiffs' services and (ii) the amount allowed by United, as well as the time-value of the money withheld from Plaintiffs.

68. For all of the Disputed Claims, United's failure to pay Plaintiffs the reasonable value of their services comes at Plaintiffs' expense because Plaintiffs are entitled to payment at the reasonable value of the services they have rendered.

69. It would be inequitable to permit United to retain the amount at issue. Plaintiffs are entitled to such amounts, which represent the difference between the reasonable value of the services Plaintiffs have rendered and the amounts allowed by United for such services, plus the time-value of that money.

70. Furthermore, Plaintiffs conferred a benefit on United by providing valuable emergency medical care to their insureds, for which United was responsible for payment.

71. In exchange for premiums and other forms of compensation, United owes its insureds an obligation to make sure the insureds receive covered medical services and to pay for the covered medical services.

72. United voluntarily accepted, retained, and enjoyed, and continues to accept, retain, and enjoy, the benefits conferred on it by Plaintiffs, knowing that Plaintiffs expected to be paid the reasonable value of their services.

73. United has been unjustly enriched by its failure and refusal to pay Plaintiffs the reasonable value of the emergency medical care provided to their insureds.

74. It would be against equity and good conscience to allow United to reap a benefit by underpaying Plaintiffs for valuable emergency medical care provided to United insureds' that Plaintiffs were compelled to render.

75. Plaintiffs seek compensation, as permitted by applicable law, in an amount which will continue to accrue through the date of trial as a result of United's continuing unjust enrichment, equal to (i) the difference between the amount United adjudicated as payable for the emergency medical care Plaintiffs rendered to United's insureds and the reasonable value of those services, plus (ii) the loss of use of that money.

Count II: Declaratory Relief (as against all Defendants)

76. Plaintiffs incorporate by reference the facts set forth above as though fully set forth herein.

77. This is an action for declaratory relief pursuant 28 U.S.C. § 2201, which is necessary and appropriate to clarify the parties' respective rights, status, and legal relations concerning United's payment obligations to Plaintiffs based on the calculation of payment rates for the emergency services provided by Plaintiffs.

78. All adverse parties are presently before the court.

79. Plaintiffs have been, and continue to be, harmed by United's underpayments for emergency services based on the determination of fraudulent "reasonable" payment rates for emergency medical services rendered by Plaintiffs.

80. Plaintiffs therefore seek a declaration establishing the appropriate payment rates and payment methodology to be used to prevent further harm to Plaintiffs.

81. Plaintiffs specifically seek a determination that (i) United has an obligation to pay Plaintiffs for the services rendered at rates equal to the reasonable value of the emergency services rendered; (ii) the rates United calculated through MultiPlan using the Data iSight service are fraudulent; and (iii) the rates paid by United for the claims at issue are inadequate and violate United's obligation to pay Plaintiffs for their services rendered at a reasonable value.

82. To avoid the potential for successive, separate actions enforcing Plaintiffs' rights, Plaintiffs seek a declaration from the Court stating that United is obligated to pay Plaintiffs prospectively for the emergency medical services rendered by Plaintiffs at the reasonable value thereof and that the Data iSight service shall not be used in the calculation of said rates.

WHEREFORE, Plaintiffs pray for relief and judgment against all Defendants, jointly and severally, as follows:

1. Payment for the reasonable value of services rendered by Plaintiffs to United's insureds;

2. Order the restitution of monies and property unlawfully obtained or retained by the Defendants;

3. Such other and further relief as the Court deems just and proper.

Jury Demand

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Plaintiffs hereby demand a trial by jury on any issue triable of right by a jury.

