25-1167-cv

United States Court of Appeals

for the

Second Circuit

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiffs-Appellant,

- v –

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK, INC., *AS PROGRAM ADMINISTRATOR FOR THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM*, AND MULTIPLAN INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

JOINT APPENDIX VOLUME 1

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APPEAL,ACO

U.S. District Court
Eastern District of New York (Central Islip)
CIVIL DOCKET FOR CASE #: 2:22-cv-04040-HG

Long Island Anesthesiologists PLLC v. United Healthcare Insurance Company of New York Inc. et al
Assigned to: Judge Hector Gonzalez
Cause: 15:1 Antitrust Litigation

Date Filed: 07/11/2022
Date Terminated: 04/08/2025
Jury Demand: Plaintiff
Nature of Suit: 410 Anti-Trust
Jurisdiction: Federal Question

Plaintiff

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V.

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Date Filed	#	Docket Text
07/11/2022	1	COMPLAINT against Multiplan Inc., The Empire Plan Medical/Surgical Program, United Healthcare Insurance Company of New York Inc. filing fee $ 402, receipt number ANYEDC-15733910 Was the Disclosure Statement on Civil Cover Sheet completed -No,, filed by Long Island Anesthesiologists PLLC. (Attachments: # 1 Civil Cover Sheet) (Breitenbach, Roy) Modified on 7/12/2022 (Jakubowski, Laura). (Entered: 07/11/2022)

07/11/2022	2	Corporate Disclosure Statement by Long Island Anesthesiologists PLLC (Breitenbach, Roy) Modified on 7/12/2022 (Jakubowski, Laura). (Entered: 07/11/2022)
07/11/2022	3	Proposed Summons. Re 1 Complaint, by Long Island Anesthesiologists PLLC (Breitenbach, Roy) Modified on 7/12/2022 (Jakubowski, Laura). (Entered: 07/11/2022)
07/11/2022	4	Proposed Summons. Re 1 Complaint, by Long Island Anesthesiologists PLLC (Breitenbach, Roy) Modified on 7/12/2022 (Jakubowski, Laura). (Entered: 07/11/2022)
07/12/2022	5	This attorney case opening filing has been checked for quality control. See the attachment for corrections that were made. (Jakubowski, Laura) (Entered: 07/12/2022)
07/12/2022		Case Assigned to Judge Hector Gonzalez. Please download and review the Individual Practices of the assigned Judges, located on our website. Attorneys are responsible for providing courtesy copies to judges where their Individual Practices require such. (Jakubowski, Laura) (Entered: 07/12/2022)
07/12/2022	6	In accordance with Rule 73 of the Federal Rules of Civil Procedure and Local Rule 73.1, the parties are notified that ***if*** all parties consent a United States magistrate judge of this court is available to conduct all proceedings in this civil action including a (jury or nonjury) trial and to order the entry of a final judgment. Attached to the Notice is a blank copy of the consent form that should be filled out, signed and filed electronically **only if all** parties wish to consent. The form may also be accessed at the following link: http://www.uscourts.gov/uscourts/FormsAndFees/Forms/AO085.pdf. **You may withhold your consent without adverse substantive consequences. Do NOT return or file the consent unless all parties have signed the consent.** (Jakubowski, Laura) (Entered: 07/12/2022)
07/12/2022	7	Summons Issued as to Multiplan Inc., United Healthcare Insurance Company of New York Inc. (Jakubowski, Laura) (Entered: 07/12/2022)
07/21/2022	8	SCHEDULING ORDER: Counsel for all parties are directed to file on the docket a joint letter describing the case and a completed civil case management plan by **AUGUST 25, 2022** as further described in the attached mandatory requirements. Requests for adjournment of the deadline for these submissions will be considered only if made in writing and otherwise in accordance with Section I.D of the Court's Individual Practices. Ordered by Judge Hector Gonzalez on 7/21/2022. (Duffy, Matthew) (Entered: 07/21/2022)
07/25/2022	9	NOTICE of Appearance by Karl Geercken on behalf of United Healthcare Insurance Company of New York Inc. (aty to be noticed) (Geercken, Karl) (Entered: 07/25/2022)
07/25/2022	10	Corporate Disclosure Statement by United Healthcare Insurance Company of New York Inc. identifying Corporate Parent UnitedHealth Group Incorporated, Other Affiliate United HealthCare Services, Inc., Other Affiliate UHIC Holdings, Inc., Other Affiliate UnitedHealthcare Insurance Company for United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 07/25/2022)
07/25/2022	11	MOTION for Extension of Time to File Answer re 1 Complaint, by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 07/25/2022)
07/26/2022		Order granting MOTION 11 for Extension of Time to File Answer: Defendant United Healthcare Insurance Company of New York Inc. may have its extension to answer until September 8, 2022. The deadline for submitting the joint letter describing the case and the case management plan 8 remains the same. Ordered by Judge Hector Gonzalez on 7/26/2022. (Duffy, Matthew) (Entered: 07/26/2022)
08/02/2022	12	Letter MOTION for Extension of Time to File Answer re 1 Complaint, by Multiplan Inc.. (Creed, Aimee) (Entered: 08/02/2022)

08/03/2022		ORDER granting Motion for Extension of Time to File Answer 12 . Defendant MultiPlan Inc.'s time to respond to Plaintiff's Complaint 1 is extended to September 8, 2022. The deadline for submitting the joint letter describing the case and the case management plan 8 remains the same. Ordered by Judge Hector Gonzalez on 8/3/2022. (Duffy, Matthew) (Entered: 08/03/2022)
08/17/2022	13	MOTION to Appear Pro Hac Vice *Errol King* Filing fee $ 150, receipt number ANYEDC-15854993. by Multiplan Inc.. (Attachments: # 1 Affidavit, # 2 Exhibit Certificate of Good Standing) (King, Errol) (Entered: 08/17/2022)
08/17/2022	14	Letter MOTION for Extension of Time to File *Case Management Plan (Joint)* by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 08/17/2022)
08/19/2022		ORDER granting 13 Motion for Leave to Appear *Pro Hac Vice*. Attorney Errol J. King, Jr. is granted permission to appear *pro hac vice* on behalf of Defendant MultiPlan, Inc. The attorney shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that he receives electronic notification of activity in this case. Ordered by Judge Hector Gonzalez on 8/19/2022. (Duffy, Matthew) (Entered: 08/19/2022)
08/19/2022		ORDER granting Motion for Extension of Time to File *Case Management Plan (Joint)* 14 . Parties' deadline to file their joint case management plan is extended to September 26, 2022. The deadline for submitting the joint letter describing the case 8 remains the same. Ordered by Judge Hector Gonzalez on 8/19/2022. (Duffy, Matthew) (Entered: 08/19/2022)
08/19/2022	15	NOTICE of Appearance by Errol J. King on behalf of Multiplan Inc. (notification declined or already on case) (King, Errol) (Entered: 08/19/2022)
08/25/2022	16	Letter *Joint pursuant to the Court's July 21, 2022 Order* by Long Island Anesthesiologists PLLC (Breitenbach, Roy) (Entered: 08/25/2022)
08/29/2022	17	MOTION to Appear Pro Hac Vice *(Craig L. Caesar)* Filing fee $ 150, receipt number ANYEDC-15889094. by Multiplan Inc.. (Attachments: # 1 Affidavit of Craig L. Caesar in Support, # 2 Certificates of Good Standing) (Caesar, Craig) (Entered: 08/29/2022)
08/31/2022	18	MOTION to Appear Pro Hac Vice *Katherine C. Mannino* Filing fee $ 150, receipt number ANYEDC-15894891. by Multiplan Inc.. (Attachments: # 1 Affidavit, # 2 Exhibit Certificate of Good Standing) (Mannino, Katherine) (Entered: 08/31/2022)
08/31/2022	19	MOTION to Appear Pro Hac Vice *Taylor Crousillac* Filing fee $ 150, receipt number ANYEDC-15895026. by Multiplan Inc.. (Attachments: # 1 Affidavit, # 2 Exhibit Certificate of Good Standing) (Crousillac, Taylor) (Entered: 08/31/2022)
09/01/2022		ORDER granting 17 Motion for Leave to Appear Pro Hac Vice. Attorney Craig L. Caesar is granted permission to appear *pro hac vice* on behalf of Defendant MultiPlan, Inc. The attorney shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that he receives electronic notification of activity in this case. Ordered by Judge Hector Gonzalez on 9/1/2022. (Duffy, Matthew) (Entered: 09/01/2022)
09/02/2022		ORDER granting 18 Motion for Leave to Appear Pro Hac Vice. Attorney Katherine C. Mannino is granted permission to appear *pro hac vice* on behalf of Defendant MultiPlan, Inc. The attorney shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that she receives electronic notification of activity in this case. Ordered by Judge Hector Gonzalez on 9/2/2022. (Duffy, Matthew) (Entered: 09/02/2022)

09/02/2022		ORDER granting 19 Motion for Leave to Appear Pro Hac Vice. Attorney Taylor Crousillac is granted permission to appear *pro hac vice* on behalf of Defendant MultiPlan, Inc. The attorney shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that he receives electronic notification of activity in this case. Ordered by Judge Hector Gonzalez on 9/2/2022. (Duffy, Matthew) (Entered: 09/02/2022)
09/08/2022	20	Letter *(Pre-Trial Conference Request)* by Multiplan Inc. (Caesar, Craig) (Entered: 09/08/2022)
09/08/2022	21	Letter MOTION for pre motion conference *for Anticipated Filing of Motion to Dismiss* by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 09/08/2022)
09/12/2022		ORDER: In lieu of a pre-motion conference, see ECF Nos. 20 21 , Defendants are permitted to file their motions to dismiss by OCTOBER 10, 2022. Plaintiff shall file its opposition to the motion by NOVEMBER 7, 2022. Defendants shall file their reply, if any, by NOVEMBER 17, 2022. Ordered by Judge Hector Gonzalez on 9/12/2022. (Duffy, Matthew) (Entered: 09/12/2022)
09/26/2022	22	Proposed Scheduling Order by Long Island Anesthesiologists PLLC (Hallak, Daniel) (Entered: 09/26/2022)
09/26/2022	23	Letter MOTION for pre motion conference *for Anticipated Filing of Motion to Stay Discovery* by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 09/26/2022)
10/03/2022	24	Letter MOTION for Leave to File Excess Pages by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 10/03/2022)
10/04/2022	25	REPLY in Opposition re 23 Letter MOTION for pre motion conference *for Anticipated Filing of Motion to Stay Discovery* filed by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 10/04/2022)
10/05/2022	26	MOTION to Appear Pro Hac Vice *for Brian D. Boone* Filing fee $ 150, receipt number ANYEDC-16009783. by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Affidavit of Brian D. Boone, # 2 Certificates of Good Standing) (Boone, Brian) (Entered: 10/05/2022)
10/05/2022	27	MOTION to Appear Pro Hac Vice *for Emily C. McGowan* Filing fee $ 150, receipt number ANYEDC-16009826. by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Affidavit of Emily C. McGowan, # 2 Certificate of Good Standing) (McGowan, Emily) (Entered: 10/05/2022)
10/05/2022	28	MOTION to Appear Pro Hac Vice *for Jordan Elise Edwards* Filing fee $ 150, receipt number ANYEDC-16009845. by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Affidavit of Jordan Elise Edwards, # 2 Certificate of Good Standing) (Edwards, Jordan) (Entered: 10/05/2022)
10/05/2022	29	MOTION to Appear Pro Hac Vice *for D. Andrew Hatchett* Filing fee $ 150, receipt number ANYEDC-16009861. by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Affidavit D. Andrew Hatchett, # 2 Certificates of Good Standing) (Hatchett, David) (Entered: 10/05/2022)
10/07/2022		ORDER granting 24 Motion for Leave to File Excess Pages. Defendant UnitedHealthcare is granted 5 extra pages for its motion to dismiss. Ordered by Judge Hector Gonzalez on 10/7/2022. (MD) (Entered: 10/07/2022)

10/07/2022		ORDER: The Court construes Defendants' premotion conference letter 23 , as well as Plaintiffs' response 25 , as Defendants' Motion to Stay. The Court grants the motion in part and denies it in part and sets a partial discovery schedule pursuant to Rule 16. The Court will set a schedule for additional discovery later this year, after it has reviewed Defendants motions to dismiss. Initial disclosures required by Fed. R. Civ. P. 26(a)(1) will be due by November 17, 2022; Procedures for producing Procedures Electronically Stored Information (ESI) will be discussed by December 1, 2022; Confidentiality order to be submitted for court approval by December 1, 2022. Requests for production of documents and interrogatories will be due November 17, 2022; Response to requests for production of documents and interrogatories will be due December 18, 2022. Requests for admissions will be due December 18, 2022. Ordered by Judge Hector Gonzalez on 10/7/2022. (MD) (Entered: 10/07/2022)
10/10/2022	30	MOTION to Dismiss for Failure to State a Claim by Multiplan Inc.. (Attachments: # 1 Memorandum in Support) (Creed, Aimee) (Entered: 10/10/2022)
10/10/2022	31	MOTION to Dismiss for Failure to State a Claim by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Memorandum in Support, # 2 Declaration of Karl Geercken, # 3 Exhibit 1, # 4 Exhibit 2, # 5 Exhibit 3, # 6 Exhibit 4) (Geercken, Karl) (Entered: 10/10/2022)
10/12/2022		ORDER granting 26 Motion for Leave to Appear Pro Hac Vice. Attorney Brian D. Boone shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that he receives electronic notification of activity in this case. Also, the attorney shall ensure the $150 admission fee be submitted to the Clerks Office via filing the event *Pro Hac Vice Filing Fee*. Ordered by Judge Hector Gonzalez on 10/12/2022. (MD) (Entered: 10/12/2022)
10/12/2022		ORDER granting 27 Motion for Leave to Appear Pro Hac Vice. Attorney Emily C. McGowan shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that she receives electronic notification of activity in this case. Also, the attorney shall ensure the $150 admission fee be submitted to the Clerks Office via filing the event *Pro Hac Vice Filing Fee*. Ordered by Judge Hector Gonzalez on 10/12/2022. (MD) (Entered: 10/12/2022)
10/12/2022		ORDER granting 28 Motion for Leave to Appear Pro Hac Vice. Attorney Jordan Elise Edwards shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that she receives electronic notification of activity in this case. Also, the attorney shall ensure the $150 admission fee be submitted to the Clerks Office via filing the event *Pro Hac Vice Filing Fee*. Ordered by Judge Hector Gonzalez on 10/12/2022. (MD) (Entered: 10/12/2022)
10/12/2022		ORDER granting 29 Motion for Leave to Appear Pro Hac Vice. Attorney David Andrew Hatchett shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that he receives electronic notification of activity in this case. Also, the attorney shall ensure the $150 admission fee be submitted to the Clerks Office via filing the event *Pro Hac Vice Filing Fee*. Ordered by Judge Hector Gonzalez on 10/12/2022. (MD) (Entered: 10/12/2022)
10/14/2022	32	NOTICE of Appearance by Brian David Boone on behalf of United Healthcare Insurance Company of New York Inc. (notification declined or already on case) (Boone, Brian) (Entered: 10/14/2022)

10/14/2022	33	NOTICE of Appearance by Emily McGowan on behalf of United Healthcare Insurance Company of New York Inc. (notification declined or already on case) (McGowan, Emily) (Entered: 10/14/2022)
10/14/2022	34	NOTICE of Appearance by Jordan Elise Edwards on behalf of United Healthcare Insurance Company of New York Inc. (notification declined or already on case) (Edwards, Jordan) (Entered: 10/14/2022)
10/14/2022	35	NOTICE of Appearance by David Andrew Hatchett on behalf of United Healthcare Insurance Company of New York Inc. (notification declined or already on case) (Hatchett, David) (Entered: 10/14/2022)
10/28/2022	36	Letter *regarding Participation of Lawyers* by United Healthcare Insurance Company of New York Inc. (Attachments: # 1 Exhibit A, # 2 Exhibit B) (Geercken, Karl) (Entered: 10/28/2022)
11/02/2022	37	MOTION to Appear Pro Hac Vice *for Karla Doe* Filing fee $ 150, receipt number ANYEDC-16098992. by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Affidavit in Support, # 2 Certificate of Good Standing) (Doe, Karla) (Entered: 11/02/2022)
11/02/2022	38	Letter MOTION for Extension of Time to File Response/Reply as to 30 MOTION to Dismiss for Failure to State a Claim , 31 MOTION to Dismiss for Failure to State a Claim *Extension of the briefing schedule on Defendants' motion to dismiss Complaint* by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 11/02/2022)
11/03/2022		ORDER granting 38 request for an extension of time to file response. The deadline for Plaintiff's opposition to Defendants' motion to dismiss is now November 14, 2022. The deadline for Defendants' reply in support of the motion is now December 5, 2022. Ordered by Judge Hector Gonzalez on 11/3/2022. (MD) (Entered: 11/03/2022)
11/03/2022		ORDER granting 37 Motion for Leave to Appear Pro Hac Vice. Attorney Karla Doe shall register for ECF, registration is available online at www.pacer.gov. Once registered, the attorney shall file a notice of appearance and ensure that she receives electronic notification of activity in this case. Also, the attorney shall ensure the $150 admission fee be submitted to the Clerks Office via filing the event *Pro Hac Vice Filing Fee*. Ordered by Judge Hector Gonzalez on 11/3/2022. (MD) (Entered: 11/03/2022)
11/03/2022	39	NOTICE of Appearance by Karla M. Doe on behalf of United Healthcare Insurance Company of New York Inc. (notification declined or already on case) (Doe, Karla) (Entered: 11/03/2022)
11/09/2022	40	Letter MOTION for Leave to File Excess Pages *10 page enlargement of page limit* by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 11/09/2022)
11/14/2022		ORDER granting 40 Motion for Leave to File Excess Pages. Ordered by Judge Hector Gonzalez on 11/14/2022. (MD) (Entered: 11/14/2022)
11/14/2022	41	DECLARATION re 31 MOTION to Dismiss for Failure to State a Claim , 30 MOTION to Dismiss for Failure to State a Claim by Long Island Anesthesiologists PLLC (Attachments: # 1 Exhibit Breitenbach Decl. Exh. 1, # 2 Exhibit Breitenbach Decl. Exh. 2, # 3 Exhibit Breitenbach Decl. Exh. 3, # 4 Exhibit Breitenbach Decl. Exh. 4, # 5 Exhibit Breitenbach Decl. Exh. 5, # 6 Exhibit Breitenbach Decl. Exh. 6, # 7 Exhibit Breitenbach Decl. Exh. 7, # 8 Exhibit Breitenbach Decl. Exh. 8, # 9 Exhibit Breitenbach Decl. Exh. 9, # 10 Exhibit Breitenbach Decl. Exh. 10, # 11 Exhibit Breitenbach Decl. Exh. 11, # 12 Exhibit Breitenbach Decl. Exh. 12, # 13 Memorandum in Opposition MOL in Opposition to Defendants' Motion to Dismiss) (Breitenbach, Roy) (Entered: 11/14/2022)

11/15/2022	42	MEMORANDUM in Opposition re 30 MOTION to Dismiss for Failure to State a Claim , 31 MOTION to Dismiss for Failure to State a Claim filed by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 11/15/2022)
11/28/2022	43	Letter MOTION for Extension of Time to File *Procedures for Producing Electronically Stored Information (ESI) and Confidentiality Order (Joint)* by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 11/28/2022)
11/30/2022		ORDER granting 43 Motion for Extension of Time to File. Parties' deadline to file procedures for producing electronically stored information (ESI) and the proposed confidentiality order is extended to December 8, 2022. Ordered by Judge Hector Gonzalez on 11/30/2022. (MD) (Entered: 11/30/2022)
12/05/2022	44	REPLY in Support re 30 MOTION to Dismiss for Failure to State a Claim filed by Multiplan Inc.. (Creed, Aimee) (Entered: 12/05/2022)
12/05/2022	45	REPLY to Response to Motion re 31 MOTION to Dismiss for Failure to State a Claim filed by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 12/05/2022)
12/08/2022	46	Joint MOTION for Protective Order *(Motion for entry of stipulated protective order and protocol regarding the discovery of electronically stored information)* by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Exhibit 1) the Stipulated Protective Order, # 2 Exhibit 2) ESI Protocol) (Geercken, Karl) (Entered: 12/08/2022)
12/09/2022	47	ORDER: The Court adopts 46 the parties' Stipulated Protective Order. Ordered by Judge Hector Gonzalez on 12/9/2022. (MD) (Entered: 12/09/2022)
07/14/2023	48	Letter by United Healthcare Insurance Company of New York Inc. (Attachments: # 1 Exhibit 1) copy of decision in Wayne Joseph v. Rebecca Corso) (Boone, Brian) (Entered: 07/14/2023)
09/18/2023	49	Letter *Response to July 14 Letter attaching decision in Joseph v. Corso* by Long Island Anesthesiologists PLLC, Mail receipt (Breitenbach, Roy) (Entered: 09/18/2023)
11/21/2023	50	ORDER: For the reasons set forth in the attached Order, the Court GRANTS Defendants' motions to dismiss. *See* ECF Nos. 30 , 31 . Plaintiff may file a motion seeking leave to amend its complaint, as described in the attached Order, on or before December 12, 2023, and Defendants may file a joint opposition brief by January 4, 2023. If Plaintiff does not seek leave to amend by December 12, 2023, judgment shall be entered, and the case closed. Ordered by Judge Hector Gonzalez on 11/21/2023. (ICP) (Entered: 11/21/2023)
12/07/2023	51	Letter MOTION for Extension of Time to File *Plaintiff's motion for leave to file an amended complaint,* by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 12/07/2023)
12/07/2023		ORDER granting 51 Motion for Extension of Time. Plaintiff may file its motion seeking leave to amend its complaint on or before January 16, 2024, and Defendants may file a joint opposition brief on or before February 16, 2024. Ordered by Judge Hector Gonzalez on 12/7/2023. (ICP) (Entered: 12/07/2023)
01/10/2024	52	Letter MOTION for Extension of Time to File *a motion seeking leave to file an amended complaint* by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 01/10/2024)
01/10/2024		ORDER granting 52 Motion for Extension of Time. Plaintiff may file its motion seeking leave to amend its complaint on or before January 26, 2024, and Defendants may file a joint opposition brief on or before February 26, 2024. No further extensions will be

		granted in the absence of extraordinary circumstances. Ordered by Judge Hector Gonzalez on 1/10/2024. (ICP) (Entered: 01/10/2024)
01/23/2024	53	MOTION for Extension of Time to Amend 1 Complaint, by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 01/23/2024)
01/24/2024		ORDER granting 53 Motion for Extension of Time. Plaintiff may file its motion seeking leave to amend its complaint on or before February 2, 2024, and Defendants may file a joint opposition brief on or before March 4, 2024. This is Plaintiff's third extension request and Plaintiff is warned that no further extensions will be granted. Ordered by Judge Hector Gonzalez on 1/24/2024. (ICP) (Entered: 01/24/2024)
02/02/2024	54	MOTION for Leave to File Document *Notice of Motion for Leave to Amend Complaint* by Long Island Anesthesiologists PLLC. (Attachments: # 1 Declaration Breitenbach Declaration in support of Motion for Leave to Amend, # 2 Exhibit Exhibit 1 to RWB Declaration - LIA Proposed Amended Complaint, # 3 Exhibit Exhibit 2 to RWB Declaration - LIA Proposed Amended Complaint to Original Complaint) (Breitenbach, Roy) (Entered: 02/02/2024)
02/02/2024	55	MEMORANDUM in Support re 54 MOTION for Leave to File Document *Notice of Motion for Leave to Amend Complaint Memorandum of Law in support of Plaintiff's Motion for Leave to Serve an Amended Complaint* filed by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 02/02/2024)
02/22/2024	56	Letter MOTION for Extension of Time to File Response/Reply as to 54 MOTION for Leave to File Document *Notice of Motion for Leave to Amend Complaint* , Letter MOTION for Leave to File Excess Pages by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 02/22/2024)
02/23/2024		ORDER granting 56 Motion for Extension of Time. Defendants shall file their joint opposition to Plaintiff's motion for leave to amend, *see* ECF No. 54 on or before March 18, 2024. Defendants may file a 25-page opposition. Ordered by Judge Hector Gonzalez on 2/23/2024. (ICP) (Entered: 02/23/2024)
03/18/2024	57	MEMORANDUM in Opposition re 54 MOTION for Leave to File Document *Notice of Motion for Leave to Amend Complaint (Joint)* filed by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 03/18/2024)
05/15/2024		ORDER GRANTING 54 Motion for Leave to File an Amended Complaint. The Court has reviewed Plaintiff's proposed Amended Complaint, *see* ECF No. [54-2] and its memorandum in support of its motion to amend, *see* ECF No. 55 , as well as Defendants' memorandum in opposition to Plaintiff's motion, *see* ECF No. 57 . The Second Circuit "strongly favors liberal grant of an opportunity to replead after dismissal of a complaint under Rule 12(b)(6)," *see Noto v. 22nd Century Grp., Inc.*, 35 F.4th 95, 107 (2d Cir. 2022), because of its "strong preference for resolving disputes on the merits," *see Williams v. Citigroup*, 659 F.3d 208, 213 (2d Cir. 2011). Leave to amend should be "freely given" in the absence of factors such as "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party..., [and] futility of amendment." *Foman v. Davis*, 371 U.S. 178, 182 (1962). Here, Defendants argue that the Court should deny Plaintiff's motion because the proposed amendment would be futile. *See* ECF No. 57 at 6. Upon a review of the proposed amended complaint and the parties' briefs, the Court disagrees. Plaintiff has pled additional facts that may be sufficient to overcome the defects that the Court identified in its Order granting Defendants' motion to dismiss, *see* ECF No. 50 . Plaintiff shall file and serve its amended complaint on or before May 28, 2024. Defendants shall answer or otherwise respond to the amended complaint on or before June 27, 2024. If

		Defendants intend to move to dismiss the Amended Complaint, they need not follow the process of filing a pre-motion letter required by Section IV.A of the Court's Individual Practices. Instead, Defendants shall file their papers in support of their motion to dismiss on or before June 27, 2024. Plaintiff shall file its opposition papers on or before July 29, 2024. Defendants' reply papers, if any, shall be filed on or before August 12, 2024. The parties are directed to review Section IV.B. of this Court's Individual Practices and to comply with the page limitations outlined therein. Ordered by Judge Hector Gonzalez on 5/15/2024. (ICP) (Entered: 05/15/2024)
05/28/2024	58	AMENDED COMPLAINT against Multiplan Inc., The Empire Plan Medical/Surgical Program, United Healthcare Insurance Company of New York Inc., filed by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 05/28/2024)
06/20/2024	59	MOTION for Extension of Time to File Answer *: Joint Stipualtion to Extend Deadline to Respond to Plaintiff's Amended Complaint [DE 58]* by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 06/20/2024)
06/21/2024		ORDER granting 59 Motion for Extension of Time. Defendants shall answer or otherwise respond to the amended complaint on or before July 18, 2024. If Defendants move to dismiss the Amended Complaint, Plaintiff shall file its opposition papers on or before August 19, 2024. Defendants' reply papers, if any, shall be filed on or before September 4, 2024. Ordered by Judge Hector Gonzalez on 6/21/2024. (ICP) (Entered: 06/21/2024)
07/18/2024	60	~~*MultiPlan, Inc.'s* ANSWER to 58 Amended Complaint by Multiplan Inc.. (King, Errol)~~ (Entered: 07/18/2024)
07/18/2024	61	MOTION to Dismiss for Failure to State a Claim *the Amended Complaint* by United Healthcare Insurance Company of New York Inc.. (Attachments: # 1 Memorandum in Support) (Geercken, Karl) (Entered: 07/18/2024)
07/18/2024	62	MOTION to Dismiss *Plaintiff's Amended Complaint* by Multiplan Inc.. (Attachments: # 1 Memorandum in Support) (King, Errol) (Entered: 07/18/2024)
07/19/2024		ORDER: Defendant Multiplan Inc. filed its motion seeking to dismiss Plaintiff's Amended Complaint as an Answer to Plaintiff's Amended Complaint, *see* ECF No. 60 , before re-filing the same document as a motion to dismiss, *see* ECF No. 62 . The Court therefore strikes ECF No. 60 . Ordered by Judge Hector Gonzalez on 7/19/2024. (PN) (Entered: 07/19/2024)
08/13/2024	63	Letter MOTION for Extension of Time to File *Ext. of Briefing Sched. - Plaintiffs opposition deadline from 8.19.2024 to 9.9.2024 and to extend Defendants response deadline from 9.4.2024 to 10. 9, 2024* by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 08/13/2024)
08/13/2024		ORDER re 63 Motion for Extension of Time to File. Plaintiff's opposition papers are due on or before September 9, 2024. Defendant's reply papers, if any, are due on or before September 30, 2024. Ordered by Judge Hector Gonzalez on 8/13/2024. (ICP) (Entered: 08/13/2024)
09/09/2024	64	MEMORANDUM in Opposition re 62 MOTION to Dismiss *Plaintiff's Amended Complaint* filed by Long Island Anesthesiologists PLLC. (Breitenbach, Roy) (Entered: 09/09/2024)
09/13/2024	65	Joint MOTION for Extension of Time to File Response/Reply *In Support of Their Motion to Dismiss* by United Healthcare Insurance Company of New York Inc.. (Geercken, Karl) (Entered: 09/13/2024)
09/13/2024		ORDER granting 65 Motion for an Extension of Time to File. Each Defendant may file its reply in support of its motion to dismiss Plaintiff's amended complaint on or before

		October 14, 2024. Ordered by Judge Hector Gonzalez on 9/13/2024. (ICP) (Entered: 09/13/2024)
10/14/2024	66	MEMORANDUM in Support re 62 MOTION to Dismiss *Plaintiff's Amended Complaint* filed by Multiplan Inc.. (King, Errol) (Entered: 10/14/2024)
10/14/2024	67	REPLY in Support re 61 MOTION to Dismiss for Failure to State a Claim *the Amended Complaint* filed by United Healthcare Insurance Company of New York Inc.. (Boone, Brian) (Entered: 10/14/2024)
10/29/2024	68	Letter *re: Joseph v. Corso Decision* by Long Island Anesthesiologists PLLC (Attachments: # 1 Exhibit Joseph v. Corso NY Opinion and Order) (Boone, Brian) (Entered: 10/29/2024)
04/07/2025	69	ORDER: For the reasons set forth in the accompanying Order, the Court GRANTS with prejudice Defendants' motions to dismiss Plaintiff's Sherman Act and Donnelly Act claims and declines to exercise supplemental jurisdiction over Plaintiff's unjust enrichment claim, which it dismisses without prejudice. *See* ECF No. 61-1; ECF No. 62-1. The Clerk of Court is respectfully requested to enter judgment and close this case. Ordered by Judge Hector Gonzalez on 4/7/2025. (DF) (Entered: 04/07/2025)
04/08/2025	70	CLERK'S JUDGMENT: hat Defendants' motions to dismiss Plaintiff's Sherman Act and Donnelly Act claims are granted with prejudice; and that the Court declines to exercise supplemental jurisdiction over Plaintiff's unjust enrichment claim, which it dismisses without prejudice. See ECF No. 61-1; ECF No. 62-1. Signed by Deputy Clerk, Jalitza Poveda, on behalf of Clerk of Court, Brenna B. Mahoney, on 4/8/2025. (JP) (Entered: 04/08/2025)
05/05/2025	71	NOTICE OF APPEAL by Long Island Anesthesiologists PLLC. Filing fee $ 605, receipt number ANYEDC-19015428. (Attachments: # 1 Exhibit Exhibit A - Judgment) (Breitenbach, Roy) (Entered: 05/05/2025)
05/05/2025		Electronic Index to Record on Appeal sent to US Court of Appeals. 71 Notice of Appeal Documents are available via Pacer. For docket entries without a hyperlink or for documents under seal, contact the court and we'll arrange for the document(s) to be made available to you. (VJ) (Entered: 05/05/2025)

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, -against- UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	**COMPLAINT** **JURY TRIAL DEMANDED** Case No.

Plaintiff, Long Island Anesthesiologists PLLC ("LI Anesthesia") by its attorneys, Harris Beach PLLC, alleges for its Complaint against the Defendants, UnitedHealthcare Insurance Company of New York Inc., as Program Administrator, The Empire Plan Medical/Surgical Program ("United") and MultiPlan Inc. ("MultiPlan"), as follows:

INTRODUCTION

1. High-quality and easily accessible anesthesia services are vitally important for the health and well-being of the New York metropolitan area's 18 million residents. These services enable patients to undergo lifesaving and life-changing medical procedures safely and comfortably and manage their pain. Without anesthesia services, much of modern medicine would be impossible. LI Anesthesia is a high-quality anesthesia provider located in southwestern Suffolk County.

2. United – described by the New York Attorney General earlier this year as a "behemoth" health insurer and plan provider – has significant market power in the New York metropolitan area. In addition to being a major commercial insurer and health plan provider, it

also is the administrator of the Empire Plan, which is the health plan for over 1 million public-sector employees.

3. United, as administrator of the Empire Plan, has significant market power. Anesthesiologists cannot pick and choose their patients and cannot turn away patients because of their health coverage or other issues. Given the number of public employees in the New York metropolitan area, anesthesia providers are largely at the mercy of United. For LI Anesthesia, and many other area anesthesia practices, approximately 40% of their revenue comes from the Empire Plan.

4. The Empire Plan historically reimbursed anesthesia providers at usual, customary, and reasonable rates. This changed in January 2022 when, at United's behest, it decreased reimbursement rates by more than 80%. United then enlisted MultiPlan to assist it in a scheme to pressure and prevent anesthesia providers into accepting these rates while requiring onerous and burdensome documentation.

5. Thus, during a time of significant economic upheaval and inflation, vitally essential anesthesia providers are suffering an unsustainable and unending 80+% reimbursement cut. This will certainly decrease the availability of high-quality anesthesia services in the New York metropolitan area; many providers will be forced out of business entirely, and others will be forced to significantly curtail their services and recruitment and retention of well-trained clinicians.

6. But these savings are not being passed on to United's customers or Empire Plan enrollees. Far from it, United is currently seeking a 19% rate increase for next year, even though it generated net earnings of over $17 billion.

7. Rather, United is reducing reimbursement rates by 80+% -- and pressuring anesthesia providers into accepting these rates – *to force these providers out of business.* As we explain below, eliminating LI Anesthesia and other similarly situated anesthesia providers benefits United because it directly provides physician services – including anesthesia services – to patients throughout the United States, including in the New York metropolitan area. Thus, eliminating LI Anesthesia and its fellow anesthesia practices is good for United's business; it removes competitors and harms competition in the market to United's advantage.

8. For these reasons, this Court must step in and immediately put an end to United's illegal, improper, and anticompetitive conduct.

PARTIES

9. Plaintiff, Long Island Anesthesiologists PLLC ("LI Anesthesia"), is a New York professional limited liability company.

10. LI Anesthesia's principal place of business is located at 1000 Montauk Highway, West Islip, New York.11795.

11. Defendant UnitedHealthcare Insurance Company of New York ("United") is licensed by the New York State Department of Financial Services to provide accident and health insurance in New York under New York Insurance Law § 1113(a).

12. Upon information and belief, United's principal place of business is located at 185 Asylum Street, Hartford, Connecticut 06103.

13. United is the Program Administrator of The Empire Plan Medical/Surgical Program.

14. Defendant MultiPlan, Inc. ("MultiPlan") is a New York domestic business corporation.

15. Upon information and belief, MultiPlan's principal place of business is located at 115 Fifth Avenue, 7th Floor, New York, New York 10003.

JURISDICTION AND VENUE

16. This Court has subject-matter jurisdiction over the Sherman Act claims in this lawsuit under 28 U.S.C. § 133, which provides original jurisdiction in this Court over "a claim or right arising under" the laws of the United States.

17. This Court has subject-matter jurisdiction over the New York state law claims in this lawsuit under 28 U.S.C. § 1367(a), which provides supplemental jurisdiction in this Court over "over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution."

18. Venue is proper in this District under 28 U.S.C. § 1391(b)(2) because the acts complained of have occurred within this District.

FACTUAL ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

LI Anesthesia

19. LI Anesthesia is a private anesthesiology practice located in West Islip, New York. It is owned by the anesthesiologists who provide services for the practice.

20. LI Anesthesia's principal line of business is to provide the anesthesia services at Good Samaritan Hospital Medical Center ("Good Samaritan") in West Islip, New York. LI Anesthesia has been providing these services since shortly after Good Samaritan opened in 1959.

21. LI Anesthesia has no ownership interest in Good Samaritan; and Good Samaritan has no ownership in LI Anesthesia. Good Samaritan is a not-for-profit hospital that is part of the Catholic Health system on Long Island.

22. During this time, Good Samaritan has grown from a 175-bed general hospital to a 537-bed tertiary care, Level II trauma center and teaching facility serving the diverse populations of central and south Long Island.

23. Good Samaritan has some of New York's highest volume emergency services, cardiac surgery services, a busy and active labor and delivery area, ambulatory and major surgery units including robotic surgery capabilities, adult and pediatric endoscopy suites, general and intensive care pediatric and neonatology units, advanced interventional cardiology, electrophysiology, and vascular suites, and dedicated surgical and medical intensive care units. LI Anesthesia's anesthesiologists care for patients in all these areas.

24. In addition to its diverse practice at Good Samaritan, LI Anesthesia additionally provides anesthesia services at physician offices and surgery centers around New York and Long Island.

25. Currently, LI Anesthesia employs 36 full-time anesthesiologists, trained mainly at the nation's top academic medical centers. Thirty-four are board-certified by the American Board of Anesthesiology.

26. Many of these anesthesiologists have areas of focus or training in major anesthesiology subspecialties such as pediatrics, obstetrics, cardiothoracic anesthesia, neuroanesthesia, critical care, regional anesthesia for orthopedics, and pain management.

27. At all locations, LI Anesthesia cares for patients with the same exacting standards. Its patients can be assured of care by highly qualified physicians with experience and expertise in complex perioperative management, from the pre-anesthesia assessment, through the delivery of anesthesia, to the alleviation of pain, and, when necessary, care for critical illness. LI Anesthesia is committed to its patients having the best outcomes possible, and the

best anesthetic experience available. LI Anesthesia highly values the privilege of patient care amidst Long Island's unique and diverse patient population.

28. Unlike most medical specialties, anesthesiologists are unable to choose their patients or to turn away prospective patients. Anesthesiologists provide services to all patients undergoing surgical or certain medical procedures at the facilities in which they work regardless of the patient's ability to pay or health coverage status.

29. This is certainly the case with LI Anesthesia. Its agreements with Good Samaritan for example obligate it to provide anesthesia and related services to all patients, without exception, and without regard to the patient's ability to pay or health coverage status.

30. Accordingly, anesthesia practices in general – and LI Anesthesia in particular – are at the mercy of health plans and other third-party payers of health care. Anesthesia practices such as LI Anesthesia cannot pick and choose what health plans to deal with or avoid treating patients of health plans that have low reimbursement rates or are otherwise difficult to deal with.

31. Accordingly, LI Anesthesia must deal with all health plans and other third-party payers of health care.

Anesthesia Reimbursement

32. Generally, there are two types of relationships that medical practices have with health plans. The first is an "in-network" or "participating provider" relationship. The second is an "out-of-network" or "non-participating provider" relationship.

33. In an in-network relationship, the health plan accepts the practice's clinicians as credentialed participating providers, and the parties enter into a participating provider agreement.

34. The parties' participating provider agreement in an in-network relationship governs the amount that the health plan will reimburse the provider for covered services, how claims are submitted, how claims are paid, how disputes are resolved, and such issues as prior approval and pre-certification.

35. The advantages that a medical practice derives from an in-network relationship are (a) being listed in the health plans' material as a participating provider (and thereby increasing referrals of health plan members); and (b) receiving reimbursement directly from the carrier.

36. The other relationship that health plans have with medical practices is an out-of-network relationship. In that type of relationship, there is no contractual agreement between the health plan and the practice. Instead, whether, and to what extent, an out-of-network provider is reimbursed for services that out-of-network providers render to the health plan's members and beneficiaries is dictated by the terms of the health plan documents. Out-of-network providers have no say or control in the terms of these plan documents.

37. Historically, in-network reimbursement rates were lower than out-of-network reimbursement rates. This is because health plans contended that the lower rates were appropriate given the increased referrals the practices would obtain from being listed in health plan directories and other materials. Health plans also contended that the lower rates were appropriate because network participating providers were receiving payment directly from the health plans, which was quicker and easier than what occurs with out-of-network providers.

38. LI Anesthesia, like most anesthesia practices in the New York metropolitan area, typically derive no benefit from being listed in participating provider directories, and accordingly have traditionally chosen to remain out of network with health plans.

United's Size

39. United is a subsidiary of UnitedHealth Group Incorporated (UHG), which is a multi-national managed healthcare and insurance company based in Minnetonka, Minnesota.

40. UHG is the world's eighth largest company by revenue, and the second largest health care company by revenue (only CVS Health is larger). It is the largest insurance company in the United States by net premiums.

41. UHG's 2021 revenues were $287.597 billion, a 12% increase over 2021. Its 2021 net earnings were $17.285 billion.

42. As the New York Attorney General stated earlier this year, UHG is a "behemoth in the healthcare industry." It has purchased over 35 healthcare companies in the last decade.

43. UHG operates, among other things, the largest health insurance company in the United States; a large network of physician groups, outpatient surgical centers, and other healthcare providers, including over 53,000 physicians across 15 states; a pharmacy benefits manager that handles over a billion prescriptions every year; and a healthcare technology business that facilitates the transmission, analysis, and review of health insurance claims.

44. UHG has been subject to significant antitrust and related scrutiny in the last several years because of its size and anticompetitive conduct. *See, e.g.*, *United States v. UnitedHealth Group Incorporated*, 22 Civ. 00481 (D.D.C. filed Feb. 24, 2022); *U.S. Anesthesia Partners v. UnitedHealthcare Insurance Company*, 2021CV31061 (Colo. Dist. Ct. Denver Cty. filed Mar. 31, 2021); *U.S. Anesthesia Partners v. UnitedHealthcare Insurance Company*, DC-2021-04103 (Tex. Dist. Ct. Dallas Cty. filed Mar. 31, 2021); *Fremont Emergency Services (Mandavia) v. UnitedHealth Group*, A-19-792978-B (Nev. 8th Dist. Ct. verdict Dec. 6, 2021) ($62.65 million jury award against UnitedHealthcare).

45. UHG divides its business into two main "platforms": Optum and UnitedHealthcare.

Optum Care Competes with LI Anesthesia

46. Optum describes itself as purportedly serving "the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its Optum Health, Optum Insight and Optum Rx businesses. These businesses improve overall health system performance by optimizing care quality and delivery, reducing costs, and improving consumer and provider experience, leveraging distinctive capabilities in data and analytics, pharmacy care services, health care operations, population health and health care delivery."

47. One of Optum Health's businesses is OptumCare, which acquires physician and other health care practices throughout the United States, and then directly manages them. In 2021, Optum Health generated approximately $54 billion in revenue.

48. Currently, OptumCare is largest employer of physicians in the United States, with more than 53,000 doctors, including anesthesiologists and anesthesia practices, and 1,450 neighborhood clinics across the country. Its current patient base is 19 million people. Last year, it set a growth target of adding 10,000 physicians.

49. In the New York area, OptumCare manages ProHealth, a large multi-specialty practice with 300 locations throughout the metropolitan area. It employs or is affiliated with over 1,000 physicians and other health care providers.

50. Founded on Long Island, ProHealth has practitioners and clinics in virtually every Long Island community. There are six practices alone in West Islip, where LI Anesthesia is

located. ProHealth offers anesthesia services on Long Island, upon information and belief employing at least 22 anesthesiologists.

51. OptumCare also manages CareMount Medical, which currently serves patients throughout New York City, Westchester, Putnam, Dutchess, Columbia, and Ulster Counties.

52. CareMount owns and operates seven urgent care locations, clinical laboratories and radiology services, as well as endoscopy suites and infusion suites. It is affiliated with Massachusetts General Hospital and Northwell Health. Upon information and belief, it currently employs 31 anesthesiologists.

53. OptumCare also manages Riverside Medical Group, a large multi-specialty provider that services patients throughout New Jersey and southern Connecticut.

54. All totaled, OptumCare has 2,100 providers in the New York metropolitan area, including over 50 anesthesiologists. It serves more than 1.6 million patients.

55. OptumCare also owns Sound Physicians, a large physician practice group in the Midwest and Southwest that is a substantial and growing anesthesia provider.

UnitedHealthcare's Market Presence

56. UnitedHealthcare offers a full-range of health benefits and insurance plans through four segments: (a) UnitedHealthcare Employer & Individual, which serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers; (b) UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees; (c) UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants; and (d) UnitedHealthcare Global provides health

and dental benefits and hospital and clinical services to employer groups and individuals in South America, and through other diversified global health services.

57. In terms of size, UnitedHealthcare's provider networks include over 1.5 million physicians and other health care professionals, and more than 7,000 hospitals and other facilities throughout the United States.

58. As of December 31, 2021, UnitedHealthcare Employer & Individual provides access to medical services for 26.6 million people on behalf of its customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

59. In 2021, UnitedHealthcare's national accounts and large group employer commercial health insurance plans had about 23 million members and generated an estimated $31 billion in revenue.

60. UnitedHealthcare Medicare & Retirement provides health benefit services to individuals aged 50 and older in all 50 states, the District of Columbia and most U.S. territories. It served 6.5 million people through its Medicare Advantage products as of December 31, 2021. It also currently serves 4.4 million seniors nationwide through various Medicare Supplement products in association with AARP.

61. UnitedHealthcare Community & State provides services to state programs caring for the poor, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. As of December 31, 2021, UnitedHealthcare Community & State participated in programs in 32 states and the District of Columbia and served 7.7 million people: including nearly 1.4 million people through Medicaid expansion programs in 18 states under the Patient Protection and Affordable Care Act (ACA).

62. UnitedHealthcare has a significant share of the market in the New York area. For example, an analysis by the American Medical Association determined that UnitedHealthcare had the largest market share of health care insurers (all products) as of January 1, 2020, in the New York-Newark-Jersey City, NY-NJ-PA Metropolitan Statistical Area, at 26%. For point-of-service products, UnitedHealthcare's share soars to 66%.

63. Likewise, another study of the market share of commercial insurers in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties) as of the third quarter of 2019 reported that UnitedHealthcare's share was 50%.

The Empire Plan

64. In the New York market, UnitedHealthcare is not just a commercial insurer. Its United subsidiary also acts as the administrator of the Medical/Surgical Program of the Empire Plan, which is part of the New York State Health Insurance Program (NYSHIP). This Program provides health coverage for public employees in New York.

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

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

67. Based on this statutory authority, NYSHIP's Empire Plan pays for covered hospital services, physicians' bills, prescription drugs, and other covered medical expenses of eligible public employees and their dependents. The Empire Plan has contracted with United to administer its Medical/Surgical Program.

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

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

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

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

Empire Plan Reimbursement

72. Historically, the Empire Plan reimbursed out-of-network physicians for providing covered medical services to Plan enrollees at amounts approximating the usual, customary, and reasonable (UCR) rate for the medical services in the geographic area where the services are provided. (2018 Empire Plan Certificate at 44).

73. The UCR rate used by the Empire Plan for out-of-network reimbursement was determined using the benchmarking databases maintained by FAIR Health, established in October 2009 as part of the settlement of an investigation by the Attorney General into conflicts of interest involving UnitedHealthcare[1] involving the adjudication of claims. FAIR Health was formed to create an independent, trusted and transparent source of data to support claims adjudication and to meet the healthcare cost and utilization information needs of all participants in the healthcare community (https://www.fairhealth.org/mission-origin).

74. While Empire Plan's standard out-of-network reimbursement rates were based on the FAIR Health-determined UCR, covered services provided by out-of-network radiologists, anesthesiologists – such as LI Anesthesia –or pathologists at an in-network hospital were reimbursed in full by the Empire Plan. The certificate provides: "If [enrollee] receive[s] anesthesia, radiology or pathology services in connection with covered inpatient or outpatient Hospital services at an Empire Plan Network Hospital and The Empire Plan provides

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

[enrollee's] Primary Coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by the Medical/ Surgical Program" (2018 Empire Plan Certificate at 63).

75. As a result of these provisions, LI Anesthesia, as well as other anesthesia groups in the New York metropolitan area, were able to obtain reasonable reimbursement for providing high-quality, medically necessary anesthesia services to Empire Plan enrollees.

76. Given that this reimbursement was based, in large part, on UCR rates established through Fair Health, the rates at which Empire Plan reimbursed LI Anesthesia, and other anesthesia groups, in the New York metropolitan area for providing medically necessary anesthesia services to Empire Plan enrollees were market rates.