Dated: February 24, 2022

s/ Wendy H. Schwartz

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EXHIBIT 11

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ACS PRIMARY CARE PHYSICIANS SOUTHWEST, P.A., HILL COUNTY EMERGENCY MEDICAL ASSOCIATES, P.A., LONGHORN EMERGENCY MEDICAL ASSOCIATES, P.A., CENTRAL TEXAS EMERGENCY ASSOCIATES, P.A., EMERGENCY ASSOCIATES OF CENTRAL TEXAS, P.A., AND EMERGENCY SERVICES OF TEXAS, P.A.,	§	C.A. NO. 4:20-CV-1282
	§	JURY
Plaintiffs,	§	
v.	§	
UNITEDHEALTHCARE INSURANCE COMPANY AND UNITEDHEALTHCARE OF TEXAS, INC.,	§	
Defendants.	§	

PLAINTIFFS' AMENDED COMPLAINT[1]

Plaintiffs ACS Primary Care Physicians Southwest, P.A., Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medical Associates, P.A., Central Texas Emergency Associates, P.A., Emergency Associates of Central Texas, P.A., and Emergency Services of Texas, P.A., ("Plaintiff Doctors") by and through undersigned counsel, file this Amended Complaint against Defendants UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc. (collectively, the "Insurance Companies"), and show the Court as follows:

[1] Plaintiffs expressly dispute that the Court has subject-matter jurisdiction over this action. This case is currently pending in federal court as a result of Defendants' improper removal. The filing of this Amended Complaint is without waiver of Plaintiffs' right to seek remand to the Texas District Court for the 190th District, Harris County. Plaintiffs' Motion to Remand will be filed immediately following submission of this Amended Complaint.

DISCOVERY CONTROL PLAN AND CLAIM FOR RELIEF

Following remand to state court, this case will be governed by Level 3 discovery pursuant to Rule 190.4 of the Texas Rules of Civil Procedure. Plaintiff Doctors seek monetary relief in excess of $1,000,000.00.

INTRODUCTION

1. Plaintiff Doctors provide emergency care to thousands of citizens of Texas. Unlike most physicians, who can choose the patients that they treat, these doctors cannot. Under compulsion of federal and state law, Plaintiff Doctors are obligated to treat all patients who present in the emergency department. In recognition of the nature and critical importance of these services, Texas law requires health insurers to compensate emergency medicine physicians at usual and customary rates. Reasonable compensation is essential to permit Plaintiff Doctors to continue to provide high-quality emergency services and to attract and retain physicians who are willing to work long hours under stressful conditions providing life-saving medical services in otherwise underserved areas of Texas.

2. In recent years, the Insurance Companies have begun reimbursing the Plaintiff Doctors at rates below those required both by statute and by the Parties' implied agreement.

3. This action seeks damages for the Insurance Companies' violations of the Texas Insurance Code and the Parties' implied-in-fact contract.

PARTIES

4. Plaintiff ACS Primary Care Physicians Southwest, P.A. is a Texas professional association that provides physician staffing to emergency departments in Texas.

5. Plaintiff Hill Country Emergency Medical Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments in Texas.

6. Plaintiff Longhorn Emergency Medical Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments in Texas.

7. Plaintiff Central Texas Emergency Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments in Texas.

8. Plaintiff Emergency Services of Texas, P.A. is a Texas professional association that provides physician staffing to emergency departments in Texas.

9. Plaintiff Emergency Associates of Central Texas, P.A. is a Texas professional association that provides physician staffing to emergency departments in Texas.

10. Defendant UnitedHealthCare Insurance Company is a corporation organized under the laws of the State of Connecticut and doing business in Texas. UnitedHealthCare Insurance Company is licensed by the Texas Department of Insurance as a life, health, or accident insurance company, and underwrites or administers preferred provider benefit plans and other health insurance products in the state of Texas. It may be served through its agent for service of process, CT Corporation System, 350 North Paul Street, Dallas, TX 75201.

11. Defendant UnitedHealthCare of Texas, Inc. is a corporation organized under the laws of the state of Texas with a principal office in Plano, Texas. UnitedHealthCare of Texas, Inc. is licensed by the Texas Department of Insurance as a basic health maintenance organization ("HMO"). It may be served through its agent for service of process, CT Corporation System, 1999 Bryan St., Suite 900, Dallas, TX 75201.