77. It was vitally important that the Empire Plan reimbursed LI Anesthesia and other anesthesia groups in the New York metropolitan area at these rates because, given the number of Empire Plan enrollees, Empire Plan reimbursement represented a significant amount of these groups' revenues.

78. For example, in the years leading up to 2022, Empire Plan represented approximately 40% of LI Anesthesia's revenues.

79. Upon information and belief, Empire Plan represented similar shares of revenues for other anesthesia groups in the New York metropolitan area.

80. Empire Plan's reimbursement levels also significantly benefitted its enrollees. They had broad access to the finest out-of-network specialty physicians in the country. They were protected against the large balance bills and surprise bills that many other patients faced when they didn't have the protections that the Empire Plan enrollees had.

New York Surprise Bill Law

81. Empire Plan enrollees and anesthesia practices such as LI Anesthesia were further benefitted in March 2015 when the New York Surprise Bill Law (Financial Services Law §§ 601-08) became effective. Through Civil Service Law § 162, the Surprise Bill Law also applied to the Empire Plan (Civil Service Law § 162[1][b][iv]).

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

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

84. The Empire Plan and other health plans subject to the Surprise Bill Law were required under the Law to reimburse the out-of-network physicians at a "reasonable amount" for their covered medical services (Financial Services Law §§ 607[a][3] [surprise bills], 605[a][1] [emergency services bills]).

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

86. A qualified independent dispute resolution (IDR) entity then reviewed the disputed bills code-by-code and selects either the out-of-network physician's fee or the health

plan's payment amount as the "reasonable fee for the services rendered" (Financial Services Law §§ 607[a][6] [surprise bills], 605[a][4] [emergency services bills]).

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

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

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

90. Accordingly, at least for those circumstances constituting a surprise bill or an emergency services bill, out-of-network physicians, such as LI Anesthesia, had a remedy if Empire Plan failed to reimburse it near the UCR for covered medical services.

LI Anesthesia Remains Out-of-Network

91. Indeed, these protections, and Empire Plan's reimbursement level, formed the basis of LI Anesthesia's refusal to enter into in-network participating provider agreements with UnitedHealthcare that included the Empire Plan business.

92. Accordingly, when, in or around 2012, UnitedHealthcare started pressuring Good Samaritan Hospital to require LI Anesthesia to become an in-network participating provider, LI

Anesthesia agreed with UnitedHealthcare to become an in-network participating provider for its commercial health plan products, but expressly excluded the Empire Plan from the participating provider agreement. This preserved the favorable Empire Plan out-of-network reimbursement rates for LI Anesthesia. The in-network reimbursement rates imposed by UnitedHealthcare were significantly below these out-of-network reimbursement rates.

93. Most other similarly situated anesthesia groups in the New York metropolitan area were similarly able to avoid entering into an in-network participating provider agreement that included the Empire Plan, to preserve the favorable out-of-network Empire Plan reimbursement rates for them as well.

United's Dramatic Reduction in Reimbursement

94. All this has changed since January 1, 2022, when LI Anesthesia – and other out-of-network physicians – have begun being reimbursed by United for providing medically necessary anesthesia services to Empire Plan enrollees at amounts dramatically less than provided for in the Plan. The reimbursement to these anesthesiologists is in most cases **more than 80% less** than what they were reimbursed for the services in December 2021.

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

96. Rather, at United's insistence, the Empire Plan has "decided" that it will be treated like a non-governmental self-funded employee health plan, which are not subject to New York insurance laws or regulation by State's Department of Financial Services. The New York Surprise Bill Law does not apply to non-governmental self-funded employee health plans; the

out-of-network reimbursement procedures for those plans are governed by the federal No Surprises Act.

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

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

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

100. And, indeed, since January, United has responded to complaints made to the Department of Financial Services by out-of-network physician practices by contending that the Empire Plan is no longer subject to regulation by that agency. Likewise, since January, United has responded to New York IDR proceedings initiated by out-of-network physician practices by contending that because it is no longer subject to New York insurance laws, its reimbursements are no longer reviewable in New York IDR.

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

102. United is also contending – wrongly – that all hospital-based anesthesia cases fall under the No Surprises Act and accordingly, intentionally reimbursing for ambulatory and day admission surgeries at artificially low rates.

No Surprises Act

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

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

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

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

107. For a state law to determine the amount upon which cost-sharing is based and the out-of-network rate, the state law must apply to: [a] the plan, issuer, or coverage involved; [b] the non-participating provider or non-participating emergency facility involved; and [c] the item or service involved. (42 U.S.C. § 300gg-111).

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

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

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

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

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

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

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

115. The New York IDR process is preferable for out-of-network physicians over the federal IDR process, because the New York process is independent and fair, focusing on the FAIR Health-determined UCR rate, while the federal IDR process focuses on the Qualifying

Payment Amount (QPA), which is biased as solely determined by the health plan, and is based on its median in-network rates for the same service in a similar geographic area (42 U.S.C. § 300gg-111[a][3][E]), 111[c][5][C][i][I]).

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

117. Unfortunately, United's efforts did not end with taking the position – wrongly – that the Empire Plan was no longer governed by New York law.[2]

United's and MultiPlan's Scheme to Deprive Anesthesia Providers of Reimbursement

118. After Empire Plan refused to participate in New York IDR for disputed reimbursement claims, LI Anesthesia and other anesthesia groups believed they had no choice but to invoke the federal IDR process under the No Surprise Act.

119. These groups have done so under complete reservations of rights; making it clear that they were seeking federal IDR only because of the Empire Plan's position. They believed that New York IDR was the proper vehicle for resolution of the disputed claims.

120. Puzzlingly, Empire Plan's response to the invocation of the federal IDR process was to contend to the IDR entity that, somehow, it was exempt from the federal IDR process as well.

[2] LI Anesthesia, along with other out-of-network physician groups, have strongly disagreed with United's position regarding the Empire Plan and, accordingly, have commenced a lawsuit in the New York Supreme Court, Albany County, challenging Empire Plan's actions, contending that they violate New York Civil Service Law § 162.

121. Accordingly, LI Anesthesia and other anesthesia groups received responses from the federal IDR entities that "[t]he non-initiating party has provided reason as to why this dispute does not apply for the IDR process. CMS will take a more detailed look into this dispute to determine eligibility. I am unable to provide a time frame at the moment but will keep you updated on the status. It was communicated to us that once a dispute is on hold the timeline is also on hold and therefore there will be no penalty if any deadlines are missed."

122. There is no statute, regulation, guidance, or case that would make the Empire Plan exempt from both the NY state and federal IDR processes for the same claims during the same time frame.

123. Unfortunately, the correspondence from the federal IDR entities was not the end of the saga. Several days after receiving the correspondence, LI Anesthesia started receiving written communications from MultiPlan, identifying itself as working with UnitedHealthcare.

124. The communications purport to respond to LI Anesthesia's "Open Negotiation Notice," and state that the claims have "been identified as a No Surprises Bill under the No Surprises Act. We are offering the Qualifying Payment Amount to resolve this for payment in response to your Open Negotiation Notice. . .. Please note the following[:] upon expiration of the 30-business-day open negotiation period required by the No Surprises Act. If you choose to submit the Federal IDR Process, you must submit a Notice of IDR Initiation through the Federal IDR Portal. . . ."

125. The first set of these notices demand a response in less than 24 hours' time. Thus, it appears from these communications, that UnitedHealthcare, through MultiPlan, was now acknowledging that the federal IDR process applied. When LI Anesthesia and other anesthesia

group representatives called MultiPlan to negotiate the payment amounts, MultiPlan representatives flatly refused, stating that they were only authorized to offer the QPA amount.

126. Thereafter, LI Anesthesia and other anesthesia practices started receiving more notices from MultiPlan as UnitedHealthcare's representative. These notices demanded a response within 45 minutes of receipt, and ominously warned LI Anesthesia that the "No Surprises Act states you must provide justification for your offer on the Open Negotiation Notice request. Some common reasons could be patient severity and acuity, provider level of training, facility teaching status or market share. Our offer is based on the information we currently have available. Failure to provide the requested information will result in your Open Negotiation Notice request being closed without a good faith engagement."

127. Once again, contrary to MultiPlan's representations, there is no statute, regulations, or guidance that obligates LI Anesthesia to provide it with detailed information regarding its reimbursement claims within 45 minutes of demand.

128. To make such demands in connection with scores of reimbursement disputes is the height of bad faith, particularly given the threat that non-compliance will result in the closure of the Open Negotiation period and the implied loss of the right to pursue the disputes.

129. The whole position is particularly disingenuous given that MultiPlan already has said that it has no intent to negotiate further. It is hard to conceive of a scenario other than that this whole process is a cynical attempt to foreclose LI Anesthesia from pursuing any type of IDR on these claims.

130. Other anesthesia groups on Long Island similarly situated to LI Anesthesia received similar correspondence from United and MultiPlan.

131. Not only does this correspondence serve to effectively deny LI Anesthesia and other similarly situated anesthesia providers the ability to contest these abysmally low reimbursement rates, but it is flooding each provider with such a large volume of correspondence demanding responses in ever shortening periods of time – as short of 15 minutes – as to make it impossible to keep up with the flood of correspondence and still keep up with the ability to routinely bill and collect for other anesthesia services.

132. Given all the circumstances, the only logical conclusion that can be drawn is that this campaign of excessive correspondence with exceedingly short deadlines is designed to force anesthesia providers from abandoning their challenges to Empire Plan's low reimbursement.

133. And this is exactly what has happened. Many practices receiving this torrent of correspondence from MultiPlan and United have made the decision not to challenge Empire Plan's low reimbursement rates simply because they lack the bandwidth or resources to keep up with the MultiPlan and United correspondence while at the same time performing routine billing and collection tasks.

Anti-Competitive Harm Caused Anesthesia Providers

134. As a result of these actions, which continue to date, LI Anesthesia and other anesthesia groups are in the untenable and unenviable position where their reimbursement for providing medically necessary anesthesia services have been dramatically cut – more than 80% –by United, with the assistance of MultiPlan, and they have no viable avenue to redress these cuts.

135. The actions of United and MultiPlan regarding the Empire Plan have caused significant harm. The sudden, precipitous decrease in reimbursement – to less than 20% of what

it was in December 2021 – is devastating to LI Anesthesia and other anesthesia providers, particularly given skyrocketing expenses due to inflation and the uncertain economic climate. As a result, many anesthesia practices will be forced to go out of business or dramatically curtail their services.

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

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

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

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

Defendants' Anti-Competitive Motives

140. Defendants' conduct is particularly egregious given that its intent in undertaking this conduct is simply anticompetitive harm and restraint of trade.

141. Put simply, United, aided by MultiPlan, is using its significant market power to drive down out-of-network anesthesia reimbursement rates in the New York metropolitan area knowing full well that the impact of lower reimbursement rates will be to drive out anesthesia providers such as LI Anesthesia.

142. Driving anesthesia providers such as LI Anesthesia from the market will significantly benefit United because, as alleged above, United, through its OptumCare subsidiary, provides anesthesia services in market and is looking to expend its delivery of all healthcare services, including anesthesia services, in the New York metropolitan area.

143. Thus, the elimination of independent anesthesia providers, such as LI Anesthesia, from the market, will significantly benefit United at the expense of LI Anesthesia and other similarly situated anesthesia providers.

144. Not only will Defendants' actions harm LI Anesthesia, but they will also harm other anesthesia providers and, indeed, the whole market.

145. Given United's size and market share, the dramatic lowering of its reimbursement rate for anesthesia services is causing, and will continue to cause, a significant number of anesthesia practices to leave the relevant market by either going out of business entirely or being forced to sell their practices to hospitals or multispecialty groups. Those that survive have will be seriously hampered in their ability to compete.

146. This will result in decreased output and quality of anesthesia services.

147. The dramatic lowering of reimbursement rates will also have a direct negative economic effect on patients, because those patients with high deductible plans or plans with large cost-sharing requirements for out-of-network services may have to pay significantly more out-of-pocket to receive medically necessary services.

148. Because of all the foregoing, Defendants' actions have greatly and irreparably harmed competition in general and LI Anesthesia in particular.

149. There is no reasonable, pro-competitive justification for Defendants' actions, much less one that outweighs these anti-competitive effects.

150. Indeed, while United is decreasing the amount it pays for anesthesia services in the relevant market, it is not passing on these savings to patients or the purchasers of health care coverage.

151. Indeed, premiums have increased. For 2022, United sought an increase in premiums for the small group market in the amount of 17.5%; it obtained an increase of 6.3%. For 2023, United seeks an increase of 19.1%.

SUMMARY OF ANTITRUST ALLEGATIONS

Relevant Product Market

152. The relevant product market at issue here is the provision of medically necessary anesthesia services to patients.

153. Anesthesia services comprises the use of various injected and inhaled medications to produce a loss of sensation in patients, making it possible to carry out procedures that would otherwise cause intolerable pain or be technically unfeasible.

154. Safe anesthesia requires in-depth knowledge of various invasive and non-invasive organ support techniques that are used to control patients' vital functions while under the effects

of anesthetic drugs; these include advanced airway management, invasive and non-invasive hemodynamic monitors, and diagnostic techniques like ultrasonography and echocardiography. Anesthesiologists are expected to have expert knowledge of human physiology, medical physics, and pharmacology, as well as a broad general knowledge of all areas of medicine and surgery in all ages of patients, with a particular focus on those aspects which may impact on a surgical procedure

155. In recent decades, the role of anesthesiologists has broadened to focus not just on administering anesthetics during the surgical procedure itself, but also beforehand to identify high-risk patients and optimize their fitness, during the procedure to maintain situational awareness of the surgery itself to improve safety, as well as afterwards to promote and enhance recovery.

156. Anesthesiologists are also responsible for ensuring adequate pain relief for patients in the immediate postoperative period. The field comprises individualized strategies for all forms of analgesia, including pain management during childbirth, neuro-modulatory technological methods such as transcutaneous electrical nerve stimulation or implanted spinal cord stimulators, regional anesthesia and nerve blocks, and specialized pharmacological regimens.

157. Only appropriately educated, trained, and experienced anesthesiologists have the necessary skills and training to provide these services.

158. Other physicians or clinicians do not have the expertise to competently provide these services and therefore cannot be considered reasonable substitutes.

159. The relevant product market at issue here is the New York metropolitan area.

Relevant Geographic Market

160. Given the chronic and urgent nature of most medical problems requiring procedures performed under anesthesia, patients need to seek this treatment close to where they live and work.

161. Generally, most patients are willing to travel, under the best of circumstances, only about 30 minutes for health care services.[3]

162. Accordingly, the relevant geographic market for anesthesia services in this lawsuit is no larger than the New York metropolitan area, including New York City, Nassau, Suffolk, and Westchester Counties.

United's Market Power

163. LI Anesthesia participates in this market as a "seller" of anesthesia services. Other anesthesia providers – including OptumCare practices – also participate in this market as sellers.

164. Accordingly, LI Anesthesia and other similarly situated anesthesia providers are horizontal competitors of United in this market.

165. The patients of LI Anesthesia, as well as the patients of the other anesthesia providers in the relevant market participate in the relevant market as consumers of anesthesia services.

166. In addition to competing in the market as a seller of anesthesia service, United -- through administering the Empire Plan and other health plans as well as directly providing health plans itself – also participates in the relevant market as a payer or "purchaser" of anesthesia services to the extent plan enrollees seek anesthesia services in the relevant market.

[3] https://altarum.org/sites/default/files/uploaded-publication-files/Altarum_Travel-and-Wait-Times-for-Health-Care-Services_Feb-22.pdf.

167. Multiplan, to the extent that it assists plans in terms of calculating reimbursement levels and facilitating reimbursement, also constitutes a market participant as a payer or purchaser of anesthesia services.

168. For these reasons, the provision of anesthesia services in the New York metropolitan area is the proper antitrust market in connection with this lawsuit.

169. United has market power in this market. As alleged above, Defendants' actions have had, and will continue to have, an actual adverse effect on competition in terms of decreased output and quality in the market for anesthesia services in the New York metropolitan area.

170. Additionally, as alleged above, United has a significant share of the market in the New York area. Depending on the health plan product involved, United's market share is as high as 66%. Its share of commercial insurers in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties) as of the third quarter of 2019 was 50%.

171. And, in the New York market, United also acts as the administrator of the Empire Plan, which is part of the New York State Health Insurance Program (NYSHIP). This Program provides health coverage for over 1.2 million public employees in New York.

172. In the New York metropolitan area, the Empire Plan represents a significant payer of reimbursement for anesthesia services. As alleged above, for LI Anesthesia and similarly situated anesthesia practices, approximately 40% of revenues is received from the Empire Plan.

Defendants' Anti-Competitive Conduct

173. As alleged above, Defendants' anti-competitive conduct here has included significantly reducing reimbursement to anesthesia providers such as LI Anesthesia to more than 80% below previous market levels.

174. Defendants have then taken steps such as bogus negotiations, applying unrealistic deadlines, and burying practices in mountains of correspondence, to force anesthesia practices to accept these low rates.

175. These actions have been undertaken as part of a contract, combination, or conspiracy between United and MultiPlan.

176. Under this contract, combination, or conspiracy, MultiPlan agreed to assist United in attempting to force low reimbursement rates and applying other pressure tactics upon LI Anesthesia and other anesthesia providers, in exchange for a share in the savings.

177. MultiPlan undertook these actions knowing that they would cause significant competitive harm to LI Anesthesia and other anesthesia providers.

178. Defendants' motive is to force LI Anesthesia and other similarly situated anesthesia providers from the market to provide a competitive advantage to United.

Harm to Competition

179. This scheme has harmed, and will continue to harm, competition in the relevant market. Given United's size and market share, the dramatic lowering of its reimbursement rate for anesthesia services is causing, and will continue to cause, a significant number of anesthesia practices to leave the relevant market by either going out of business entirely or being forced to sell their practices to hospitals or multispecialty groups. Those that survive have will be seriously hampered in their ability to compete. This will result in decreased output and quality of anesthesia services.

180. The dramatic lowering of reimbursement rates will also have a direct negative economic effect on patients, because those patients with high deductible plans or plans with large cost-sharing requirements for out-of-network services may have to pay significantly more out-of-pocket to receive medically necessary services.

181. Moreover, there is no reasonable, pro-competitive justification for Defendants' actions, much less one that outweighs these anti-competitive effects. Indeed, while United is decreasing the amount it pays for anesthesia services in the relevant market, it is not passing on these savings to patients or the purchasers of health care coverage.

182. For these reasons, judicial intervention is vitally needed.

FIRST CAUSE OF ACTION

183. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

184. At all times relevant to this Complaint, under the circumstances listed above, Defendants have entered contracts, combinations, or conspiracies in unreasonable restraint of trade in violation of Section 1 of the Sherman Act (15 U.S.C. § 1).

185. These contracts, combinations, or conspiracies have caused substantial anticompetitive effects, including the exclusion of competition by LI Anesthesia and other anesthesia providers, ultimately leading to lower quality and output of anesthesia services available to patients.

186. These contracts, combinations, or conspiracies have no legitimate business justification or offsetting procompetitive benefit. They achieve no legitimate efficiency benefit to counterbalance the anticompetitive effects that they cause.

187. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

SECOND CAUSE OF ACTION

188. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

189. United possesses monopsony power in market for the reimbursement of anesthesia services in the New York metropolitan area.

190. United is willfully maintaining that monopsony power through anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market.

191. United is leveraging that monopsony power to gain anticompetitive advantage in the market for the provision of anesthesia services in the New York metropolitan area.

192. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

THIRD CAUSE OF ACTION

193. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

194. United has engaged in predatory or anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market.

195. United undertook this conduct with the specific intent to monopsonize.

196. United has a dangerous probability of achieving monopsony power.

197. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

FOURTH CAUSE OF ACTION

198. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

199. Defendants possess and exercise market power in the relevant product and geographic markets identified in this Complaint.

200. At all times relevant to this Complaint, Defendants, have entered contracts, combinations, or conspiracies in unreasonable restraint of trade in violation of the Donnelly Act, General Business Law §§ 340, *et seq*.

201. These contracts, combinations, or conspiracies have caused substantial anticompetitive effects, including the exclusion of competition by LI Anesthesia and other providers of anesthesia services, ultimately leading to lower quality anesthesia services available to patients.

202. These contracts, combinations, or conspiracies have no legitimate business justification or offsetting procompetitive benefit. They achieve no legitimate efficiency benefit to counterbalance the anticompetitive effects that they cause.

203. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

FIFTH CAUSE OF ACTION

204. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

205. Defendants were enriched by receiving fees and retaining reimbursement through its scheme of improperly reducing LI Anesthesia's reimbursement.

206. This enrichment was at the expense of LI Anesthesia.

207. It is against equity and good conscience to permit Defendants to retain what is sought to be recovered.

208. By reason of the foregoing, LI Anesthesia been damaged in an amount to be determined at trial.

209. By reason of the foregoing, Defendants have engaged in reckless and morally reprehensible conduct, therefore entitling LI Anesthesia to recover punitive damages.

DEMAND FOR RELIEF

WHEREFORE, the Plaintiff, Long Island Anesthesiologists, PLLC, respectfully requests the following relief:

(a) On the first cause of action, a declaration that Defendants' conduct constitutes violations of Sherman Act § 1, 15 U.S.C. § 1; a permanent injunction preventing Defendants and their agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages in an amount to be determined at trial, to be trebled according to law, to compensate LI Anesthesia for the damages it incurred from Defendants' violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(b) On the second cause of action, a declaration that United's conduct constitutes violations of Sherman Act § 2, 15 U.S.C. § 2; a permanent injunction preventing United and its agents and employees from continuing their unlawful actions set

forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages, in an amount to be determined at trial, to be trebled according to law, to compensate LI Anesthesia for the damages it incurred from United's violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(c) On the third cause of action, a declaration that United's conduct constitutes violations of Sherman Act § 2, 15 U.S.C. § 2; a permanent injunction preventing United and its agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages, in an amount to be determined at trial, to be trebled according to law, to compensate LI Anesthesia for the damages it incurred from United's violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

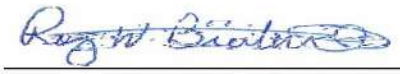
(d) On the fourth cause of action, an award of damages in an amount to be determined at trial.

(e) On the fifth cause of action, an award of compensatory and punitive damages in an amount to be determined at trial.

(f) Such other and further relief this Court deems just and proper including the costs, disbursements, attorney's fees, and other allowances of this action.

Dated: Uniondale, New York
June 30, 2022

HARRIS BEACH, PLLC.
Attorneys for Plaintiff

By 

Roy W. Breitenbach
Daniel Hallak

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(516) 880-8378

TO: UNITEDHEALTHCARE INSURANCE
COMPANY OF NEW YORK, INC.
185 Asylum Street,
Hartford, Connecticut 06103

MULTIPLAN, INC.
115 Fifth Avenue, 7th Floor
New York, New York 10003

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Case No.: 2:22-cv-04040-HG

Plaintiff,

v.

UNITEDHEATLHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC.,

Defendants.

MULTIPLAN, INC.'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT

PLEASE TAKE NOTICE THAT Defendant MultiPlan, Inc. ("MultiPlan"), by and through its undersigned counsel, will move the Honorable Hector Gonzalez of the United States District Court for the Eastern District of New York, located at 225 Cadman Plaza East, Brooklyn, New York, 11201, Courtroom 6A South, on a date and a time to be designated by the court for an Order, pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure, to dismiss the Complaint filed by Long Island Anesthesiologists PLLC ("Plaintiff"), because all of Plaintiff's causes of action against MultiPlan fail to state claims upon which relief can be granted.

MultiPlan requests that the Court dismiss the Complaint in its entirety with prejudice. This Motion is based on the Memorandum of Law filed concurrently herewith, all pleadings on file with this Court, and on such oral argument as may be presented at the hearing on this matter.

October 10, 2022

Respectfully Submitted,

/s/ Aimee Leigh Creed
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Attorneys for Defendant MultiPlan, Inc.

CERTIFICATE OF SERVICE

I, Aimee L. Creed, certify that on October 10, 2022, I caused the foregoing Motion to Dismiss and Memorandum of Law in Support of the Motion to Dismiss to be filed with Clerk of the Court and served upon all counsel of record via the Court's CM/ECF system.

Dated: October 10, 2022

/s/ Aimee Leigh Creed
Aimee Leigh Creed

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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

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

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

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

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

United requests oral argument on its motion.