JURISDICTION & VENUE

12. The United States District Court does NOT have subject-matter jurisdiction over this dispute. Plaintiff Doctors file their Amended Complaint in this Court only because Defendants have improperly removed this action from state court, despite the absence of federal subject-matter

jurisdiction.

13. The state District Court of Texas has subject-matter jurisdiction because this dispute involves an amount in controversy in excess of that Court's minimum jurisdictional requirements.

14. Venue is proper in the state District Court of Harris County, Texas pursuant to Section 15.002(a)(1) of the Texas Civil Practice & Remedies Code because a substantial part of the events or omissions giving rise to Plaintiff Doctors' claims occurred in Harris County, Texas.

15. Insurance Companies are each subject to personal jurisdiction in Texas pursuant to Tex. Civ. Prac. & Rem. Code § 17.042(1) because they have entered into contracts to provide insurance to Texas residents and conduct business in this State.

FACTS

Plaintiffs Provide Necessary Emergency Care

16. This is an action for damages stemming from Insurance Companies' failure to properly reimburse Plaintiff Doctors for emergency services provided to members of Insurance Companies' health plans in Texas.[2]

17. Plaintiff Doctors are emergency medicine physicians who staff hospital emergency departments 24 hours a day, 7 days a week. Plaintiff Doctors provide emergency department coverage at more than 25 Texas emergency departments.

[2] Plaintiff Doctors do not assert any causes of action with respect to any patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or the Federal Employee Health Benefits Act (FEHBA). Plaintiff Doctors also do not assert any claims relating to Defendants' Managed Medicare business. Plaintiff Doctors will serve, via encrypted transmission, a list of the individual healthcare claims at issue in this litigation. To the extent that list contains any healthcare claims relating to Managed Medicare, FEHBA, or Managed Medicaid business, Plaintiff Doctors will remove them upon notice by Defendants. Additionally, Plaintiff Doctors do not assert any causes of action under ERISA and are not suing derivatively to enforce an ERISA plan beneficiary's claim for benefits. Thus, there is no federal question jurisdiction pursuant to ERISA.

18. Plaintiff Doctors and the hospitals whose emergency departments they staff are obligated by both Texas and federal law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; Tex. Health & Safety Code Ann. §§ 311.022–.024; Tex. Health & Safety Code Ann. §§ 241.027–.028, 241.055–.056. Plaintiff Doctors fulfill this obligation for the hospitals and facilities which they staff. In this role, Plaintiff Doctors provide emergency medical services to all patients, including to patients with insurance coverage issued and/or underwritten by Insurance Companies (the "Members").

19. The Texas Insurance Code explicitly requires insurers and HMOs, such as Insurance Companies, to reimburse emergency medical providers at either the "usual and customary rate" or an "agreed rate." Tex. Ins. Code § 1271.155(a) (HMO plans); Tex. Ins. Code § 1301.0053(a) (EPO plans); § 1301.155(b) (PPO plans).

Insurance Companies Underpaid Plaintiff Doctors for Emergency Services

20. Insurance Companies operate as an HMO under Chapter 843 of the Texas Insurance Code and as an insurer under Chapter 1301 of the Texas Insurance Code. Insurance Companies provide, either directly or through arrangements with providers such as hospitals and Plaintiff Doctors, healthcare benefits to their Members.

21. Because there is no express, written contract between Insurance Companies and any of the Plaintiff Doctors for the healthcare claims at issue in this litigation, Plaintiff Doctors are designated as "non-participating" or "out-of-network" for all claims at issue. Nonetheless, the Plaintiff Doctors and Insurance Companies have impliedly demonstrated their mutual assent to an agreement requiring the Insurance Companies to reimburse the Plaintiff Doctors at a usual and

customary rate for emergency medical services rendered to the Insurance Companies' Members and requiring the Plaintiff Doctors to accept reimbursement at a usual and customary rate as payment in full. As such, the Parties have formed an enforceable, implied-in-fact contract.