Dated: October 10, 2022

ALSTON & BIRD LLP

/s/ Karl Geercken

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Attorney for Defendant UnitedHealthcare Insurance Company of New York

CERTIFICATE OF SERVICE

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

/s/ Karl Geercken

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

Attorney for Defendant UnitedHealthcare Insurance Company of New York

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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

DECLARATION OF KARL GEERCKEN

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

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

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

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

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

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

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

Dated: October 10, 2022
New York, New York

/s/ Karl Geercken
Karl Geercken

EXHIBIT 1

FILED: ALBANY COUNTY CLERK 03/28/2022 05:04 PM INDEX NO. 902227-22
NYSCEF DOC. NO. 2 RECEIVED NYSCEF: 03/28/2022

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

WAYNE JOSEPH; THOMAS COTTONE, SONYA HWANG COTTONE: LORETTA POST; LONG ISLAND ANESTHESIOLOGISTS, PLLC; LONG ISLAND ANESTHESIA PHYSICIANS, LLP.; NEW YORK CARDIOVASCULAR ANESTHESIOLOGISTS, P.C.; SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C.; ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC.; DA MEDICAL SERVICES PLLC; DA SILVA PLASTIC & RECONSTRUCTIVE SURGERY, P.C.; HAND ASSOCIATES OF LONG ISLAND, P.C.; ISLANDWIDE SURGICAL, P.C.; K. JACOB COHEN-KASHI, M.D. & LAWRENCE C. LIN, MD, PLLC; LISA CORRENTE, M.D., P.C.; LONG ISLAND NEUROSURGICAL & PAIN SPECIALISTS, PLLC; LONG ISLAND THORACIC SURGERY, P.C.; MONTAUK MEDICAL ASSOCIATES PLLC.; PERFORMANCE MEDICAL PRACTICE PLLC; SAGTIKOS MEDICAL SERVICES, P.C.; SPINE MEDICAL SERVICES, PLLC; and UNITED MEDICAL MONITORING, P.C., Plaintiffs, vs REBECCA CORSO, as Acting Commissioner, NEW YORK STATE DEPARTMENT OF CIVIL SERVICE; UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM; and ADRIENNE A. HARRIS, as Superintendent, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, Defendants.	Index No. _____/2022

COMPLAINT

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

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

PRELIMINARY STATEMENT

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

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

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

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

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

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

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[1] Financial Services Law §§ 601-08.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FACTS COMMON TO ALL CAUSES OF ACTION

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

NYSHIP

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

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

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

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

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

25-1167-cv

United States Court of Appeals

for the

Second Circuit

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiffs-Appellant,

- v –

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK, INC., *AS PROGRAM ADMINISTRATOR FOR THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM*, AND MULTIPLAN INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

JOINT APPENDIX VOLUME 2

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- Order granting motions to dismiss (ECF 50)……...JA 0576
- Motion for Leave to Amend Complaint (ECF 54)……...JA 0594
- Order granting motion for leave, dated 5/15/24……...JA 0595
- Amended Complaint (ECF 58)……JA 0598
- United's Motion to Dismiss Amended Complaint (ECF 61) ……..JA 0661
- MultiPlan's Motion to Dismiss Amended Complaint (ECF 62) ……JA 0664
- Notice of Supplemental Authority (ECF 68) with the attached exhibit……...JA 0667
- Order granting Motion to Dismiss Amended Complaint (ECF 69)……JA 0687
- Clerk's Judgment (ECF 70)……..JA 0718
- Notice of Appeal (ECF 71)……...JA 0719

Civil Service Law § 162

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

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

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

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

The Empire Plan

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

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

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

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

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

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

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

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

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

New York Surprise Bill Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No Surprises Act

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Empire Plan's Illegal Actions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Irreparable Harm Caused by Empire Plan's Illegal Actions

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

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

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

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

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

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

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

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

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

FIRST CAUSE OF ACTION

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

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

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

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

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

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

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

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

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

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

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

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

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

128. Plaintiffs have no adequate remedy at law.

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

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

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

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

SECOND CAUSE OF ACTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

148. Plaintiffs have no adequate remedy at law.

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

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

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

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

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

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

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

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

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

Dated: Uniondale, New York
March 28, 2022

Respectfully submitted,

HARRIS BEACH PLLC

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EXHIBIT 2

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

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

Plaintiffs,

-against-

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

Respondents/Defendants.

AFFIDAVIT
Index No. 902227-22

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

DANIEL YANULAVICH, being duly sworn, deposes and says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

added).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DATED: Albany, New York
August 31, 2022

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

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

Notary Public

JEFFREY M. BRAUDE
Notary Public, State of New York
Qualified in Albany Co. No. 02BR6140609
Commission Expires Jan. 30, 2026

25-1167-cv

United States Court of Appeals

for the

Second Circuit

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiffs-Appellant,

- v –

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK, INC., *AS PROGRAM ADMINISTRATOR FOR THE EMPIRE PLAN MEDICAL / SURGICAL PROGRAM*, AND MULTIPLAN INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

JOINT APPENDIX VOLUME 3

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EXHIBIT 3

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

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

Plaintiffs,

-against-

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

Respondents/Defendants.

Index No. 902227-22

MEMORANDUM OF LAW
IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

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Date: August 31, 2022

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PRELIMINARY STATEMENT

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

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

STATEMENT OF FACTS/PROCEDURAL HISTORY

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

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

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

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

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

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

I. The Surprise Bill Law

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

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

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

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

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

NY Fin. Servs. Law §603(c).

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

II. The No Surprises Act

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

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

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

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

III. Plaintiffs' Claims

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

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

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

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

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

ARGUMENT

I. STANDARD OF REVIEW

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

Dated: Albany, New York
August 31, 2022

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

By: /s/ *William A. Scott*
WILLIAM A. SCOTT
Assistant Attorney General, of Counsel
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TO: All Counsel of Record by NYSCEF

EXHIBIT 4

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

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

Plaintiffs,

-against-

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

Respondents/Defendants.

AFFIRMATION
Index No. 902227-22

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dated: June 3, 2022

_____
JOHN POWELL

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, -against- UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	**DECLARATION OF ROY W. BREITENBACH** Case No. 2:22-cv-04040-HG

I, **Roy W. Breitenbach**, hereby declare under the penalties of perjury and pursuant to 28 U.S.C. § 1746, that:

1. I am an attorney admitted to practice before this Court and a member of the law firm Harris Beach PLLC, attorneys for the Plaintiff Long Island Anesthesiologists PLLC.

2. I submit this declaration in opposition to Defendants' motion to dismiss, which were filed on October 10, 2022 (Dkt 30-31.)

3. Attached as Exhibit 1 is a true and correct copy of the Complaint filed in this action, filed on July 11, 2022.

4. Attached as Exhibit 2 is a true and correct copy of the Complaint filed in *Joseph, et al. v. Corso*, *et al.,* Index No. 902227-22, New York Supreme Court, Albany County, filed on March 28, 2022.

5. Attached as Exhibit 3 is a true and correct copy of the Affidavit of Daniel Yanulavich, dated August 31, 2022, filed in *Joseph, et al. v. Corso*, *et al.,* Index No. 902227-22, New York Supreme Court, Albany County.

6. Attached as Exhibit 4 is a true and correct copy of the docket activity in *Joseph, et. al v. Corso*, *et. al,* Index No. 902227-22, New York Supreme Court, Albany County.

7. Attached as Exhibit 5 is a true and correct copy of the Court's decision in *Anesthesia Assocs. of Ann Arbor, PLLC v. Blue Cross Blue Shield of Mich.*, 20-CV-12916-TGB-APP (E.D. Mich. Sept. 28, 2022).

8. Attached as Exhibit 6 is a true and correct copy of MPI's No Surprises Act statement, which can also be accessed at https://www.MPI.us/no-surprises-act/ (accessed Nov. 11, 2022).

9. Attached as Exhibit 7 is a true and correct copy of MPI's Annual Report (SEC Form 10-K) dated February 25, 2022.

10. Attached as Exhibit 8 is a true and correct copy of MPI's Stockholder Update, which can also be accessed at https://www.MPI.us/MPI-corporation-releases-stockholder-update/#:~:text=UHC%20is%20an%20extraordinary%20customer,wide%20information%20and%20proprietary%20network (accessed Nov. 12, 2022).

11. Attached as Exhibit 9 is a true and correct copy of Churchill Capital/MultiPlan's Virtual Analyst Day presentation, dated August 18, 2020.

12. Attached as Exhibit 10 is a true and correct copy of MPI's Analytic Based Service statement, which can also be accessed at https://www.MPI.us/services/analytics-based/ (accessed Nov. 12, 2022).

13. Attached as Exhibit 11 is a true and correct copy of the Complaint filed in *VHS Liquidating Trust v. MPI Corporation*, CGC-21-594966 (Calif. Super. Ct. San Francisco County Sept 8, 2021).

14. Attached as Exhibit 12 is a true and correct copy of Thomas P. DiNapoli, *Preventing Inappropriate and Excessive Costs in the New York State Health Insurance Program* (N.Y. State Comptroller Audit 2016-D-1 (May 2018).

15. For all the reasons set forth in the accompanying Memorandum of Law, this Court should deny Defendants' motion to dismiss in their entirety.

Dated: November 14, 2022
Uniondale, New York

By: */s/ Roy W. Breitenbach*
Roy W. Breitenbach, Esq.

EXHIBIT 1

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, -against- UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	**COMPLAINT** **JURY TRIAL DEMANDED** Case No.

Plaintiff, Long Island Anesthesiologists PLLC ("LI Anesthesia") by its attorneys, Harris Beach PLLC, alleges for its Complaint against the Defendants, UnitedHealthcare Insurance Company of New York Inc., as Program Administrator, The Empire Plan Medical/Surgical Program ("United") and MultiPlan Inc. ("MultiPlan"), as follows:

INTRODUCTION

1. High-quality and easily accessible anesthesia services are vitally important for the health and well-being of the New York metropolitan area's 18 million residents. These services enable patients to undergo lifesaving and life-changing medical procedures safely and comfortably and manage their pain. Without anesthesia services, much of modern medicine would be impossible. LI Anesthesia is a high-quality anesthesia provider located in southwestern Suffolk County.

2. United – described by the New York Attorney General earlier this year as a "behemoth" health insurer and plan provider – has significant market power in the New York metropolitan area. In addition to being a major commercial insurer and health plan provider, it

also is the administrator of the Empire Plan, which is the health plan for over 1 million public-sector employees.

3. United, as administrator of the Empire Plan, has significant market power. Anesthesiologists cannot pick and choose their patients and cannot turn away patients because of their health coverage or other issues. Given the number of public employees in the New York metropolitan area, anesthesia providers are largely at the mercy of United. For LI Anesthesia, and many other area anesthesia practices, approximately 40% of their revenue comes from the Empire Plan.

4. The Empire Plan historically reimbursed anesthesia providers at usual, customary, and reasonable rates. This changed in January 2022 when, at United's behest, it decreased reimbursement rates by more than 80%. United then enlisted MultiPlan to assist it in a scheme to pressure and prevent anesthesia providers into accepting these rates while requiring onerous and burdensome documentation.

5. Thus, during a time of significant economic upheaval and inflation, vitally essential anesthesia providers are suffering an unsustainable and unending 80+% reimbursement cut. This will certainly decrease the availability of high-quality anesthesia services in the New York metropolitan area; many providers will be forced out of business entirely, and others will be forced to significantly curtail their services and recruitment and retention of well-trained clinicians.

6. But these savings are not being passed on to United's customers or Empire Plan enrollees. Far from it, United is currently seeking a 19% rate increase for next year, even though it generated net earnings of over $17 billion.

7. Rather, United is reducing reimbursement rates by 80+% -- and pressuring anesthesia providers into accepting these rates – *to force these providers out of business.* As we explain below, eliminating LI Anesthesia and other similarly situated anesthesia providers benefits United because it directly provides physician services – including anesthesia services – to patients throughout the United States, including in the New York metropolitan area. Thus, eliminating LI Anesthesia and its fellow anesthesia practices is good for United's business; it removes competitors and harms competition in the market to United's advantage.

8. For these reasons, this Court must step in and immediately put an end to United's illegal, improper, and anticompetitive conduct.

PARTIES

9. Plaintiff, Long Island Anesthesiologists PLLC ("LI Anesthesia"), is a New York professional limited liability company.

10. LI Anesthesia's principal place of business is located at 1000 Montauk Highway, West Islip, New York.11795.

11. Defendant UnitedHealthcare Insurance Company of New York ("United") is licensed by the New York State Department of Financial Services to provide accident and health insurance in New York under New York Insurance Law § 1113(a).

12. Upon information and belief, United's principal place of business is located at 185 Asylum Street, Hartford, Connecticut 06103.

13. United is the Program Administrator of The Empire Plan Medical/Surgical Program.

14. Defendant MultiPlan, Inc. ("MultiPlan") is a New York domestic business corporation.

15. Upon information and belief, MultiPlan's principal place of business is located at 115 Fifth Avenue, 7th Floor, New York, New York 10003.

JURISDICTION AND VENUE

16. This Court has subject-matter jurisdiction over the Sherman Act claims in this lawsuit under 28 U.S.C. § 133, which provides original jurisdiction in this Court over "a claim or right arising under" the laws of the United States.

17. This Court has subject-matter jurisdiction over the New York state law claims in this lawsuit under 28 U.S.C. § 1367(a), which provides supplemental jurisdiction in this Court over "over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution."

18. Venue is proper in this District under 28 U.S.C. § 1391(b)(2) because the acts complained of have occurred within this District.

FACTUAL ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

LI Anesthesia

19. LI Anesthesia is a private anesthesiology practice located in West Islip, New York. It is owned by the anesthesiologists who provide services for the practice.

20. LI Anesthesia's principal line of business is to provide the anesthesia services at Good Samaritan Hospital Medical Center ("Good Samaritan") in West Islip, New York. LI Anesthesia has been providing these services since shortly after Good Samaritan opened in 1959.

21. LI Anesthesia has no ownership interest in Good Samaritan; and Good Samaritan has no ownership in LI Anesthesia. Good Samaritan is a not-for-profit hospital that is part of the Catholic Health system on Long Island.

22. During this time, Good Samaritan has grown from a 175-bed general hospital to a 537-bed tertiary care, Level II trauma center and teaching facility serving the diverse populations of central and south Long Island.

23. Good Samaritan has some of New York's highest volume emergency services, cardiac surgery services, a busy and active labor and delivery area, ambulatory and major surgery units including robotic surgery capabilities, adult and pediatric endoscopy suites, general and intensive care pediatric and neonatology units, advanced interventional cardiology, electrophysiology, and vascular suites, and dedicated surgical and medical intensive care units. LI Anesthesia's anesthesiologists care for patients in all these areas.

24. In addition to its diverse practice at Good Samaritan, LI Anesthesia additionally provides anesthesia services at physician offices and surgery centers around New York and Long Island.

25. Currently, LI Anesthesia employs 36 full-time anesthesiologists, trained mainly at the nation's top academic medical centers. Thirty-four are board-certified by the American Board of Anesthesiology.

26. Many of these anesthesiologists have areas of focus or training in major anesthesiology subspecialties such as pediatrics, obstetrics, cardiothoracic anesthesia, neuroanesthesia, critical care, regional anesthesia for orthopedics, and pain management.

27. At all locations, LI Anesthesia cares for patients with the same exacting standards. Its patients can be assured of care by highly qualified physicians with experience and expertise in complex perioperative management, from the pre-anesthesia assessment, through the delivery of anesthesia, to the alleviation of pain, and, when necessary, care for critical illness. LI Anesthesia is committed to its patients having the best outcomes possible, and the

best anesthetic experience available. LI Anesthesia highly values the privilege of patient care amidst Long Island's unique and diverse patient population.

28. Unlike most medical specialties, anesthesiologists are unable to choose their patients or to turn away prospective patients. Anesthesiologists provide services to all patients undergoing surgical or certain medical procedures at the facilities in which they work regardless of the patient's ability to pay or health coverage status.

29. This is certainly the case with LI Anesthesia. Its agreements with Good Samaritan for example obligate it to provide anesthesia and related services to all patients, without exception, and without regard to the patient's ability to pay or health coverage status.

30. Accordingly, anesthesia practices in general – and LI Anesthesia in particular – are at the mercy of health plans and other third-party payers of health care. Anesthesia practices such as LI Anesthesia cannot pick and choose what health plans to deal with or avoid treating patients of health plans that have low reimbursement rates or are otherwise difficult to deal with.

31. Accordingly, LI Anesthesia must deal with all health plans and other third-party payers of health care.

Anesthesia Reimbursement

32. Generally, there are two types of relationships that medical practices have with health plans. The first is an "in-network" or "participating provider" relationship. The second is an "out-of-network" or "non-participating provider" relationship.

33. In an in-network relationship, the health plan accepts the practice's clinicians as credentialed participating providers, and the parties enter into a participating provider agreement.

34. The parties' participating provider agreement in an in-network relationship governs the amount that the health plan will reimburse the provider for covered services, how claims are submitted, how claims are paid, how disputes are resolved, and such issues as prior approval and pre-certification.

35. The advantages that a medical practice derives from an in-network relationship are (a) being listed in the health plans' material as a participating provider (and thereby increasing referrals of health plan members); and (b) receiving reimbursement directly from the carrier.

36. The other relationship that health plans have with medical practices is an out-of-network relationship. In that type of relationship, there is no contractual agreement between the health plan and the practice. Instead, whether, and to what extent, an out-of-network provider is reimbursed for services that out-of-network providers render to the health plan's members and beneficiaries is dictated by the terms of the health plan documents. Out-of-network providers have no say or control in the terms of these plan documents.

37. Historically, in-network reimbursement rates were lower than out-of-network reimbursement rates. This is because health plans contended that the lower rates were appropriate given the increased referrals the practices would obtain from being listed in health plan directories and other materials. Health plans also contended that the lower rates were appropriate because network participating providers were receiving payment directly from the health plans, which was quicker and easier than what occurs with out-of-network providers.

38. LI Anesthesia, like most anesthesia practices in the New York metropolitan area, typically derive no benefit from being listed in participating provider directories, and accordingly have traditionally chosen to remain out of network with health plans.

United's Size

39. United is a subsidiary of UnitedHealth Group Incorporated (UHG), which is a multi-national managed healthcare and insurance company based in Minnetonka, Minnesota.

40. UHG is the world's eighth largest company by revenue, and the second largest health care company by revenue (only CVS Health is larger). It is the largest insurance company in the United States by net premiums.

41. UHG's 2021 revenues were $287.597 billion, a 12% increase over 2021. Its 2021 net earnings were $17.285 billion.

42. As the New York Attorney General stated earlier this year, UHG is a "behemoth in the healthcare industry." It has purchased over 35 healthcare companies in the last decade.

43. UHG operates, among other things, the largest health insurance company in the United States; a large network of physician groups, outpatient surgical centers, and other healthcare providers, including over 53,000 physicians across 15 states; a pharmacy benefits manager that handles over a billion prescriptions every year; and a healthcare technology business that facilitates the transmission, analysis, and review of health insurance claims.

44. UHG has been subject to significant antitrust and related scrutiny in the last several years because of its size and anticompetitive conduct. *See, e.g.*, *United States v. UnitedHealth Group Incorporated*, 22 Civ. 00481 (D.D.C. filed Feb. 24, 2022); *U.S. Anesthesia Partners v. UnitedHealthcare Insurance Company*, 2021CV31061 (Colo. Dist. Ct. Denver Cty. filed Mar. 31, 2021); *U.S. Anesthesia Partners v. UnitedHealthcare Insurance Company*, DC-2021-04103 (Tex. Dist. Ct. Dallas Cty. filed Mar. 31, 2021); *Fremont Emergency Services (Mandavia) v. UnitedHealth Group*, A-19-792978-B (Nev. 8th Dist. Ct. verdict Dec. 6, 2021) ($62.65 million jury award against UnitedHealthcare).

45. UHG divides its business into two main "platforms": Optum and UnitedHealthcare.

Optum Care Competes with LI Anesthesia

46. Optum describes itself as purportedly serving "the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its Optum Health, Optum Insight and Optum Rx businesses. These businesses improve overall health system performance by optimizing care quality and delivery, reducing costs, and improving consumer and provider experience, leveraging distinctive capabilities in data and analytics, pharmacy care services, health care operations, population health and health care delivery."

47. One of Optum Health's businesses is OptumCare, which acquires physician and other health care practices throughout the United States, and then directly manages them. In 2021, Optum Health generated approximately $54 billion in revenue.

48. Currently, OptumCare is largest employer of physicians in the United States, with more than 53,000 doctors, including anesthesiologists and anesthesia practices, and 1,450 neighborhood clinics across the country. Its current patient base is 19 million people. Last year, it set a growth target of adding 10,000 physicians.

49. In the New York area, OptumCare manages ProHealth, a large multi-specialty practice with 300 locations throughout the metropolitan area. It employs or is affiliated with over 1,000 physicians and other health care providers.

50. Founded on Long Island, ProHealth has practitioners and clinics in virtually every Long Island community. There are six practices alone in West Islip, where LI Anesthesia is

located. ProHealth offers anesthesia services on Long Island, upon information and belief employing at least 22 anesthesiologists.

51. OptumCare also manages CareMount Medical, which currently serves patients throughout New York City, Westchester, Putnam, Dutchess, Columbia, and Ulster Counties.

52. CareMount owns and operates seven urgent care locations, clinical laboratories and radiology services, as well as endoscopy suites and infusion suites. It is affiliated with Massachusetts General Hospital and Northwell Health. Upon information and belief, it currently employs 31 anesthesiologists.

53. OptumCare also manages Riverside Medical Group, a large multi-specialty provider that services patients throughout New Jersey and southern Connecticut.

54. All totaled, OptumCare has 2,100 providers in the New York metropolitan area, including over 50 anesthesiologists. It serves more than 1.6 million patients.

55. OptumCare also owns Sound Physicians, a large physician practice group in the Midwest and Southwest that is a substantial and growing anesthesia provider.

UnitedHealthcare's Market Presence

56. UnitedHealthcare offers a full-range of health benefits and insurance plans through four segments: (a) UnitedHealthcare Employer & Individual, which serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers; (b) UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees; (c) UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants; and (d) UnitedHealthcare Global provides health

and dental benefits and hospital and clinical services to employer groups and individuals in South America, and through other diversified global health services.

57. In terms of size, UnitedHealthcare's provider networks include over 1.5 million physicians and other health care professionals, and more than 7,000 hospitals and other facilities throughout the United States.

58. As of December 31, 2021, UnitedHealthcare Employer & Individual provides access to medical services for 26.6 million people on behalf of its customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

59. In 2021, UnitedHealthcare's national accounts and large group employer commercial health insurance plans had about 23 million members and generated an estimated $31 billion in revenue.

60. UnitedHealthcare Medicare & Retirement provides health benefit services to individuals aged 50 and older in all 50 states, the District of Columbia and most U.S. territories. It served 6.5 million people through its Medicare Advantage products as of December 31, 2021. It also currently serves 4.4 million seniors nationwide through various Medicare Supplement products in association with AARP.

61. UnitedHealthcare Community & State provides services to state programs caring for the poor, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. As of December 31, 2021, UnitedHealthcare Community & State participated in programs in 32 states and the District of Columbia and served 7.7 million people: including nearly 1.4 million people through Medicaid expansion programs in 18 states under the Patient Protection and Affordable Care Act (ACA).

62. UnitedHealthcare has a significant share of the market in the New York area. For example, an analysis by the American Medical Association determined that UnitedHealthcare had the largest market share of health care insurers (all products) as of January 1, 2020, in the New York-Newark-Jersey City, NY-NJ-PA Metropolitan Statistical Area, at 26%. For point-of-service products, UnitedHealthcare's share soars to 66%.

63. Likewise, another study of the market share of commercial insurers in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties) as of the third quarter of 2019 reported that UnitedHealthcare's share was 50%.

The Empire Plan

64. In the New York market, UnitedHealthcare is not just a commercial insurer. Its United subsidiary also acts as the administrator of the Medical/Surgical Program of the Empire Plan, which is part of the New York State Health Insurance Program (NYSHIP). This Program provides health coverage for public employees in New York.

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

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

67. Based on this statutory authority, NYSHIP's Empire Plan pays for covered hospital services, physicians' bills, prescription drugs, and other covered medical expenses of eligible public employees and their dependents. The Empire Plan has contracted with United to administer its Medical/Surgical Program.

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

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

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

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

Empire Plan Reimbursement

72. Historically, the Empire Plan reimbursed out-of-network physicians for providing covered medical services to Plan enrollees at amounts approximating the usual, customary, and reasonable (UCR) rate for the medical services in the geographic area where the services are provided. (2018 Empire Plan Certificate at 44).

73. The UCR rate used by the Empire Plan for out-of-network reimbursement was determined using the benchmarking databases maintained by FAIR Health, established in October 2009 as part of the settlement of an investigation by the Attorney General into conflicts of interest involving UnitedHealthcare[1] involving the adjudication of claims. FAIR Health was formed to create an independent, trusted and transparent source of data to support claims adjudication and to meet the healthcare cost and utilization information needs of all participants in the healthcare community (https://www.fairhealth.org/mission-origin).

74. While Empire Plan's standard out-of-network reimbursement rates were based on the FAIR Health-determined UCR, covered services provided by out-of-network radiologists, anesthesiologists – such as LI Anesthesia –or pathologists at an in-network hospital were reimbursed in full by the Empire Plan. The certificate provides: "If [enrollee] receive[s] anesthesia, radiology or pathology services in connection with covered inpatient or outpatient Hospital services at an Empire Plan Network Hospital and The Empire Plan provides

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

[enrollee's] Primary Coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by the Medical/ Surgical Program" (2018 Empire Plan Certificate at 63).

75. As a result of these provisions, LI Anesthesia, as well as other anesthesia groups in the New York metropolitan area, were able to obtain reasonable reimbursement for providing high-quality, medically necessary anesthesia services to Empire Plan enrollees.

76. Given that this reimbursement was based, in large part, on UCR rates established through Fair Health, the rates at which Empire Plan reimbursed LI Anesthesia, and other anesthesia groups, in the New York metropolitan area for providing medically necessary anesthesia services to Empire Plan enrollees were market rates.

77. It was vitally important that the Empire Plan reimbursed LI Anesthesia and other anesthesia groups in the New York metropolitan area at these rates because, given the number of Empire Plan enrollees, Empire Plan reimbursement represented a significant amount of these groups' revenues.

78. For example, in the years leading up to 2022, Empire Plan represented approximately 40% of LI Anesthesia's revenues.

79. Upon information and belief, Empire Plan represented similar shares of revenues for other anesthesia groups in the New York metropolitan area.

80. Empire Plan's reimbursement levels also significantly benefitted its enrollees. They had broad access to the finest out-of-network specialty physicians in the country. They were protected against the large balance bills and surprise bills that many other patients faced when they didn't have the protections that the Empire Plan enrollees had.

New York Surprise Bill Law

81. Empire Plan enrollees and anesthesia practices such as LI Anesthesia were further benefitted in March 2015 when the New York Surprise Bill Law (Financial Services Law §§ 601-08) became effective. Through Civil Service Law § 162, the Surprise Bill Law also applied to the Empire Plan (Civil Service Law § 162[1][b][iv]).

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

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

84. The Empire Plan and other health plans subject to the Surprise Bill Law were required under the Law to reimburse the out-of-network physicians at a "reasonable amount" for their covered medical services (Financial Services Law §§ 607[a][3] [surprise bills], 605[a][1] [emergency services bills]).

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

86. A qualified independent dispute resolution (IDR) entity then reviewed the disputed bills code-by-code and selects either the out-of-network physician's fee or the health

plan's payment amount as the "reasonable fee for the services rendered" (Financial Services Law §§ 607[a][6] [surprise bills], 605[a][4] [emergency services bills]).

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

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

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

90. Accordingly, at least for those circumstances constituting a surprise bill or an emergency services bill, out-of-network physicians, such as LI Anesthesia, had a remedy if Empire Plan failed to reimburse it near the UCR for covered medical services.

LI Anesthesia Remains Out-of-Network

91. Indeed, these protections, and Empire Plan's reimbursement level, formed the basis of LI Anesthesia's refusal to enter into in-network participating provider agreements with UnitedHealthcare that included the Empire Plan business.

92. Accordingly, when, in or around 2012, UnitedHealthcare started pressuring Good Samaritan Hospital to require LI Anesthesia to become an in-network participating provider, LI

Anesthesia agreed with UnitedHealthcare to become an in-network participating provider for its commercial health plan products, but expressly excluded the Empire Plan from the participating provider agreement. This preserved the favorable Empire Plan out-of-network reimbursement rates for LI Anesthesia. The in-network reimbursement rates imposed by UnitedHealthcare were significantly below these out-of-network reimbursement rates.

93. Most other similarly situated anesthesia groups in the New York metropolitan area were similarly able to avoid entering into an in-network participating provider agreement that included the Empire Plan, to preserve the favorable out-of-network Empire Plan reimbursement rates for them as well.

United's Dramatic Reduction in Reimbursement

94. All this has changed since January 1, 2022, when LI Anesthesia – and other out-of-network physicians – have begun being reimbursed by United for providing medically necessary anesthesia services to Empire Plan enrollees at amounts dramatically less than provided for in the Plan. The reimbursement to these anesthesiologists is in most cases **more than 80% less** than what they were reimbursed for the services in December 2021.

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

96. Rather, at United's insistence, the Empire Plan has "decided" that it will be treated like a non-governmental self-funded employee health plan, which are not subject to New York insurance laws or regulation by State's Department of Financial Services. The New York Surprise Bill Law does not apply to non-governmental self-funded employee health plans; the

out-of-network reimbursement procedures for those plans are governed by the federal No Surprises Act.

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

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

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

100. And, indeed, since January, United has responded to complaints made to the Department of Financial Services by out-of-network physician practices by contending that the Empire Plan is no longer subject to regulation by that agency. Likewise, since January, United has responded to New York IDR proceedings initiated by out-of-network physician practices by contending that because it is no longer subject to New York insurance laws, its reimbursements are no longer reviewable in New York IDR.

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

102. United is also contending – wrongly – that all hospital-based anesthesia cases fall under the No Surprises Act and accordingly, intentionally reimbursing for ambulatory and day admission surgeries at artificially low rates.

No Surprises Act

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

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

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

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

107. For a state law to determine the amount upon which cost-sharing is based and the out-of-network rate, the state law must apply to: [a] the plan, issuer, or coverage involved; [b] the non-participating provider or non-participating emergency facility involved; and [c] the item or service involved. (42 U.S.C. § 300gg-111).

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

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

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

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

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

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

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

115. The New York IDR process is preferable for out-of-network physicians over the federal IDR process, because the New York process is independent and fair, focusing on the FAIR Health-determined UCR rate, while the federal IDR process focuses on the Qualifying

Payment Amount (QPA), which is biased as solely determined by the health plan, and is based on its median in-network rates for the same service in a similar geographic area (42 U.S.C. § 300gg-111[a][3][E]), 111[c][5][C][i][I]).

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

117. Unfortunately, United's efforts did not end with taking the position – wrongly – that the Empire Plan was no longer governed by New York law.[2]

United's and MultiPlan's Scheme to Deprive Anesthesia Providers of Reimbursement

118. After Empire Plan refused to participate in New York IDR for disputed reimbursement claims, LI Anesthesia and other anesthesia groups believed they had no choice but to invoke the federal IDR process under the No Surprise Act.

119. These groups have done so under complete reservations of rights; making it clear that they were seeking federal IDR only because of the Empire Plan's position. They believed that New York IDR was the proper vehicle for resolution of the disputed claims.

120. Puzzlingly, Empire Plan's response to the invocation of the federal IDR process was to contend to the IDR entity that, somehow, it was exempt from the federal IDR process as well.

[2] LI Anesthesia, along with other out-of-network physician groups, have strongly disagreed with United's position regarding the Empire Plan and, accordingly, have commenced a lawsuit in the New York Supreme Court, Albany County, challenging Empire Plan's actions, contending that they violate New York Civil Service Law § 162.

121. Accordingly, LI Anesthesia and other anesthesia groups received responses from the federal IDR entities that "[t]he non-initiating party has provided reason as to why this dispute does not apply for the IDR process. CMS will take a more detailed look into this dispute to determine eligibility. I am unable to provide a time frame at the moment but will keep you updated on the status. It was communicated to us that once a dispute is on hold the timeline is also on hold and therefore there will be no penalty if any deadlines are missed."

122. There is no statute, regulation, guidance, or case that would make the Empire Plan exempt from both the NY state and federal IDR processes for the same claims during the same time frame.

123. Unfortunately, the correspondence from the federal IDR entities was not the end of the saga. Several days after receiving the correspondence, LI Anesthesia started receiving written communications from MultiPlan, identifying itself as working with UnitedHealthcare.

124. The communications purport to respond to LI Anesthesia's "Open Negotiation Notice," and state that the claims have "been identified as a No Surprises Bill under the No Surprises Act. We are offering the Qualifying Payment Amount to resolve this for payment in response to your Open Negotiation Notice. . .. Please note the following[:] upon expiration of the 30-business-day open negotiation period required by the No Surprises Act. If you choose to submit the Federal IDR Process, you must submit a Notice of IDR Initiation through the Federal IDR Portal. . . ."

125. The first set of these notices demand a response in less than 24 hours' time. Thus, it appears from these communications, that UnitedHealthcare, through MultiPlan, was now acknowledging that the federal IDR process applied. When LI Anesthesia and other anesthesia

group representatives called MultiPlan to negotiate the payment amounts, MultiPlan representatives flatly refused, stating that they were only authorized to offer the QPA amount.

126. Thereafter, LI Anesthesia and other anesthesia practices started receiving more notices from MultiPlan as UnitedHealthcare's representative. These notices demanded a response within 45 minutes of receipt, and ominously warned LI Anesthesia that the "No Surprises Act states you must provide justification for your offer on the Open Negotiation Notice request. Some common reasons could be patient severity and acuity, provider level of training, facility teaching status or market share. Our offer is based on the information we currently have available. Failure to provide the requested information will result in your Open Negotiation Notice request being closed without a good faith engagement."

127. Once again, contrary to MultiPlan's representations, there is no statute, regulations, or guidance that obligates LI Anesthesia to provide it with detailed information regarding its reimbursement claims within 45 minutes of demand.

128. To make such demands in connection with scores of reimbursement disputes is the height of bad faith, particularly given the threat that non-compliance will result in the closure of the Open Negotiation period and the implied loss of the right to pursue the disputes.

129. The whole position is particularly disingenuous given that MultiPlan already has said that it has no intent to negotiate further. It is hard to conceive of a scenario other than that this whole process is a cynical attempt to foreclose LI Anesthesia from pursuing any type of IDR on these claims.

130. Other anesthesia groups on Long Island similarly situated to LI Anesthesia received similar correspondence from United and MultiPlan.

131. Not only does this correspondence serve to effectively deny LI Anesthesia and other similarly situated anesthesia providers the ability to contest these abysmally low reimbursement rates, but it is flooding each provider with such a large volume of correspondence demanding responses in ever shortening periods of time – as short of 15 minutes – as to make it impossible to keep up with the flood of correspondence and still keep up with the ability to routinely bill and collect for other anesthesia services.

132. Given all the circumstances, the only logical conclusion that can be drawn is that this campaign of excessive correspondence with exceedingly short deadlines is designed to force anesthesia providers from abandoning their challenges to Empire Plan's low reimbursement.

133. And this is exactly what has happened. Many practices receiving this torrent of correspondence from MultiPlan and United have made the decision not to challenge Empire Plan's low reimbursement rates simply because they lack the bandwidth or resources to keep up with the MultiPlan and United correspondence while at the same time performing routine billing and collection tasks.

Anti-Competitive Harm Caused Anesthesia Providers

134. As a result of these actions, which continue to date, LI Anesthesia and other anesthesia groups are in the untenable and unenviable position where their reimbursement for providing medically necessary anesthesia services have been dramatically cut – more than 80% –by United, with the assistance of MultiPlan, and they have no viable avenue to redress these cuts.

135. The actions of United and MultiPlan regarding the Empire Plan have caused significant harm. The sudden, precipitous decrease in reimbursement – to less than 20% of what

it was in December 2021 – is devastating to LI Anesthesia and other anesthesia providers, particularly given skyrocketing expenses due to inflation and the uncertain economic climate. As a result, many anesthesia practices will be forced to go out of business or dramatically curtail their services.

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

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

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

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

Defendants' Anti-Competitive Motives

140. Defendants' conduct is particularly egregious given that its intent in undertaking this conduct is simply anticompetitive harm and restraint of trade.

141. Put simply, United, aided by MultiPlan, is using its significant market power to drive down out-of-network anesthesia reimbursement rates in the New York metropolitan area knowing full well that the impact of lower reimbursement rates will be to drive out anesthesia providers such as LI Anesthesia.

142. Driving anesthesia providers such as LI Anesthesia from the market will significantly benefit United because, as alleged above, United, through its OptumCare subsidiary, provides anesthesia services in market and is looking to expend its delivery of all healthcare services, including anesthesia services, in the New York metropolitan area.

143. Thus, the elimination of independent anesthesia providers, such as LI Anesthesia, from the market, will significantly benefit United at the expense of LI Anesthesia and other similarly situated anesthesia providers.

144. Not only will Defendants' actions harm LI Anesthesia, but they will also harm other anesthesia providers and, indeed, the whole market.

145. Given United's size and market share, the dramatic lowering of its reimbursement rate for anesthesia services is causing, and will continue to cause, a significant number of anesthesia practices to leave the relevant market by either going out of business entirely or being forced to sell their practices to hospitals or multispecialty groups. Those that survive have will be seriously hampered in their ability to compete.

146. This will result in decreased output and quality of anesthesia services.

147. The dramatic lowering of reimbursement rates will also have a direct negative economic effect on patients, because those patients with high deductible plans or plans with large cost-sharing requirements for out-of-network services may have to pay significantly more out-of-pocket to receive medically necessary services.

148. Because of all the foregoing, Defendants' actions have greatly and irreparably harmed competition in general and LI Anesthesia in particular.

149. There is no reasonable, pro-competitive justification for Defendants' actions, much less one that outweighs these anti-competitive effects.

150. Indeed, while United is decreasing the amount it pays for anesthesia services in the relevant market, it is not passing on these savings to patients or the purchasers of health care coverage.

151. Indeed, premiums have increased. For 2022, United sought an increase in premiums for the small group market in the amount of 17.5%; it obtained an increase of 6.3%. For 2023, United seeks an increase of 19.1%.

SUMMARY OF ANTITRUST ALLEGATIONS

Relevant Product Market

152. The relevant product market at issue here is the provision of medically necessary anesthesia services to patients.

153. Anesthesia services comprises the use of various injected and inhaled medications to produce a loss of sensation in patients, making it possible to carry out procedures that would otherwise cause intolerable pain or be technically unfeasible.

154. Safe anesthesia requires in-depth knowledge of various invasive and non-invasive organ support techniques that are used to control patients' vital functions while under the effects

of anesthetic drugs; these include advanced airway management, invasive and non-invasive hemodynamic monitors, and diagnostic techniques like ultrasonography and echocardiography. Anesthesiologists are expected to have expert knowledge of human physiology, medical physics, and pharmacology, as well as a broad general knowledge of all areas of medicine and surgery in all ages of patients, with a particular focus on those aspects which may impact on a surgical procedure

155. In recent decades, the role of anesthesiologists has broadened to focus not just on administering anesthetics during the surgical procedure itself, but also beforehand to identify high-risk patients and optimize their fitness, during the procedure to maintain situational awareness of the surgery itself to improve safety, as well as afterwards to promote and enhance recovery.

156. Anesthesiologists are also responsible for ensuring adequate pain relief for patients in the immediate postoperative period. The field comprises individualized strategies for all forms of analgesia, including pain management during childbirth, neuro-modulatory technological methods such as transcutaneous electrical nerve stimulation or implanted spinal cord stimulators, regional anesthesia and nerve blocks, and specialized pharmacological regimens.

157. Only appropriately educated, trained, and experienced anesthesiologists have the necessary skills and training to provide these services.

158. Other physicians or clinicians do not have the expertise to competently provide these services and therefore cannot be considered reasonable substitutes.

159. The relevant product market at issue here is the New York metropolitan area.

Relevant Geographic Market

160. Given the chronic and urgent nature of most medical problems requiring procedures performed under anesthesia, patients need to seek this treatment close to where they live and work.

161. Generally, most patients are willing to travel, under the best of circumstances, only about 30 minutes for health care services.[3]

162. Accordingly, the relevant geographic market for anesthesia services in this lawsuit is no larger than the New York metropolitan area, including New York City, Nassau, Suffolk, and Westchester Counties.

United's Market Power

163. LI Anesthesia participates in this market as a "seller" of anesthesia services. Other anesthesia providers – including OptumCare practices – also participate in this market as sellers.

164. Accordingly, LI Anesthesia and other similarly situated anesthesia providers are horizontal competitors of United in this market.

165. The patients of LI Anesthesia, as well as the patients of the other anesthesia providers in the relevant market participate in the relevant market as consumers of anesthesia services.

166. In addition to competing in the market as a seller of anesthesia service, United -- through administering the Empire Plan and other health plans as well as directly providing health plans itself – also participates in the relevant market as a payer or "purchaser" of anesthesia services to the extent plan enrollees seek anesthesia services in the relevant market.

[3] https://altarum.org/sites/default/files/uploaded-publication-files/Altarum_Travel-and-Wait-Times-for-Health-Care-Services_Feb-22.pdf.

167. Multiplan, to the extent that it assists plans in terms of calculating reimbursement levels and facilitating reimbursement, also constitutes a market participant as a payer or purchaser of anesthesia services.

168. For these reasons, the provision of anesthesia services in the New York metropolitan area is the proper antitrust market in connection with this lawsuit.

169. United has market power in this market. As alleged above, Defendants' actions have had, and will continue to have, an actual adverse effect on competition in terms of decreased output and quality in the market for anesthesia services in the New York metropolitan area.

170. Additionally, as alleged above, United has a significant share of the market in the New York area. Depending on the health plan product involved, United's market share is as high as 66%. Its share of commercial insurers in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties) as of the third quarter of 2019 was 50%.

171. And, in the New York market, United also acts as the administrator of the Empire Plan, which is part of the New York State Health Insurance Program (NYSHIP). This Program provides health coverage for over 1.2 million public employees in New York.

172. In the New York metropolitan area, the Empire Plan represents a significant payer of reimbursement for anesthesia services. As alleged above, for LI Anesthesia and similarly situated anesthesia practices, approximately 40% of revenues is received from the Empire Plan.

Defendants' Anti-Competitive Conduct

173. As alleged above, Defendants' anti-competitive conduct here has included significantly reducing reimbursement to anesthesia providers such as LI Anesthesia to more than 80% below previous market levels.

174. Defendants have then taken steps such as bogus negotiations, applying unrealistic deadlines, and burying practices in mountains of correspondence, to force anesthesia practices to accept these low rates.

175. These actions have been undertaken as part of a contract, combination, or conspiracy between United and MultiPlan.

176. Under this contract, combination, or conspiracy, MultiPlan agreed to assist United in attempting to force low reimbursement rates and applying other pressure tactics upon LI Anesthesia and other anesthesia providers, in exchange for a share in the savings.

177. MultiPlan undertook these actions knowing that they would cause significant competitive harm to LI Anesthesia and other anesthesia providers.

178. Defendants' motive is to force LI Anesthesia and other similarly situated anesthesia providers from the market to provide a competitive advantage to United.

Harm to Competition

179. This scheme has harmed, and will continue to harm, competition in the relevant market. Given United's size and market share, the dramatic lowering of its reimbursement rate for anesthesia services is causing, and will continue to cause, a significant number of anesthesia practices to leave the relevant market by either going out of business entirely or being forced to sell their practices to hospitals or multispecialty groups. Those that survive have will be seriously hampered in their ability to compete. This will result in decreased output and quality of anesthesia services.

180. The dramatic lowering of reimbursement rates will also have a direct negative economic effect on patients, because those patients with high deductible plans or plans with large cost-sharing requirements for out-of-network services may have to pay significantly more out-of-pocket to receive medically necessary services.

181. Moreover, there is no reasonable, pro-competitive justification for Defendants' actions, much less one that outweighs these anti-competitive effects. Indeed, while United is decreasing the amount it pays for anesthesia services in the relevant market, it is not passing on these savings to patients or the purchasers of health care coverage.

182. For these reasons, judicial intervention is vitally needed.

FIRST CAUSE OF ACTION

183. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

184. At all times relevant to this Complaint, under the circumstances listed above, Defendants have entered contracts, combinations, or conspiracies in unreasonable restraint of trade in violation of Section 1 of the Sherman Act (15 U.S.C. § 1).

185. These contracts, combinations, or conspiracies have caused substantial anticompetitive effects, including the exclusion of competition by LI Anesthesia and other anesthesia providers, ultimately leading to lower quality and output of anesthesia services available to patients.

186. These contracts, combinations, or conspiracies have no legitimate business justification or offsetting procompetitive benefit. They achieve no legitimate efficiency benefit to counterbalance the anticompetitive effects that they cause.

187. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

SECOND CAUSE OF ACTION

188. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

189. United possesses monopsony power in market for the reimbursement of anesthesia services in the New York metropolitan area.

190. United is willfully maintaining that monopsony power through anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market.

191. United is leveraging that monopsony power to gain anticompetitive advantage in the market for the provision of anesthesia services in the New York metropolitan area.

192. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

THIRD CAUSE OF ACTION

193. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

194. United has engaged in predatory or anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market.

195. United undertook this conduct with the specific intent to monopsonize.

196. United has a dangerous probability of achieving monopsony power.

197. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

FOURTH CAUSE OF ACTION

198. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

199. Defendants possess and exercise market power in the relevant product and geographic markets identified in this Complaint.

200. At all times relevant to this Complaint, Defendants, have entered contracts, combinations, or conspiracies in unreasonable restraint of trade in violation of the Donnelly Act, General Business Law §§ 340, *et seq*.

201. These contracts, combinations, or conspiracies have caused substantial anticompetitive effects, including the exclusion of competition by LI Anesthesia and other providers of anesthesia services, ultimately leading to lower quality anesthesia services available to patients.

202. These contracts, combinations, or conspiracies have no legitimate business justification or offsetting procompetitive benefit. They achieve no legitimate efficiency benefit to counterbalance the anticompetitive effects that they cause.

203. Because of the foregoing, LI Anesthesia has been damaged in an amount to be determined at trial.

FIFTH CAUSE OF ACTION

204. LI Anesthesia repeats and re-alleges each of the above paragraphs as though fully set forth herein.

205. Defendants were enriched by receiving fees and retaining reimbursement through its scheme of improperly reducing LI Anesthesia's reimbursement.

206. This enrichment was at the expense of LI Anesthesia.

207. It is against equity and good conscience to permit Defendants to retain what is sought to be recovered.

208. By reason of the foregoing, LI Anesthesia been damaged in an amount to be determined at trial.

209. By reason of the foregoing, Defendants have engaged in reckless and morally reprehensible conduct, therefore entitling LI Anesthesia to recover punitive damages.

DEMAND FOR RELIEF

WHEREFORE, the Plaintiff, Long Island Anesthesiologists, PLLC, respectfully requests the following relief:

(a) On the first cause of action, a declaration that Defendants' conduct constitutes violations of Sherman Act § 1, 15 U.S.C. § 1; a permanent injunction preventing Defendants and their agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages in an amount to be determined at trial, to be trebled according to law, to compensate LI Anesthesia for the damages it incurred from Defendants' violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(b) On the second cause of action, a declaration that United's conduct constitutes violations of Sherman Act § 2, 15 U.S.C. § 2; a permanent injunction preventing United and its agents and employees from continuing their unlawful actions set

forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages, in an amount to be determined at trial, to be trebled according to law, to compensate LI Anesthesia for the damages it incurred from United's violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(c) On the third cause of action, a declaration that United's conduct constitutes violations of Sherman Act § 2, 15 U.S.C. § 2; a permanent injunction preventing United and its agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages, in an amount to be determined at trial, to be trebled according to law, to compensate LI Anesthesia for the damages it incurred from United's violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(d) On the fourth cause of action, an award of damages in an amount to be determined at trial.

(e) On the fifth cause of action, an award of compensatory and punitive damages in an amount to be determined at trial.

(f) Such other and further relief this Court deems just and proper including the costs, disbursements, attorney's fees, and other allowances of this action.