22. From January 2016 through the present, Plaintiff Doctors have provided emergency medical services to thousands of Insurance Companies' Members.

23. Insurance Companies' Members have received a wide variety of emergency services (in some instances, life-saving services) from Plaintiff Doctors, including treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric distress, and obstetrical distress. Most recently, the Plaintiff Doctors have provided and continue to provide care to critically ill COVID-19 patients.

24. In recent years, Insurance Companies have dramatically decreased the reimbursements to Plaintiff Doctors for services provided to certain of their Members.

25. Despite Insurance Companies' obligations under both the Texas Insurance Code and the Parties' implied-in-fact contract, these new reimbursement levels are significantly below the usual and customary rates for the services provided.

26. From January 2016 through the present, Plaintiff Doctors have identified thousands of emergency service claims that Insurance Companies paid at unacceptably low rates, in violation of both the above-referenced sections of the Texas Insurance Code and the Parties' implied-in-fact contract.[3]

27. For each of the healthcare claims at issue, Insurance Companies have already

[3] Pursuant to the recently enacted Senate Bill 1264, medical providers must submit to mandatory arbitration prior to filing suit for underpayment of certain out-of-network claims for medical services rendered on or after January 1, 2020. *See* Tex. Ins. Code § 1467.085. This action does not seek recovery for underpayment of any claim for reimbursement subject to mandatory arbitration.

determined the claims to be payable pursuant to the terms of the Members' respective health plans and have actually paid the claims. Thus, this action involves no dispute over whether the relevant claims are covered by the Members' health benefits. Rather, this action solely involves a dispute over whether the Insurance Companies have paid the appropriate rates of reimbursement for the undisputedly covered claims.

28. Plaintiff Doctors bring this action to collect damages from the Insurance Companies for the Insurance Companies' failure to comply with the Texas Insurance Code and breach of the Parties' implied-in-fact contract, and to compel the Insurance Companies to pay Plaintiff Doctors the usual and customary rate for the emergency services that Plaintiff Doctors have provided to Insurance Companies' Members.

29. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

CAUSES OF ACTION

COUNT I – Violation of the Texas Insurance Code

30. Plaintiff Doctors re-allege and restate paragraphs 1-29 as if they were fully set forth herein.

31. Defendant UnitedHealthCare of Texas, Inc. is an HMO under the Texas Insurance Code. Defendant UnitedHealthCare Insurance Company is a life, health, and accident insurer under the Texas Insurance Code, and is an insurer under Chapter 1301 of the Texas Insurance Code. Plaintiff Doctors are out-of-network providers who have provided emergency care to Insurance Companies' Members.

32. Section 1271.155(a) of the Texas Insurance Code requires an HMO to pay for emergency care provided by out-of-network providers such as Plaintiff Doctors "at the usual and customary rate or at an agreed rate." Section 1301.0053(a) imposes the same requirement on an

insurer that offers exclusive provider benefit plans. Section 1301.155(b) imposes the same requirement on an insurer that offers preferred provider benefit plans.

33. Here, the "usual and customary rate" and the "agreed rate" are identical, as the Parties have agreed that the Insurance Companies will reimburse the Plaintiff Doctors at the usual and customary rate.

34. Insurance Companies have failed to fulfill those obligations under the Texas Insurance Code by failing to pay for emergency care at the usual and customary rate on the claims submitted by Plaintiff Doctors for emergency care rendered to Insurance Companies' Members.

35. Plaintiff Doctors are entitled to recover the difference between the usual and customary rate and the amount Insurance Companies have paid for emergency services that Plaintiff Doctors rendered to Insurance Companies' Members.

COUNT II – Breach of Contract Implied in Fact

36. Plaintiff Doctors re-allege and restate paragraphs 1-29 as if they were fully set forth herein.

37. Insurance Companies and Plaintiff Doctors have demonstrated their mutual agreement and understanding that Insurance Companies will reimburse Plaintiff Doctors at the usual and customary rate for any emergency services rendered to Insurance Companies' Members, and that Plaintiff Doctors will accept reimbursement at the usual and customary rate as payment in full for the provision of such emergency services. Accordingly, the Parties have formed an enforceable, implied-in-fact contract.