Dated: Uniondale, New York
June 30, 2022

HARRIS BEACH, PLLC.
Attorneys for Plaintiff

By

Roy W. Breitenbach
Daniel Hallak

The Omni
333 Earle Ovington Boulevard
Uniondale, New York 11553
(516) 880-8378

TO: UNITEDHEALTHCARE INSURANCE
COMPANY OF NEW YORK, INC.
185 Asylum Street,
Hartford, Connecticut 06103

MULTIPLAN, INC.
115 Fifth Avenue, 7th Floor
New York, New York 10003

JS 44 (Rev. 4-29-21)

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

LONG ISLAND ANESTHESIOLOGISTS PLLC

(b) County of Residence of First Listed Plaintiff Suffolk
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Roy W. Breitenbach, Esq. - Harris Beach, PLLC.
333 Earle Ovington Boulevard, Uniondale, NY 11553
516-880-8484

DEFENDANTS

United Heathcare Ins. Co. OF NY Inc., as Program Administrator, The Empire Plan Medical/Surgical Program

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)*

Does this action include a motion for temporary restraining order or order to show cause? Yes ☐ No ☑

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)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☒ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

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)*:
15 USC 1, 2

Brief description of cause:
Defendants engaged in monopsonistic and other anticompetitive conduct that harmed plaintiff and other market participants

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $ TBD

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions)*:

JUDGE _____ DOCKET NUMBER _____

DATE
July 1, 2022

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

CERTIFICATION OF ARBITRATION ELIGIBILITY

Local Arbitration Rule 83.7 provides that with certain exceptions, actions seeking money damages only in an amount not in excess of $150,000, exclusive of interest and costs, are eligible for compulsory arbitration. The amount of damages is presumed to be below the threshold amount unless a certification to the contrary is filed.

Case is Eligible for Arbitration ☐

I, Roy Breitenbach, counsel for Plaintiff, do hereby certify that the above captioned civil action is ineligible for compulsory arbitration for the following reason(s):

☑ monetary damages sought are in excess of $150,000, exclusive of interest and costs,

☑ the complaint seeks injunctive relief,

☐ the matter is otherwise ineligible for the following reason

DISCLOSURE STATEMENT - FEDERAL RULES CIVIL PROCEDURE 7.1

Identify any parent corporation and any publicly held corporation that owns 10% or more or its stocks:

RELATED CASE STATEMENT (Section VIII on the Front of this Form)

Please list all cases that are arguably related pursuant to Division of Business Rule 50.3.1 in Section VIII on the front of this form. Rule 50.3.1 (a) provides that "A civil case is "related" to another civil case for purposes of this guideline when, because of the similarity of facts and legal issues or because the cases arise from the same transactions or events, a substantial saving of judicial resources is likely to result from assigning both cases to the same judge and magistrate judge." Rule 50.3.1 (b) provides that " A civil case shall not be deemed "related" to another civil case merely because the civil case: (A) involves identical legal issues, or (B) involves the same parties." Rule 50.3.1 (c) further provides that "Presumptively, and subject to the power of a judge to determine otherwise pursuant to paragraph (d), civil cases shall not be deemed to be "related" unless both cases are still pending before the court."

NY-E DIVISION OF BUSINESS RULE 50.1(d)(2)

1.) Is the civil action being filed in the Eastern District removed from a New York State Court located in Nassau or Suffolk County? ☐ Yes ☑ No

2.) If you answered "no" above:

a) Did the events or omissions giving rise to the claim or claims, or a substantial part thereof, occur in Nassau or Suffolk County? ☑ Yes ☐ No

b) Did the events or omissions giving rise to the claim or claims, or a substantial part thereof, occur in the Eastern District? ☑ Yes ☐ No

c) If this is a Fair Debt Collection Practice Act case, specify the County in which the offending communication was received:

If your answer to question 2 (b) is "No," does the defendant (or a majority of the defendants, if there is more than one) reside in Nassau or Suffolk County, or, in an interpleader action, does the claimant (or a majority of the claimants, if there is more than one) reside in Nassau or Suffolk County? ☐ Yes ☐ No

(Note: A corporation shall be considered a resident of the County in which it has the most significant contacts).

BAR ADMISSION

I am currently admitted in the Eastern District of New York and currently a member in good standing of the bar of this court.

☑ Yes ☐ No

Are you currently the subject of any disciplinary action (s) in this or any other state or federal court?

☐ Yes (If yes, please explain ☑ No

I certify the accuracy of all information provided above.

Signature: _____

Last Modified: 11/27/2017

EXHIBIT 2

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

WAYNE JOSEPH; THOMAS COTTONE, SONYA HWANG COTTONE: LORETTA POST; LONG ISLAND ANESTHESIOLOGISTS, PLLC; LONG ISLAND ANESTHESIA PHYSICIANS, LLP.; NEW YORK CARDIOVASCULAR ANESTHESIOLOGISTS, P.C.; SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C.; ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC.; DA MEDICAL SERVICES PLLC; DA SILVA PLASTIC & RECONSTRUCTIVE SURGERY, P.C.; HAND ASSOCIATES OF LONG ISLAND, P.C.; ISLANDWIDE SURGICAL, P.C.; K. JACOB COHEN-KASHI, M.D. & LAWRENCE C. LIN, MD, PLLC; LISA CORRENTE, M.D., P.C.; LONG ISLAND NEUROSURGICAL & PAIN SPECIALISTS, PLLC; LONG ISLAND THORACIC SURGERY, P.C.; MONTAUK MEDICAL ASSOCIATES PLLC.; PERFORMANCE MEDICAL PRACTICE PLLC; SAGTIKOS MEDICAL SERVICES, P.C.; SPINE MEDICAL SERVICES, PLLC; and UNITED MEDICAL MONITORING, P.C., Plaintiffs, vs REBECCA CORSO, as Acting Commissioner, NEW YORK STATE DEPARTMENT OF CIVIL SERVICE; UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM; and ADRIENNE A. HARRIS, as Superintendent, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, Defendants.	Index No. _____/2022

COMPLAINT

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

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

PRELIMINARY STATEMENT

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

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

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

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

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

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

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[1]Financial Services Law §§ 601-08.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FACTS COMMON TO ALL CAUSES OF ACTION

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

NYSHIP

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

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

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

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

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

Civil Service Law § 162

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

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

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

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

The Empire Plan

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

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

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

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

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

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

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

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

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

New York Surprise Bill Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No Surprises Act

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Empire Plan's Illegal Actions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Irreparable Harm Caused by Empire Plan's Illegal Actions

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

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

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

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

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

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

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

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

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

FIRST CAUSE OF ACTION

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

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

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

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

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

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

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

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

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

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

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

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

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

128. Plaintiffs have no adequate remedy at law.

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

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

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

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

SECOND CAUSE OF ACTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

148. Plaintiffs have no adequate remedy at law.

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

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

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

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

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

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

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

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

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

Dated: Uniondale, New York
March 28, 2022

Respectfully submitted,

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25-1167-cv

United States Court of Appeals

for the

Second Circuit

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiffs-Appellant,

- v –

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK, INC., *AS PROGRAM ADMINISTRATOR FOR THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM*, AND MULTIPLAN INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

JOINT APPENDIX VOLUME 4

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EXHIBIT 3

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

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

Plaintiffs,

-against-

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

Respondents/Defendants.

AFFIDAVIT
Index No. 902227-22

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

DANIEL YANULAVICH, being duly sworn, deposes and says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

added).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DATED: Albany, New York
August 31, 2022

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

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

Notary Public

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

EXHIBIT 4

NYSCEF - New York State Courts Electronic Filing (Live System)

902227-22 - Albany County Supreme Court

Short Caption: **WAYNE JOSEPH et al v. REBECCA CORSO et al**
Case Type: **Commercial Division**
Case Status: **Active**
eFiling Status: **Full Participation Recorded**
Assigned Judge: **Roger Mcdonough**

E-mail Participating Parties

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Motion Info: Please select... Filed Date:
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Document Number:
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#	Document	Filed By	Status
1	SUMMONS *Summons*	Breitenbach, R. Filed: 03/28/2022 *Received: 03/28/2022*	**Processed** Confirmation Notice
2	COMPLAINT	Breitenbach, R. Filed: 03/28/2022 *Received: 03/28/2022*	**Processed** Confirmation Notice
3	EXHIBIT(S) - A *NYSHIP Complaint Exh A (Empire Plan 2018 Certificate)*	Breitenbach, R. Filed: 03/28/2022 *Received: 03/28/2022*	**Processed** Confirmation Notice
4	EXHIBIT(S) - B *NYSHIP Complaint Exh B (NYSHIP OON Disclosures 2020)*	Breitenbach, R. Filed: 03/28/2022 *Received: 03/28/2022*	**Processed** Confirmation Notice
5	EXHIBIT(S) - C *NYSHIP Complaint Exh C (DFS Circular Letter 10-2021)*	Breitenbach, R. Filed: 03/28/2022 *Received: 03/28/2022*	**Processed** Confirmation Notice
6	SUMMONS (PRE RJI) (AMENDED) *Amended Summons*	Breitenbach, R. Filed: 03/29/2022 *Received: 03/29/2022*	**Processed** Confirmation Notice
7	AFFIDAVIT *Affidavit of Service - Attorney General of the State of NY*	Breitenbach, R. Filed: 03/31/2022 *Received: 03/31/2022*	**Processed** Confirmation Notice
8	AFFIDAVIT *Affidavit of Service - Rebecca Corso - NYS Dept. of Civil Service*	Breitenbach, R. Filed: 03/31/2022 *Received: 03/31/2022*	**Processed** Confirmation Notice
9	AFFIDAVIT *Affidavit of Service Upon Unitedhealthcare Insurance Company of NY*	Breitenbach, R. Filed: 04/07/2022 *Received: 04/07/2022*	**Processed** Confirmation Notice
10	AFFIDAVIT *Affidavit of Service Upon The Empire Plan Medical/Surgical Program*	Breitenbach, R. Filed: 04/07/2022 *Received: 04/07/2022*	**Processed** Confirmation Notice
11	ORDER TO SHOW CAUSE (PROPOSED) *Proposed OTSC*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice Payment Receipt
12	AFFIDAVIT *Affidavit of John Von Lintig*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
13	EXHIBIT(S) - 1 *Von Lintig Exhibit 1*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
14	AFFIDAVIT *Affidavit of Wayne Joseph*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
15	AFFIDAVIT *Affidavit of Loretta Post*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
16	AFFIDAVIT *Affidavit of Steven Schulman, M.D.*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
#	Document	Filed By	Status

#	Document	Filed/Received	Status
17	EXHIBIT(S) - 1 *Schulman Exhibit 1*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
18	MEMORANDUM OF LAW *MOL in Support of Preliminary Injunction*	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
19	RJI -RE: ORDER TO SHOW CAUSE	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice Payment Receipt
20	ADDENDUM - GENERAL (840A)	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
21	ADDENDUM - COMMERCIAL DIVISION (840C)	Hallak, D. Filed: 05/03/2022 *Received: 05/03/2022*	**Processed** Confirmation Notice
22	LETTER/CORRESPONDENCE FROM COURT	Court User **Filed: 05/05/2022** *Received: 05/05/2022*	**Processed** Confirmation Notice
23	ORDER TO SHOW CAUSE-SIGNED (Motion #1)	Court User **Filed: 05/11/2022** *Received: 05/11/2022*	**Processed** Confirmation Notice
24	AFFIDAVIT *Affidavit of Service - OTSC with Supporting Docs*	Breitenbach, R. Filed: 05/13/2022 *Received: 05/13/2022*	**Processed** Confirmation Notice
25	ADJOURNMENT OF MOTION -REQUEST *Letter Requesting Extension of Time to Oppose OTSC Submitted on Consent*	Scott, W. Filed: 05/25/2022 *Received: 05/25/2022*	**Processed** Confirmation Notice
26	LETTER/CORRESPONDENCE - SO ORDERED	Court User **Filed: 05/26/2022** *Received: 05/26/2022*	**Processed** Confirmation Notice
27	LETTER / CORRESPONDENCE TO JUDGE (Motion #1) *6.3.22 Ltr. to Judge McDonough Requesting Ext. Reply & OA*	Breitenbach, R. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice
28	NOTICE OF MOTION (Motion #2) *Notice of Motion for Admission of Emily C. McGowan an Pro Hac Vice*	Geercken, K. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice Payment Receipt
29	AFFIDAVIT OR AFFIRMATION IN SUPPORT OF MOTION (Motion #2) *Affirmation of Karl Geercken*	Geercken, K. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice
30	AFFIDAVIT OR AFFIRMATION IN SUPPORT OF MOTION (Motion #2) *Affidavit of Emily C. McGowan*	Geercken, K. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice
31	EXHIBIT(S) - A (Motion #2) *Certificate of Good Standing*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
32	ORDER (PROPOSED) (Motion #2) *Proposed Order*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
33	NOTICE OF MOTION (Motion #3) *Notice of Motion for Admission of Brian D. Boone an Pro Hac Vice*	Geercken, K. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice Payment Receipt
34	AFFIDAVIT OR AFFIRMATION IN SUPPORT OF MOTION (Motion #3) *Affirmation of Karl Geercken*	Geercken, K. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice
35	AFFIDAVIT OR AFFIRMATION IN SUPPORT OF MOTION (Motion #3) *Affidavit of Brian D. Boone*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
36	EXHIBIT(S) - A (Motion #3) *Certificate of Good Standing*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
37	EXHIBIT(S) - B (Motion #3) *Certificate of Good Standing*	Geercken, K. **Filed: 06/03/2022** *Received: 06/03/2022*	**Processed** Confirmation Notice
38	EXHIBIT(S) - C (Motion #3) *Certificate of Good Standing*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
39	ORDER (PROPOSED) (Motion #3) *Proposed Order*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice

40	MEMORANDUM OF LAW IN OPPOSITION	Scott, W. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
41	AFFIDAVIT *Affidavit of Daniel Yanulavich*	Scott, W. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
42	AFFIRMATION *Affirmation of John Powell*	Scott, W. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
43	EXHIBIT(S) - A *Circular Letter 10*	Scott, W. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
44	NO FEE AUTHORIZATION (LETTER/ORDER/AFFIRMATION)	Scott, W. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
45	MEMORANDUM OF LAW IN OPPOSITION (Motion #1) *UnitedHealthcare Insurance Company of New Yorks Memorandum in Opposition to Plaintiffs Motion for a ... show more*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
46	AFFIDAVIT OR AFFIRMATION IN OPPOSITION TO ORDER TO SHOW CAUSE (Motion #1) *Affidavit of Sandra Galien*	Geercken, K. Filed: 06/03/2022 *Received: 06/03/2022*	**Processed** Confirmation Notice
47	LETTER / CORRESPONDENCE TO JUDGE *Letter Requesting Extension to File Reply Papers*	Breitenbach, R. Filed: 06/08/2022 *Received: 06/08/2022*	**Processed** Confirmation Notice
48	MEMORANDUM OF LAW IN SUPPORT	Breitenbach, R. Filed: 06/13/2022 *Received: 06/13/2022*	**Processed** Confirmation Notice
49	AFFIRMATION	Breitenbach, R. Filed: 06/13/2022 *Received: 06/13/2022*	**Processed** Confirmation Notice
50	EXHIBIT(S) - 1 *Exhibit 1 - Out of Network Reimbursement Disclosure*	Breitenbach, R. Filed: 06/13/2022 *Received: 06/13/2022*	**Processed** Confirmation Notice
51	EXHIBIT(S) - 2 *Exhibit 2*	Breitenbach, R. Filed: 06/13/2022 *Received: 06/13/2022*	**Processed** Confirmation Notice
52	EXHIBIT(S) - 3 *Exhibit 3 - Appendix B:Department of Health & department of Financial Services letter to Physicians*	Breitenbach, R. Filed: 06/13/2022 *Received: 06/13/2022*	**Processed** Confirmation Notice
53	LETTER / CORRESPONDENCE TO JUDGE *Letter Requesting Extension Reply & OA*	Breitenbach, R. Filed: 06/23/2022 *Received: 06/23/2022*	**Processed** Confirmation Notice
54	NOTICE OF MOTION (Motion #4)	Geercken, K. Filed: 07/12/2022 *Received: 07/12/2022*	**Processed** Confirmation Notice Payment Receipt
55	AFFIDAVIT OR AFFIRMATION IN SUPPORT (Motion #4)	Geercken, K. Filed: 07/12/2022 *Received: 07/12/2022*	**Processed** Confirmation Notice
56	EXHIBIT(S) - 1 (Motion #4) *True copy of complaint*	Geercken, K. Filed: 07/12/2022 *Received: 07/12/2022*	**Processed** Confirmation Notice
57	MEMORANDUM OF LAW IN SUPPORT (Motion #4)	Geercken, K. Filed: 07/12/2022 *Received: 07/12/2022*	**Processed** Confirmation Notice
58	AFFIDAVIT OR AFFIRMATION IN SUPPORT OF MOTION *Schulman Fully Executed Affidavit (correcting Docket #16)*	Breitenbach, R. Filed: 07/19/2022 *Received: 07/19/2022*	**Processed** Confirmation Notice
59	ORDER (PROPOSED) *Proposed Order*	Breitenbach, R. Filed: 07/21/2022 *Received: 07/21/2022*	**Processed** Confirmation Notice
60	STIPULATION - OTHER (Motion #4)	Breitenbach, R. Filed: 07/28/2022 *Received: 07/28/2022*	**Processed** Confirmation Notice
61	ORDER - OTHER (Motion #1)	Court User Filed: 08/03/2022 *Received: 08/02/2022*	**Processed** Confirmation Notice
62	ORDER - OTHER (Motion #2)	Court User	**Processed**

		Filed: 08/03/2022 *Received: 08/02/2022*	Confirmation Notice
63	ORDER - OTHER (Motion #3)	Court User Filed: 08/03/2022 *Received: 08/02/2022*	**Processed** Confirmation Notice
64	NOTICE OF ENTRY *Notice of Entry*	Breitenbach, R. Filed: 08/03/2022 *Received: 08/03/2022*	**Processed** Confirmation Notice
65	EXHIBIT(S) - A *Order dated 8/3/2022*	Breitenbach, R. Filed: 08/03/2022 *Received: 08/03/2022*	**Processed** Confirmation Notice
66	STIPULATION - BRIEFING SCHEDULE (Motion #4) *Stip. Enlarging Deadlines & Adjourning Def's Motion to Dismiss*	Hallak, D. Filed: 08/12/2022 *Received: 08/12/2022*	**Processed** Confirmation Notice
67	STIPULATION - BRIEFING SCHEDULE (Motion #4) *Stip. Enlarging Deadlines & Adjourning Def's Motion to Dismiss*	Hallak, D. Filed: 08/30/2022 *Received: 08/30/2022*	**Processed** Confirmation Notice
68	NOTICE OF MOTION (Motion #5)	Scott, W. Filed: 08/31/2022 *Received: 08/31/2022*	**Processed** Confirmation Notice
69	MEMORANDUM OF LAW (Motion #5)	Scott, W. Filed: 08/31/2022 *Received: 08/31/2022*	**Processed** Confirmation Notice
70	AFFIRMATION (Motion #5) *Affirmation of John Powell*	Scott, W. Filed: 08/31/2022 *Received: 08/31/2022*	**Processed** Confirmation Notice
71	EXHIBIT(S) - A (Motion #5) *Circular Letter 10*	Scott, W. Filed: 08/31/2022 *Received: 08/31/2022*	**Processed** Confirmation Notice
72	AFFIDAVIT (Motion #5) *Affidavit of Daniel Yanulavich*	Scott, W. Filed: 08/31/2022 *Received: 08/31/2022*	**Processed** Confirmation Notice
73	MEMORANDUM OF LAW IN OPPOSITION (Motion #4)	Hallak, D. Filed: 09/06/2022 *Received: 09/06/2022*	**Processed** Confirmation Notice
74	MEMORANDUM OF LAW IN REPLY (Motion #4) *UnitedHealthcare Insurance Company of New Yorks Reply in Support of Its Motion to Dismiss Under C.P. ... show more*	Geercken, K. Filed: 09/21/2022 *Received: 09/21/2022*	**Processed** Confirmation Notice
75	NOTICE OF CROSS-MOTION (Motion #6) *Plaintiff's Notice Of Cross-Motion*	Breitenbach, R. Filed: 10/14/2022	**Processed** Confirmation Notice

NYSCEF - New York State Courts Electronic Filing (Live System)

902227-22 - Albany County Supreme Court

Short Caption: **WAYNE JOSEPH et al v. REBECCA CORSO et al**
Case Type: **Commercial Division**
Case Status: **Active**
eFiling Status: **Full Participation Recorded**
Assigned Judge: **Roger Mcdonough**

E-mail Participating Parties

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#	Document	Filed By	Status
76	AFFIRMATION (Motion #6) *Affidavit of Email Service on Defendants*	Haflak, D. Filed: 10/14/2022 *Received: 10/14/2022*	**Processed** Confirmation Notice
77	MEMORANDUM OF LAW IN OPPOSITION TO CROSS-MOTION AND IN FURTHER SUPPORT OF MOTION (Motion #5)	Scott, W. Filed: 10/20/2022 *Received: 10/20/2022*	**Processed** Confirmation Notice
78	AFFIDAVIT (Motion #5) *Affidavit of Daniel Yanulavich in Reply*	Scott, W. Filed: 10/20/2022 *Received: 10/20/2022*	**Processed** Confirmation Notice
79	MEMORANDUM OF LAW IN OPPOSITION (Motion #6) *UnitedHealthcare Insurance Company of New York's Memorandum of Law in Opposition to Plaintiffs' Moti ... show more*	Geercken, K. Filed: 10/20/2022 *Received: 10/20/2022*	**Processed** Confirmation Notice
80	LETTER/CORRESPONDENCE - SO ORDERED	Court User Filed: 10/24/2022	**Processed** Confirmation Notice

EXHIBIT 5

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

ANESTHESIA ASSOCIATES OF ANN ARBOR PLLC, Plaintiff, v. **BLUE CROSS BLUE SHIELD OF MICHIGAN,** Defendant.	**2:20-CV-12916-TGB-APP** **ORDER DENYING IN PART AND GRANTING IN PART PLAINTIFF'S MOTION FOR LEAVE TO FILE AMENDED COMPLAINT (ECF NO. 43)**

This action arises from Plaintiff Anesthesia Associates of Ann Arbor's ("A4") allegations of a decades-long scheme by Defendant Blue Cross Blue Shield of Michigan ("BCBS-MI") to unlawfully dominate the market for buying anesthesiology services in Michigan. For the following reasons, A4's motion to amend is **DENIED in part and GRANTED in part.**

I. BACKGROUND

On October 29, 2020, Plaintiff Anesthesia Associates of Ann Arbor ("A4") brought suit against Defendant Blue Cross Blue Shield of Michigan ("BCBS-MI"), alleging that BCBS-MI used its dominant position as a buyer of healthcare services to pay A4's anesthesiologists artificially depressed reimbursement rates in violation of the Sherman

Act, Clayton Act, and state law. ECF No. 1. On January 4, 2021, BCBS-MI moved to dismiss A4's Complaint for failure to state a claim under Rule 12(b)(6). ECF No. 13. On September 14, 2021, this Court granted BCBS-MI's motion but permitted A4 to seek leave to amend its Complaint. ECF No. 41. A4 subsequently filed its motion for leave to amend. ECF No. 43.

Currently before the Court is A4's motion for leave to amend its Complaint. ECF Nos. 43, 43-2. In its September 14, 2021 Order dismissing A4's Complaint, the Court addressed only the issue of antitrust standing because it found that A4 failed to plausibly allege any injury "of the type that the antitrust statute was intended to forestall." ECF No. 41, PageID.1463.

A4's initial theory of liability centered around BCBS-MI acting in concert with hospitals to refuse "to deal with anesthesiologists who are out of BCBS's network." ECF No. 22, PageID.515. This alleged refusal to deal insulated BCBS-MI from competition, enabling it to require Michigan anesthesiologists to accept below-competitive rates. The Court determined, however, that A4 had not plausibly alleged a boycott or price-fixing conspiracy between BCBS-MI and its hospital affiliates, Trinity and Beaumont. ECF No. 41, PageID.1478–80. And pursuant to the First Circuit's holding in *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F. 2d 922 (1st Cir. 1984), BCBS-MI's mere imposition of low prices—absent conspiracy—is not actionable. *Id.* at PageID.1469–70.

The Court also found that A4 did not adequately plead the requisite causation to establish antitrust standing. *Id.* at PageID.1485. Although A4 alleged that BCBS-MI's conspiracy began in April 2019 and culminated in October 2020, "its allegations of harm to competition—low reimbursement rates for anesthesiology services leads to reduced output and quality—precede[d] the time period when the conspiracy was formed." *Id.* A4 also failed to plausibly allege that BCBS-MI's "low reimbursement rates for anesthesiologists hurt consumers in the form of higher prices, reduced output, or reduced quality." *Id.* at PageID.1484. Relatedly, the Court found that A4's alleged injury was too indirect because it was derivative of the harm to healthcare consumers. *Id.* at PageID.1487. Moreover, as pled, A4's interest in seeking higher reimbursement rates directly conflicted with consumers' interest in keeping insurance premiums and provider payments low. *Id.* at PageID.1489. Therefore, A4 failed to show that its injury was causally related to the alleged antitrust law violations.