38. However, after Plaintiff Doctors rendered emergency medical services to Insurance Companies' members, Insurance Companies paid to Plaintiff Doctors amounts significantly less than the usual and customary rates for the services rendered.

39. The Insurance Companies' failure to reimburse Plaintiff Doctors at a usual and customary rate constitutes a breach of the Parties' implied-in-fact contract.

40. Consequently, Plaintiff Doctors seek damages for the breach, in the amount of the difference between the usual and customary rates and the amounts Insurance Companies have paid for emergency services that Plaintiff Doctors rendered to Insurance Companies' Members.

COUNT III – Quantum Meruit

41. Plaintiff Doctors re-allege and restate paragraphs 1-29 as if they were fully set forth herein.

42. Plaintiff Doctors rendered valuable emergency services to Insurance Companies' members.

43. Insurance Companies received the benefit of having its healthcare obligations to its plan members discharged and their members received the benefit of the emergency care provided to them by Plaintiff Doctors.

44. As insurers, Insurance Companies were reasonably aware that medical service providers, including Plaintiff Doctors, would expect to be paid by Insurance Companies for the emergency services provided to their members. Indeed, as pleaded above, this obligation is codified in the Texas Insurance Code and accompanying regulations and was impliedly agreed to by the Parties.

45. Insurance Companies accepted the benefit of the services provided by Plaintiff Doctors to members of their health plans. However, Insurance Companies have arbitrarily and unilaterally reimbursed Plaintiff Doctors at amounts far lower than the value of the services provided by Plaintiff Doctors.

46. Therefore, Plaintiff Doctors are entitled to *quantum meruit* recovery.

47. As a result of Insurance Companies' actions, Plaintiff Doctors have been damaged and are entitled to recover the difference between the amount Insurance Companies paid for emergency care Plaintiff Doctors rendered to Insurance Companies' members and the reasonable value of the services that Plaintiff Doctors rendered to Insurance Companies by discharging their obligations to Insurance Companies' plan members.

RULE 193.7 NOTICE[4]

48. Pursuant to Rule 193.7 of the Texas Rules of Civil Procedure, Plaintiff Doctors hereby give notice to Insurance Companies that Plaintiff Doctors intend to use all documents exchanged and produced between the parties (including, but not limited to, correspondence, pleadings, records, and discovery responses) during the trial of this matter.

RULE 194 REQUEST FOR DISCLOSURE AND DISCOVERY REQUESTS

49. Pursuant to Texas Rule of Civil Procedure 194, Plaintiff Doctors request that Insurance Companies disclose, within 50 days of service of this request, the information or material described in Rule 194.2.

JURY DEMAND

50. Plaintiff Doctors hereby demand a trial by jury of the above-styled action.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs ACS Primary Care Physicians Southwest, P.A., Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medical Associates, P.A., Central Texas Emergency Associates, P.A., Emergency Associates of Central Texas, P.A., and Emergency Services of Texas, P.A. hereby request that Defendants UnitedHealthCare Insurance Company and

[4] Following remand, this Amended Complaint will serve as the action's operative pleading in Texas state court. Accordingly, Plaintiff Doctors include notices required by Rules 193.7 and 194 of the Texas Rules of Civil Procedure.

UnitedHealthCare of Texas, Inc., be cited to appear and answer this Amended Complaint, and that upon final trial and determination thereof, judgment be entered in favor of Plaintiffs awarding them the following relief:

A. Monetary damages equaling the difference between the amount Defendants have already paid on the healthcare claims at issue and the usual and customary rate;

B. quantum meruit recovery;

C. court costs;

D. pre-judgment and post-judgment interest; and

E. such other and further relief to which the Plaintiffs may be entitled.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on April 28, 2020, a true and correct copy of the above and foregoing has been served via CM/ECF on all counsel of record.

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