A4's proposed Amended Complaint has reduced its causes of actions from ten to nine: (1) tortious interference with a contract under Michigan law; (2) civil conspiracy to commit tortious interference with a contract under Michigan law; (3) unlawful and malicious threats under Michigan law; (4) duress under Michigan law; (5) conspiracy in violation of Section 1 of the Sherman Act; (6) monopsonization in violation of Section 2 of the Sherman Act; (7) attempted monopsonization in

violation of Section 2 of the Sherman Act; (8) a claim for injunctive relief under Section 16 of the Clayton Act; and (9) a claim for injunctive relief under Michigan law. ECF No. 43-2.

As A4 summarizes in its motion for leave to amend, its proposed Amended Complaint now alleges:

> (1) that A4, as a seller of anesthesiology services, is the direct victim of decades-long conspiracies by [BCBS-MI] to monopsonize the market for buying anesthesiology services in Michigan; (2) that [BCBS-MI's] actions have resulted in reduced quality and increased quality-adjusted prices for consumers; and (3) that stopping [BCBS-MI's] anticompetitive actions would result in higher quality service and lower-quality adjusted prices for consumers, even as reimbursements for certain high-quality anesthesiologists, such as A4, would go up.

Plaintiff's Motion for Leave to Amend Complaint, ECF No. 43, PageID.1507.

BCBS-MI contends that the proposed Amended Complaint suffers from the same defects as the original, such that the Court should deny leave to amend as futile. Defendant's Opposition to Plaintiff's Motion for Leave to Amend, ECF No. 46, PageID.1719.

II. LEGAL STANDARD

Under Federal Rule of Civil Procedure 15, if amendment as a matter of course is unavailable, a party may amend the pleading "only with the opposing party's written consent or the court's leave." "The court should freely give leave when justice so requires." Fed. R. Civ. P.

15(a)(2). Before deciding whether to grant leave to amend, a court must consider several factors including: "[u]ndue delay in filing, lack of notice to the opposing party, bad faith by the moving party, repeated failure to cure deficiencies by previous amendments, undue prejudice to the opposing party, and futility of amendment." *Wade v. Knoxville Utils. Bd.*, 259 F.3d 452, 458 (6th Cir. 2001); *see also Szoke v. UPS of Am., Inc.*, 398 F. App'x 145, 153 (6th Cir. 2010) (citation omitted). A court may deny leave to amend "for futility 'if the court concludes that the pleadings as amended could not withstand a motion to dismiss.'" *Midkiff v. Adams Cnty. Reg'l Water Dist.*, 409 F.3d 758, 767 (6th Cir. 2005) (quoting *Martin v. Assoc. Truck Lines, Inc.*, 801 F.2d 246, 249 (6th Cir. 1986)).

III. DISCUSSION

A. A4's Proposed Amended Complaint Cures Some of Its Antitrust Standing Issues

In granting BCBS-MI's initial motion to dismiss, the Court focused its opinion on A4's lack of antitrust standing. To address the Court's standing concerns, and without having evidence of predatory pricing, A4 now strategically pleads that it is a seller injured by BCBS-MI's conspiracies to monopsonize, rather than a competitor or consumer in the relevant market. ECF No. 43, PageID.1507. The Court finds that this amendment solves some of A4's pleading problems. But because seller-based standing is contingent upon A4's ability to plausibly plead

the existence of an underlying conspiracy, some of A4's amendments are futile.

As detailed below, the Court finds that A4's proposed Amended Complaint fails to plausibly plead a Hospital Conspiracy, such that it lacks antitrust standing to pursue claims on that theory. On the other hand, the Court finds that A4 has plausibly pled the existence of the Blues Conspiracy, thus permitting A4 to attain seller-based standing on the Blues Conspiracy theory only.

1. A4's Prior Antitrust Standing Issues

In its previous Order, this Court found that A4's alleged injury was not the type of harm that antitrust laws intended to prevent. First, A4 failed to adequately plead facts that would overcome the "natural inference that as a buyer of anesthesiology services on behalf of patients, Defendant has incentives to procure the best quality at the lowest price." ECF No. 41, PageID.1486. Second, A4's allegations simply did not establish that BCBS-MI conspired with hospitals to fix prices at a depressed reimbursement rate. *Id.* at PageID.1478–79. Rather, the Court determined that A4's "theory of a conspiracy center[ed] not on pricing but on an agreement to refuse to deal with providers that leave Defendant's network." *Id.* at PageID.1478. BCBS-MI's "unilateral decision on reimbursement rates for anesthesiology services" thus did not give rise to a plausible antitrust injury. *Id.* at PageID.1478–79.

Additionally, the Court found that BCBS-MI's requirement for hospitals to restrict access to only in-network anesthesiologists did not permit inferring a conspiracy between BCBS-MI and the hospitals. *Id.* at PageID.1479. Moreover, even if there was a conspiracy, A4 did not clearly show whether consumers would benefit from lower prices if BCBS-MI paid a higher reimbursement rate, making A4's claims even more unavailing. *Id.* Lastly, the Court found that A4's allegation that low reimbursement rates tend to decrease quality and output were not sufficiently strong to withstand a motion to dismiss. *Id.* at PageID.1480.

2. A4's Proposed Amendments Attempt to Plead Seller-Based Standing

"The antitrust standing requirement makes certain that the laws are used only to deal with the economic problems whose solutions these policies were intended to effect." *HyPoint Tech., Inc. v. Hewlett-Packard Co.*, 949 F.2d 874, 877 (6th Cir. 1991). As part of establishing antitrust standing, a plaintiff must demonstrate that it has suffered an "antitrust injury," which is an "(1) 'injury of the type that the antitrust laws were intended to prevent' and (2) injury 'that flows from that which makes defendants' acts unlawful.'" *Rodney v. Nw. Airlines, Inc.*, 146 F. App'x 783, 790 (6th Cir. 2005) (quoting *In re Cardizem*, 332 F.3d 896, 909 (6th Cir. 2003)). Pleading a cognizable "antitrust injury" as part of antitrust standing is essential to surviving a motion to dismiss—the standard that A4 must meet here to be granted leave to amend its Complaint.

Hodges v. WSM, Inc., 26 F.3d 36, 38 (6th Cir. 1994); *Valley Prod. Co. v. Landmark, a Div. of Hosp. Franchise Sys., Inc.*, 128 F.3d 398, 406 (6th Cir. 1997).

A4's proposed Amended Complaint clarifies that A4 is not solely challenging BCBS-MI's rates, but instead emphasizes that BCBS-MI conspired to create and maintain monopsony power in the market of *buying* anesthesiology services. A4 contends that "insurers compete to purchase anesthesiology services," while hospitals in turn "compete . . . to recruit anesthesiologists," with A4 being a *seller* of the services that BCBS-MI and the hospitals want to buy. ECF No. 43, PageID.1514, PageID.1518; *see also Todd v. Exxon Corp.*, 275 F.3d 191, 201 (2d Cir. 2001) ("The Sherman Act . . . also applies to abuse of market power on the buyer side—often taking the form of monopsony or oligopsony."); *Nat'l Hockey League Players Ass'n v. Plymouth Whalers Hockey Club*, 419 F.3d 462, 474 (6th Cir. 2005) (distinguishing competition between NHL players and "between NHL clubs for these players' services"). BCBS-MI thus injured A4 as a seller of anesthesiology services.

As such, "[a] plaintiff may state a Sherman Act Section 1 claim for lower prices, for example, as a result of a buyers' cartel where a group of buyers sets a price below competitive levels." *Rio Grande Royalty Co. v. Energy Transfer Partners, L.P.*, 786 F. Supp. 2d 1190, 1195 n.6 (S.D. Tex. 2009). A4 argues that its amendments align its seller-based claims with those at issue in *In re Southeastern Milk Antitrust Litigation*,

where the court held that milk sellers had plausibly pled antitrust injury caused by milk buyers' conspiracy to monopsonize. 555 F. Supp. 2d 934, 945 (E.D. Tenn. 2008). A4 claims that like the milk sellers in *In re Southeastern Milk*, it also "[has] no other option but to sell at the price set by [BCBS-MI]. . . . In other words, the jury may find that [A4] ha[s] suffered an antitrust injury because of [BCBS-MI's] monopsonistic behavior." 801 F. Supp. 2d. 705, 731 (E.D. Tenn. 2011).

In positioning itself as an injured seller, A4 seeks to correct two main problems from its initial pleading. First, A4 attempts to invoke the "conspiracy" exception from *Kartell v. Blue Cross Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984). *Kartell* establishes that physicians selling medical services to insurers cannot claim antitrust injury when the insurer lowers the amount it is willing to pay for their services because buyers are free to decide "what to seek to buy and what to offer to pay." *Id.* at 929. But the *Kartell* court suggested that this general rule is inapplicable where the seller shows that the buyer's pricing power was gained through "conspiracy" or "agreements to fix prices." *Id.* at 930, 932. Second, assuming A4 can plausibly plead that BCBS-MI engaged in a conspiracy, it can assert antitrust injury even without evidence of predatory pricing. *See* ECF No. 41, PageID.1469–74; *see also Kartell*, 749 F.2d at 932; *In re Se. Milk*, 555 F. Supp. 2d at 945–46.

Importantly, pleading seller-based standing inherently requires A4 to plausibly plead the existence of a conspiracy. Without sufficient evidence of illegal concerted action, what A4 complains of—being underpaid for medical services purchased by BCBS-MI as an insurer-buyer—does not raise a cognizable antitrust injury. *See, e.g.*, *Kartell*, 749 F.2d at 925 ("Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold."); *Westchester Radiological Assocs. P.C. v. Empire Blue Cross & Blue Shield, Inc.*, 707 F. Supp. 708, 713 (S.D.N.Y.), *aff'd*, 884 F.2d 707 (2d Cir. 1989) ("[I]f [the radiologists] wish to sell to Blue Cross, they must sell Blue Cross the package it wants to buy, and they must agree that the price charged to Blue Cross will be the only charge for the services."); *Mich. State Podiatry Ass'n v. Blue Cross & Blue Shield of Mich.*, 671 F. Supp. 1139, 1152 (E.D. Mich. 1987) ("[The plaintiffs'] argument merely is that podiatrists make less money from BCBSM than previously. Such a claim is insufficient to state an antitrust violation."); *see also Expert Masonry, Inc. v. Boone Cnty.*, 440 F.3d 336, 347 (6th Cir. 2006) ("[I]t is the appropriate nature of a functioning competitive marketplace that buyers are free to choose from whom they will buy, sellers are free to choose to whom they will sell, and salesmen battle and strive to curry favor and close the deal.").

For the reasons discussed below, A4's proposed amendments fail to plausibly support the alleged Hospital Conspiracy. As such, A4's

amendments regarding the Hospital Conspiracy are futile because they cannot correct A4's lack of antitrust standing and antitrust injury. However, A4's amended allegations do plausibly establish the existence of a nationwide Blues Conspiracy. Therefore, A4's proposed amendments clarifying its position as a seller injured by the Blues Conspiracy can rectify the original Complaint's antitrust standing and antitrust injury defects.

B. A4's Amended Pleadings Raise Two Horizontal Conspiracies

There are two main types of antitrust conspiracies: horizontal and vertical. As the Sixth Circuit explained in *Crane & Shovel Sales Corp. v. Bucyrus-Erie Co.*:

> Horizontal conspiracies involve agreements among competitors at the same level of competition to restrain trade, such as agreements among manufacturers to fix prices for a given product and geographic market, or among distributors to fix prices for a given market. Vertical conspiracies, on the other hand, involve agreements between competitors at different levels of competition to restrain trade, such as agreements between a manufacturer and its distributors to exclude another distributor from a given product and geographic market.

854 F.2d 802, 805 (6th Cir. 1988).

Here, A4 alleges two horizontal conspiracies: (1) the Hospital Conspiracy; and (2) the Blues Conspiracy. Pursuant to its Hospital Conspiracy theory, A4 alleges that hospitals agree with BCBS-MI and each other to compensate Michigan anesthesiologists "at a single, uniform rate by [BCBS-MI], regardless of quality, and that if an

anesthesiologist rejects that rate, that doctor will not be permitted to serve patients at those facilities." ECF No. 43, PageID.1516 (citing ECF No. 43-2, PageID.1539–40). But A4 also clarifies that the Hospital Conspiracy theory has a "vertical component, between BCBS and each hospital." ECF No. 43-2, PageID.1540. Specifically, A4 posits that BCBS-MI convinces hospitals to sign a uniform agreement with BCBS-MI and enforces this agreement through "illegal boycott and price fixing agreements by steering [patients] away from any hospital" if anesthesiologists seek a different rate from BCBS-MI. *Id.*

A4's alleged Blues Conspiracy "also involves a boycott and price-fixing conspiracy, coupled with a geographic market allocation conspiracy." ECF No. 43, PageID.1516–17. According to A4, BCBS-MI participates in a horizontal conspiracy scheme with other Blue Cross Blue Shield insurers (the "Blues") to "divide the markets for health insurance in the United States and [] fix the prices paid to providers of medical services, including anesthesiology services." ECF No. 43-2, PageID.1540. As a result, A4 alleges that BCBS-MI "is insulated in Michigan from competition from other Blue Cross Blue Shield health insurers that would otherwise enter the Michigan markets." *Id.*

Although the "traditional horizontal conspiracy case involves an agreement among sellers with the purpose of raising prices to supracompetitive levels," the Sherman Act "also applies to abuse of market power on the buyer side—often taking the form of monopsony or

oligopsony." *Todd*, 275 F.3d at 201 (citing Roger D. Blair & Jeffrey L. Harrison, *Antitrust Policy and Monopsony*, 76 Cornell L. Rev. 297, 297–301, 308 (1991)). A4 correctly notes that "a horizontal conspiracy among buyers to stifle competition is as unlawful as one among sellers." *Id*. But the question here is whether A4 can plead facts to plausibly show that a horizontal conspiracy exists amongst BCBS-MI, the hospitals, and/or the Blues.

In general, to allege an agreement between antitrust co-conspirators, the complaint must allege facts such as a "specific time, place, or person involved in the alleged conspiracies" to give a defendant seeking to respond to allegations of a conspiracy an idea of where to begin. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 565 n.10 (2007). "[A]n allegation of parallel conduct and a bare assertion of conspiracy will not suffice." *Id*. at 556. The plaintiff must provide more specific evidence, such as "a written agreement or even a basis for inferring a tacit agreement." *Id.* at 557. Ultimately, the court must assess "whether the challenged anticompetitive conduct 'stem[s] from independent decision or from an agreement.'" *Id.* at 553 (quoting *Theatre Enters., Inc. v. Paramount Film Distrib. Corp.*, 346 U.S. 537, 540 (1954)). Based on these plausibility standards, the Court examines whether the factual allegations in A4's proposed Amended Complaint are sufficient to answer the questions of "Who, what, when, and where?" with respect to the alleged conspiracies.

1. The Hospital Conspiracy

A4's Hospital Conspiracy theory assumes that no hospital would independently coerce its anesthesiologists into accepting BCBS-MI's low uniform reimbursement rates. Instead, in an ordinary market, A4 claims that hospitals would permit anesthesiologists to demand higher prices for providing higher quality care. A4 contends that without a conspiracy binding all hospitals in partnership with BCBS-MI, a hospital would inevitably lose anesthesiologists to other hospitals that do not cap reimbursement at such low rates. *See* ECF No. 43, PageID.1514–15.

A4 also explains that the alleged hospital conspiracy involves both a vertical component and a horizontal component. *Id.* At the vertical level, BCBS-MI signs "template agreements" with hospitals that in turn require their anesthesiologists to accept BCBS-MI's low uniform rate terms. *Id.* at PageID.1515. At the horizontal level, the hospitals agree with each other to inhibit anesthesiologists' ability to demand higher rates. *Id.* Together, these horizontal and vertical agreements eliminate "collective-action risk," by having "nearly every[] Michigan hospital agree with [BCBS-MI] and each other to restrict anesthesiologists' ability to negotiate with [BCBS-MI], regardless of the hospital." *Id.* at PageID.1515.

A4 alleges that surgeons may choose to service a particular hospital based on the quality of available anesthesiologists, which

ultimately determines the patient's decision as to where to seek health care services. *Id.* at PageID.1514–15. Because surgeries potentially account for up to 80% of hospital revenue, A4 points out that "it makes no economic sense for a hospital to agree to prohibit high-quality anesthesiologists from negotiating rates with [BCBS-MI]," as better anesthesiologists bring in higher surgery revenue. *Id.* at PageID.1515.

A4 posits that BCBS-MI "facilitated" the horizontal aspect of the conspiracy by:

> (1) publicly acknowledging that it uses a template agreement with hospitals (which [] contains a term restricting anesthesiology reimbursement just as in [BCBS-MI's] executed hospital agreements); (2) consistently agreeing, over decades and with different hospitals, to essentially-identical restrictions on anesthesiologist reimbursement, even as other aspects of its hospital agreements changed; and (3) enforcing the conspiracy in 2019 after A4's decision to leave BCBS's network caused co-conspirators Trinity and Beaumont, where A4 served patients, to be non-compliant.

Id. at PageID.1516–17.

BCBS-MI contends, and the Court agrees, that A4 lacks direct, "smoking gun" evidence of conspiracy between the hospitals. *Hyland v. HomeServices of Am., Inc.*, 771 F.3d 310, 318 (6th Cir. 2014) (explaining that direct evidence of a conspiracy in a Section 1 case "must be evidence that is explicit and requires no inferences to establish the proposition or conclusion being asserted"). Without smoking gun evidence, a horizontal price-fixing conspiracy may be "inferred" by

"conscious parallelism," where "interdependent conduct is accompanied by circumstantial evidence and plus factors such as defendants' use of facilitating practices." *Todd*, 275 F.3d at 198. But "circumstantial evidence alone cannot support a finding of conspiracy when the evidence is equally consistent with independent conduct." *Sancap Abrasives Corp. v. Swiss Indus. Abrasives*, 19 F. App'x 181, 187 (6th Cir. 2001). The Sixth Circuit has identified certain "plus factors" that must accompany circumstantial evidence to indicate concerted action:

> 1) whether defendants' actions, if taken independently, would be contrary to their economic interests; 2) product uniformity; 3) whether the defendants have been uniform in their actions; 4) whether the defendants have exchanged or have had the opportunity to exchange information relative to the alleged conspiracy; and 5) whether the defendants have a common motive to conspire or have engaged in a large number of communications.

Hyland, 771 F.3d at 320.

The Ninth Circuit's decision in *Barry v. Blue Cross of California*, closely tracks the facts at issue here. In *Barry*, the plaintiffs alleged that Blue Cross of California orchestrated "a horizontal agreement among competing physicians" to engage in price-fixing and a group boycott. 805 F.2d 866, 868 (9th Cir. 1986). The plaintiffs claimed that the conspiring physicians acted with "conscious parallelism [in] a tacit conspiracy," by pointing to evidence "that several thousand physicians signed identical contracts with Blue Cross and that physicians participated in creating the plan." *Id.* The court plainly rejected the

plaintiffs' argument "that because several thousand physicians all signed identical contracts, we should infer a tacit conspiracy." *Id.* at 869. In emphasizing that a horizontal conspiracy must involve participants being "economically interdependent," the court articulated three key factors for inferring a conspiracy: (1) "whether each physician had an independent business reason for his conduct"; (2) "whether joining the Plan required a commitment contrary to the physicians' economic self-interest"; and (3) "whether an alleged conspirator would have benefited from having other physicians join the alleged conspiracy." *Id.* at 870.

First, the *Barry* court determined that each physician had a "good independent reason for joining the Plan: each obtained access to Blue Cross customers." *Id.* Second, the court found that joining the Plan was not against the physician's self-interest. Although the contract required physicians to accept lower fees when treating Plan patients, "each physician was free to resign from the Plan at any time" if they were unsatisfied with their earnings. *Id.* And finally, the court determined that the participating physicians as alleged co-conspirators "did not benefit from having other physicians join" the scheme. *Id.* Assuming "that a certain number of member physicians is necessary to make the Plan workable" at its inception, the participating physicians likely would have benefited from recruiting new members. *Id.* But "once the Plan was functioning, participating physicians did not benefit from

having other physicians join," as each new physician would then be competing with the existing physicians "for the patronage of Plan subscribers." *Id*. Therefore, the *Barry* court affirmed the district court's grant of summary judgment in favor of Blue Cross of California.

i. A4 Fails to Plausibly Allege the Existence of the Hospital Conspiracy

A4 has not plausibly alleged a horizontal conspiracy between hospitals based on circumstantial evidence and "plus factors." Specifically, A4 fails to demonstrate that the hospitals conspired with one another in an illegal scheme orchestrated by BCBS-MI.

In its initial Order, the Court determined A4's allegation that BCBS-MI's anti-competitive conduct began in April 2019 and culminated in October 2020, failed to adequately plead a causal link between BCBS-MI's conduct and the alleged injury. Because the artificially low-reimbursement rates A4 cited were from 2018, the alleged injury "*preced[ed]* the time period when the conspiracy was formed." ECF No. 41, PageID.1485.

In the proposed Amended Complaint, A4 has attempted to correct this flaw:

> Whereas the Complaint focused on allegations that BCBS, Trinity, and Beaumont conspired in 2019 after A4 signaled its intent to leave BCBS's network, the Amended Complaint clarifies that those actions were instead efforts to enforce a conspiracy that had been ongoing ***for decades prior***. Pursuant to that underlying conspiracy, which is memorialized in written agreements produced in discovery

> by BCBS, hospitals in Michigan have agreed with BCBS, and each other, that anesthesiologists will not be permitted to access the hospitals to treat patients unless they accept BCBS's statewide, uniform rate for anesthesiology services. See Ex. 1 at ¶¶ 1, 26-35, 104-117 (proposed Amended Complaint). Because anesthesiologists require access to hospitals to serve patients, the conspiracy requires anesthesiologists to accept BCBS's uniform rate if they wish to practice in Michigan.

ECF No. 43, PageID.1514 (emphasis added).

In response, BCBS-MI suggests that the more rational explanation is that "hospitals independently find it more valuable to contract with [BCBS-MI] than to contract with any particular anesthesiology group." ECF No. 46, PageID.1738. The hospitals therefore agreed with BCBS-MI to an in-network provision, "irrespective of whether the hospital's currently-admitted anesthesiologists go elsewhere." *Id.* at PageID.1738–39. Furthermore, BCBS-MI contends that if hospitals cannot afford to leave BCBS-MI, that is an independent and valid reason for accepting BCBS-MI's terms. *Id.* at PageID.1720–21. Finally, BCBS-MI posits that in this case, it is "only natural" that each hospital would choose to stay in-network with BCBS-MI and replace its anesthesiologists, if faced with that choice. *Id.* at PageID.1739–40.

The Court agrees that A4 has not adequately supported its Hospital Conspiracy theory. First, the fact that the hospitals signed an identical template agreement is insufficient to demonstrate a tacit

conspiracy. *See Barry*, 805 F.2d at 869. And the proposed Amended Complaint provides only sparse support for other indicators of concerted action between the hospitals. For example, A4 states that an unnamed hospital, as an alleged co-conspirator, contacted Trinity to threaten Trinity with steering away potential patients. ECF No. 43-2, PageID.1606–07. But the proposed Amended Complaint does not allege any other facts that the hospitals conspired together rather than acting independently. Moreover, the fact that some agreements were signed nearly two decades apart further cuts against finding tacit conspiracy. *See In re Travel Agent Comm'n Antitrust Litig.*, 583 F.3d 896, 911 (6th Cir. 2009) (discounting statement evidencing parallel conduct because the statement was made "too remote[ly] in time to support a plausible inference of agreement"); *cf. Home Quarters Real Est. Grp., LLC v. Mich. Data Exch., Inc.*, No. 07-12090, 2009 WL 276796, at *4 (E.D. Mich. Feb. 5, 2009) (adopting magistrate judge's findings that the "temporal proximity of Defendants' actions," which occurred within the same 24-hour period, demonstrates tacit conspiracy).

Second, as in *Barry*, there is a good independent reason for each hospital to want to contract with BCBS-MI: guaranteed access to BCBS-MI customers. Relatedly, it is not contrary to a hospital's economic self-interest to partner with BCBS-MI. By pursuing an agreement with BCBS-MI, hospitals are opening themselves up to "compete for the same consumer's business . . . and give customers *more* options." *Stop &*

Shop Supermarket Co. v. Blue Cross & Blue Shield of R.I., 373 F.3d 57, 62 (1st Cir. 2004).

Third, increasing the number of participating hospitals could be considered beneficial if a threshold number of partnering hospitals is necessary to make the uniform rate agreement economical. But after a certain point, each new partnering hospital will become unwanted competition for recruiting anesthesiologists and BCBS-MI subscribers. As such, the hospitals do not have a significant economic incentive to recruit additional "co-conspirators."

Lastly, the Court finds that A4's proposed amendments fail to address crucial causation issues. Even assuming BCBS-MI possesses significant market power and it "uses that power to obtain 'lower than competitive' prices," *Kartell*, 749 F.2d at 927, this does not solve the problem of whether the uniform rates are caused by the alleged Hospital Conspiracy. Indeed, "even a monopolist is free to exploit whatever market power it may possess when that exploitation takes the form of charging uncompetitive prices." *Id.* A4's proposed Amended Complaint also notes that Beaumont contracts with a competitor insurer that does not require the low uniform rates imposed by BCBS-MI. ECF No. 43-2, PageID.1591, ¶ 108. But A4 does not allege whether a more generous rate schedule has alleviated the problems it complains of with respect to BCBS-MI's low fees. Because a hospital can independently contract with a BCBS-MI competitor insurer under

different terms, and BCBS-MI does not prevent providers from treating any patients nor patients from receiving treatment from any anesthesiologist, A4 has failed to demonstrate "impermissible market distortions" caused by the Hospital Conspiracy. *See Barry*, 805 F.2d at 872.

The Court finds that A4 has failed to plead factual allegations giving rise to a Hospital Conspiracy. As such, A4 lacks seller-based standing to raise a cognizable antitrust injury premised on the Hospital Conspiracy, and its motion for leave to amend these allegations is **DENIED in part** as futile.

ii. A4 Fails to Plead Subject Matter Jurisdiction over Its Hospital Conspiracy Claims

Independent of its findings that A4's proposed amendments on the Hospital Conspiracy theory would be futile to establishing antitrust standing and antitrust injury, the Court also finds that A4 has failed to sufficiently plead subject matter jurisdiction over claims premised on the Hospital Conspiracy.

The Court is permitted to raise concerns about subject matter jurisdiction at any time and of its own volition. *Apple v. Glenn*, 183 F.3d 477, 479 (6th Cir. 1999). In *McLain v. Real Estate Board of New Orleans, Inc.*, the Supreme Court emphasized that to satisfy the Sherman Act's "jurisdictional requirement," the plaintiff must show "either that defendants' activity is itself in interstate commerce or, if it

is local in nature, that it has an effect on some other appreciable activity demonstrably in interstate commerce." 444 U.S. 232, 242 (1980). The Sixth Circuit has interpreted *McLain* to require the plaintiff to "allege[] sufficient facts to support an 'interstate commerce' nexus to bring the case within the parameters of the Sherman Act." *Stone v. William Beaumont Hosp.*, 782 F.2d 609, 614 (6th Cir. 1986); *see also Mich. State Podiatry Ass'n v. Blue Cross & Blue Shield of Mich.*, 671 F. Supp. 1139, 1155 (E.D. Mich. 1987) ("[T]he Sixth Circuit requires a showing that the challenged activity itself has some impact on interstate commerce.").

In *Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan*, the court found that the plaintiffs failed to establish "the requisite effect on interstate commerce," thus stripping the court of subject matter jurisdiction over their Sherman Act claims. 671 F. Supp. at 1155. The plaintiffs, an organization representing most podiatrists in Michigan, alleged that BCBS-MI illegally conspired with other doctors to decrease reimbursement rates for podiatric procedures. *Id.* at 1142. To satisfy the jurisdictional interstate commerce requirement, the plaintiffs alleged that:

> (1) BCBSM pays out-of-state physicians for health care services rendered to BCBSM subscribers;
> (2) BCBSM provides prepaid health care plans to cover the work force of virtually all Michigan manufacturers, such as Chrysler, whose products are sold in interstate and foreign commerce and

> which depend upon BCBSM's proper and legal administration of health care benefits for their workers;
> (3) BCBSM administers, in large part, the federal Medicaid and Medicare programs which entail transfers of large amounts of out-of-state monies into the State of Michigan; and
> (4) BCBSM draws resources from a national pool of health care funds available to prepaid health care plans and commercial insurance policies from within and without the State of Michigan.

Id. at 1154.

Even so, the court found that "[a]s a matter of practical economics," lowering reimbursement rates for "procedures performed on in state patients" by Michigan-based podiatrists could not demonstrate an "appropriate nexus with interstate commerce." *Id.* at 1155. Therefore, the court concluded that the plaintiffs had failed to satisfy the Sherman Act's jurisdictional prerequisite. *Id.*

Similarly here, A4 generally alleges that "BCBSM is engaged in interstate commerce," and A4's claims involve conduct that "substantially affects interstate commerce." ECF No. 43-2, PageID.1572, ¶ 67. More specifically, A4 claims that because of BCBS-MI's depressed reimbursement rates, "multiple anesthesiologists" have left Michigan for Ohio, and Michigan providers are struggling to recruit anesthesiologists nationwide. *Id.* Furthermore, "BCBSM provides commercial health insurance that covers Michigan residents when they travel across state lines, purchases health care in interstate commerce when Michigan residents require health care out of state, and receives payments from customers located outside Michigan." *Id.*

But with respect to the Hospital Conspiracy, A4's allegations demonstrate that BCBS-MI's conduct is fundamentally local in nature, and it cannot demonstrate that lowering anesthesiology reimbursement rates for Michigan anesthesiologists serving primarily Michigan patients has a substantial impact on interstate commerce. Moreover, as in *Michigan State Podiatry*, A4 "cannot rely on BCBS-MI's overall business activities," nor that BCBS-MI pays for out-of-state services to demonstrate an interstate commerce nexus. 671 F. Supp. at 1155.

The Hospital Conspiracy centers around BCBS-MI's uniform rates for anesthesiologists in Michigan, based on agreements with Michigan hospitals, impacting the quantity and quality of anesthesiologists in Michigan. A4's allegation that an unspecified number of anesthesiologists have left Michigan to work in Ohio is insufficient to establish a substantial effect on interstate commerce. In fact, A4 acknowledges that "commuting [to Ohio] is not an option generally available to Michigan anesthesiologists," and "anesthesiology services, are also, by their nature, primarily local, as people tend to visit hospitals close to where they live and work." ECF No. 43-2, PageID.1634, ¶ 204. With respect to its allegations of difficulty recruiting out-of-state anesthesiologists, A4 introduces inconsistency to its position that it is an injured seller. As a "recruiter," A4 functions as a buyer of anesthesiology services, which A4 repeatedly notes is unrelated to the conspiracies it challenges as an injured seller.

Therefore, A4's proposed amendments to its Hospital Conspiracy allegations fail to satisfy the Sherman Act's jurisdictional requirement, and the Court must deny leave to amend those allegations.

2. The Blues Conspiracy

A4 also alleges a second conspiracy. A4 contends that BCBS-MI conspired with other "Blues" (commercial health insurance companies licensing the Blue Cross Blue Shield brand), to suppress competition and monopsonize the markets for buying anesthesiology services. ECF No. 43-2, PageID.1596. A4 alleges that the Blues Conspiracy is a horizontal conspiracy implemented through an "amended license agreement" with the Blue Cross Blue Shield Association ("BCBSA"). *Id.* at PageID.1596–97. A4 explains that "BCBSA owns the Blue Cross Blue Shield branding and is in turn owned and controlled by the Blues." *Id.* at PageID.1597. Pursuant to these agreements, A4 alleges that the Blues refrain, with "limited exceptions, from competing in each other's service areas and will curtail competition involving their non-Blue affiliates." *Id.* By restraining competition with the other Blues and their affiliates, BCBS-MI can lower costs and increase control over the Michigan commercial health insurance market. *Id.* at PageID.1598.

In addition, A4 argues that "the 'amended license agreement' requires Blues to fix prices and boycott healthcare providers outside their service area." *Id.* at PageID.1599. Specifically, A4 alleges the following:

> The Price Fixing and Boycott aspect of the license agreement involves the BlueCard program, which the "amended license agreement" requires the Blues to use. The BlueCard program is a method through which [BCBS-MI] can process claims by a provider in its service area on behalf of a patient covered by another Blue plan, and vice versa. Under the BlueCard program, the patient's Blue insurer is referred to as the "Home Plan," while the Blue located where the medical service is provided is the "Host Plan." If a healthcare provider treats someone covered by a Blue plan in another state, the healthcare provider must submit their claim to the Host Plan, after which the claim is transmitted to the Home Plan for processing. The provider is paid based on the reimbursement rates in his or her contract with the Host Plan—thereby fixing prices between the Host Plan and the Home Plan.
>
> …
>
> As part of the Price Fixing and Boycott conspiracy, [BCBS-MI] and the other Blues have also agreed not to contract with providers outside of their respective service areas. This boycott means that A4's only option for providing services in Michigan to patients insured under other Blues is to do so through [BCBS-MI], using the BlueCard program. A4 is therefore forced to accept [BCBS-MI's] anesthesiology rate when it covers patients insured by any of the Blues, regardless of what those insurers' rates are. This price fixing in turn keeps the anesthesiology rates in Michigan artificially suppressed.

Id.

In response, BCBS-MI argues that the Blues Conspiracy allegations must fail because A4 does not identify "any ready, willing, and able entrants" to compete with BCBS-MI in the Michigan insurance market. ECF No. 46, PageID.1742. A4 contends that the "ready, willing, and able" test does not apply to 'market-division agreements' barring

'potential' competition." ECF No. 47, PageID.1798 (citing Philip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles & Their Application* ¶ 2030b (4th ed.)).

BCBS-MI has not adequately supported the applicability of the "ready, willing, and able" test to the present circumstances. Moreover, the Court finds that the "ready, willing, and able" standard need not dictate whether A4 has adequately pled the existence of a horizontal price-fixing and market-division conspiracy. Here, A4 alleges that absent a market-division conspiracy, other Blues would compete with BCBS-MI in Michigan. In other words, the Blues Conspiracy constitutes an illegal horizontal agreement between BCBS-MI and other out-of-state BCBSA insurers. Importantly, antitrust doctrine generally considers this type of arrangement illegal per se, without demanding an independent showing of anticompetitive effects. *See United States v. Topco Assocs., Inc.*, 405 U.S. 596, 608 (1972) ("One of the classic examples of a per se violation of [Section 1 of the Sherman Act] is an agreement between competitors at the same level of the market structure to allocate territories in order to minimize competition."); *In re Cardizem CD Antitrust Litig.*, 332 F.3d 896, 909 (6th Cir. 2003) ("[T]he law is clear that once . . . a restraint is subject to per se analysis, the claimed lack of any actual anticompetitive effects or presence of procompetitive effects is irrelevant.").

The ultimate question is whether A4 has plausibly alleged the existence of the Blues Conspiracy to obtain seller-based antitrust standing. In pending multidistrict litigation in the Northern District of Alabama, healthcare providers alleged that "the Defendant Blue Cross/Blue Shield Plans, which are independent companies, along with the Blue Cross Blue Shield Association, have engaged in a conspiracy to horizontally allocate geographic markets." *In re Blue Cross Blue Shield Antitrust Litig.*, 26 F. Supp. 3d 1172, 1180 (N.D. Ala. 2014). The *In re Blue Cross* court's summary of the provider-plaintiffs' allegations closely track A4's allegations against BCBS-MI:

> [T]he Providers allege that Defendants previously reached an explicit agreement to divide the United States into what they term "Service Areas" and then to allocate those geographic markets among the Blues, free of competition from one another. The Providers specifically allege that Defendants have created geographic markets and allocated those among themselves by agreeing not to compete with each other within those markets. The Providers further allege that, as a result of decreased competition due to the market allocation, they are paid much less by the Blues than they would be absent Defendants' conspiratorial conduct.

Id. at 1180. The *In re Blue Cross* court concluded that "Plaintiffs have alleged a viable market allocation scheme" to survive the defendants' motions to dismiss, but it declined to decide whether the alleged horizontal conspiracy should be treated as a per se violation at the motion to dismiss phase. *Id.* at 1184.

BCBS-MI has not attempted to distinguish A4's Blues Conspiracy allegations from those that survived a motion to dismiss in *In re Blue Cross*. Indeed, BCBS-MI notes that these exact claims "are the subject of pending multidistrict litigation." ECF No. 46, PageID.1742. The uncanny similarity between A4's Blues Conspiracy allegations and the *In re Blue Cross* healthcare providers' claims persuade the Court that such nearly identical circumstances compel a consistent result. A4 plausibly alleges the existence of a conspiracy through "amended license agreements" between BCBS-MI and other Blues that geographically divides markets and prevents competition between the Blues. ECF No. 43-2, PageID.1596–96, ¶¶ 119–20. For example, these agreements prohibit BCBS-MI from competing with out-of-state Blues, while also insulating itself from other Blue competitors. *Id.* at PageID.1597–98, ¶ 122. In addition, the agreements bar BCBS-MI and other Blues from earning "more than 20% of its revenue from non-Blue business in its designated service area," thus prohibiting the Blues from "competing with each other using non-Blue subsidiaries." *Id.* at PageID.1597, ¶ 121. A4 also alleges that these horizontal agreements reduce reimbursement prices paid across the Blues' network and require Michigan anesthesiologists to accept BCBS-MI's lower uniform rate even if their patient is insured by an out-of-state Blue with a higher rate. *Id.* at PageID.1599–1600, ¶¶124–28.

But crucially, at this stage, the Court's holding "does not resolve the issues of causation and damages," which A4 will still need to prove to recover. *In re Cardizem*, 332 F.3d at 909. Nor is the Court required to decide whether the alleged Blues Conspiracy is considered a per se violation or should be subject to the rule of reason analysis. *See In re Blue Cross*, 26 F. Supp. 3d at 1187 (denying the defendants' motions to dismiss the plaintiffs' horizontal market allocation conspiracy claims but declining to establish the standard of review without a developed factual record).

By plausibly alleging the existence of the Blues Conspiracy and asserting seller-based standing, the Court merely finds that A4 has partially corrected its original Complaint's antitrust standing and antitrust injury deficiencies. Therefore, with respect to its amended allegations regarding the Blues Conspiracy and seller-based standing, A4's motion for leave to amend is **GRANTED in part**.

IV. CONCLUSION

For the foregoing reasons, Plaintiff's Motion for Leave to Amend is **DENIED in part and GRANTED in part**. Plaintiff is permitted to proceed on its federal antitrust claims based solely on its allegations related to the Blues Conspiracy. The Court retains supplemental jurisdiction over Plaintiff's state law claims raised in the Amended Complaint pursuant to 28 U.S.C. § 1367.

IT IS SO ORDERED.

Dated: September 28, 2022

s/Terrence G. Berg
TERRENCE G. BERG
UNITED STATES DISTRICT JUDGE

Certificate of Service

I hereby certify that this Order was electronically filed, and the parties and/or counsel of record were served on September 28, 2022.

s/Karri Sandusky for A. Chubb
Case Manager

25-1167-cv

United States Court of Appeals

for the

Second Circuit

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiffs-Appellant,

- v –

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK, INC., *AS PROGRAM ADMINISTRATOR FOR THE EMPIRE PLAN MEDICAL / SURGICAL PROGRAM*, AND MULTIPLAN INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

JOINT APPENDIX VOLUME 5

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EXHIBIT 6

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MEMBERS PROVIDERS PAYORS Find a Provider

Services Markets Company Careers KnowledgeHub Investors

Our End-to-End Surprise Billing Service

With expertise in every step of the process, we can administer the entire NSA process on your behalf. Our easy-to-implement services can help your organization achieve compliance quickly.

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We calculate the Qualifying Payment Amount (QPA) and include it on the processed claim so that you can complete the adjudication.

3 Price Claim

We can reprice claims at QPA or an amount just below or above it. Alternatively, we can use another of our Analytics-Based services to determine a fair amount that providers are likely to accept.

4 Negotiate Settlement

Providers that reject the initial payment contact us to start the process. We leverage technology, data, and experienced staff to negotiate a settlement.

5 Arbitrate

When settlement isn't reached, we'll own the IDR process from start to finish. In calculating a payment offer, we analyze data from millions of claims, actual facility costs, and more.

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(MARK ONE)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2021

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-39228

MULTIPLAN CORPORATION

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**84-3536151**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

115 Fifth Avenue

New York, NY 10003

(Address of principal executive offices)

(212) 780-2000

(Issuer's telephone number)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading Symbol**	**Name of each exchange on which registered**
Shares of Class A common stock, $0.001 par value per share	MPLN	New York Stock Exchange
Warrants	MPLN.WS	New York Stock Exchange

Indicate by check mark if the registrant is a well-seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Check whether the issuer (1) filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the past 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See definitions of "large accelerated filer", "accelerated filer", "smaller reporting company", and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management assessment of effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting stock held by non-affiliates of the registrant, based on the closing price of shares of common stock on the New York Stock Exchange on June 30, 2021, was approximately $2,566.4 million.

As of February 21, 2022, 638,595,450 shares of Class A common stock, par value $0.0001 per share, were issued and outstanding.

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Unless otherwise noted, "we," "us," "our", "MultiPlan", and the "Company" and similar terms refer to MultiPlan Corporation and its subsidiaries.

GLOSSARY

Unless otherwise stated in this Annual Report on Form 10-K (this "Annual Report") or the context otherwise requires, references to:

"2020 Omnibus Incentive Plan" are to our 2020 Omnibus Incentive Plan, as it may be amended and/or restated from time to time;

"5.50% Senior Secured Notes" are to the $1,050,000,000 in aggregate principal amount of 5.50% Senior Secured Notes due 2028 issued by MPH;

"5.750% Notes" are to the $1,300,000,000 in aggregate principal amount of 5.750% Senior Notes due 2028 issued by MPH;

"7.125% Notes" are to the 7.125% Senior Notes due 2024 issued by MPH. All of the outstanding 7.125% Notes were redeemed on October 29, 2020;

"Adjusted EPS" are to adjusted earnings per share;

"Affordable Care Act" are to the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act;

"AMPS" are to Advanced Medical Pricing Solutions;

"ASC" are to Accounting Standards Codification;

"ASU" are to Accounting Standard Update;

"Board" are to the board of directors of the Company;

"CARES Act" are to The Coronavirus Aid, Relief, and Economic Security Act;

"Cash Interest" are to interest paid in cash on the Senior Convertible PIK Notes;

"CECL" are to the accounting standard on the current expected credit losses methodology issued by the FASB;

"Churchill" are to Churchill Capital Corp III, a Delaware corporation, which changed its name to MultiPlan Corporation following the consummation of the Transactions;

"Churchill IPO" are to the initial public offering by Churchill which closed on February 19, 2020;

"Churchill's Class A common stock" are, prior to consummation of the Transactions, to Churchill's Class A common stock, par value $0.0001 per share and, following consummation of the Transactions, to our Class A common stock, par value $0.0001 per share;

"Churchill's Class B common stock" are to Churchill's Class B common stock, par value $0.0001 per share;

"Class A common stock" are to MultiPlan's Class A common stock, par value $0.0001 per share;

"Closing" are to the consummation of the Mergers;

"Closing Date" are to October 8, 2020, the date on which the Transactions were consummated;

"CMS" are to the Centers for Medicare and Medicaid Services;

"Common PIPE Investment" are to the private placement pursuant to which Churchill entered into subscription agreements with certain investors whereby such investors subscribed for (a) 130,000,000 shares of Churchill's Class A common stock at a purchase price of $10.00 per share for an aggregate commitment of $1,300,000,000 and (b) warrants to purchase 6,500,000 shares of Churchill's Class A Common Stock (for each share of Churchill's Class A common stock subscribed, the investor

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received 1/20th of a warrant to purchase one share of Churchill's Class A common stock, with each whole warrant having a strike price of $12.50 per share and a maturity date of October 8, 2025). The Common PIPE Investment was subject to an original issue discount (which was paid in additional shares of Churchill's Class A common stock) of 1% for subscriptions of $250,000,000 or less and 2.5% for subscriptions of more than $250,000,000, which resulted in an additional 2,050,000 shares of Churchill's Class A common stock being issued. The Common PIPE Investment was consummated on the Closing Date;

"Common PIPE Investors" are to the investors participating in the Common PIPE Investment;

"common stock" are, prior to the consummation of the Transactions, to Churchill's Class A common stock and Churchill's Class B common stock and, following consummation of the Transactions, to the Class A common stock;

"Company" are, prior to the consummation of the Transactions, to Churchill and, following consummation of the Transactions, to MultiPlan Corporation;

"Consumers" are to payors and their insureds, policyholders or health plan members;

"Convertible PIPE Investment" are to the private placement pursuant to which the Company entered into subscription agreements with certain investors whereby such investors agreed to buy $1,300,000,000 in aggregate principal amount of Senior Convertible PIK Notes. The Convertible PIPE Investment was consummated on the Closing Date;

"COVID-19" are to the COVID-19 pandemic;

"DGCL" are to the Delaware General Corporation Law, as amended;

"DHP" are to Discovery Health Partners;

"Director RSUs" are to restricted stock units issued to the Company's Non-Employee Directors under the 2020 Omnibus Incentive Plan (other than those Non-Employee Directors who have elected to forego their right to director compensation);

"Employee RS" are to grants of restricted stock awarded to certain employees under the 2020 Omnibus Incentive Plan;

"Employee RSUs" are to grants of restricted stock units awarded to certain employees under the 2020 Omnibus Incentive Plan;

"Employee NQSOs" are to grants of non-qualified stock options awarded to certain employees under the 2020 Omnibus Incentive Plan;

"EDI" are to electronic data interchange;

"Employee RS" are to grants of restricted stock awarded to certain employees under the 2020 Omnibus Incentive Plan;

"EPS" are to Loss and Earnings Per Share;

"ERISA" are to the Employee Retirement Income Security Act of 1974, as amended;

"ESRD" are to End Stage Renal Disease;

"Exchange Act" are to the Securities Exchange Act of 1934, as amended;

"FASB" are to the Financial Accounting Standards Board;

"First Health" are to First Health Group Corp., an indirect wholly owned subsidiary of Aetna, Inc;

"First Merger Sub" are to Music Merger Sub I, Inc., a Delaware corporation and direct, wholly owned subsidiary of the Company;

"Fixed Value RSUs" are to restricted stock units granted based on a fixed monetary amount under the 2020 Omnibus Incentive Plan in accordance with the terms of the related side letter;

"founder shares" are to shares of Churchill's Class B common stock and Churchill's Class A common stock issued upon the automatic conversion thereof in connection with the Closing;

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"GAAP" are to generally accepted accounting principles in United States of America;

"H&F" are to Hellman & Friedman Capital Partners VIII, L.P.;

"HIPAA" are to the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act, each as amended, and the regulations that implement such laws;

"HMOs" are to a health maintenance organizations;

"Holdings" are to Polaris Investment Holdings, L.P.;

"Holdings Board" is Board of Directors of Holdings, established by its general partner, Polaris Investment Holdings GP, LLC;

"HST" are to HSTechnology Solutions, Inc.;

"Insiders" are to Michael Klein, Jay Taragin, Jeremy Paul Abson, Glenn R. August, Mark Klein, Malcolm S. McDermid, and Karen G. Mills;

"Integration expenses" are costs associated with the integration of acquired companies into MultiPlan;

"Investor Rights Agreement" are to the Investor Rights Agreement, dated as of July 12, 2020, by and among the Company, the Sponsor, Holdings, H&F, the PIF and certain other parties thereto;

"IPO Corporation" are to an entity resulting from a reorganization, conversion, redomiciliation, distribution, exchange or other transaction undertaken in preparation for an initial public offering;

"KG" are to The Klein Group, LLC, an affiliate of Michael Klein and the Sponsor and an affiliate and wholly owned subsidiary of M. Klein and Company. KG (and not the Sponsor) was engaged by Churchill to act as Churchill's financial advisor in connection with the Transactions, and as a placement agent in connection with the PIPE Investment as more fully described herein;

"LIBOR" are to London Interbank Offered Rate;

"Liquidity Event" are to any transaction or series or related transactions involving (i) the sale of all or substantially all of the assets of Holdings on a consolidated basis to a person, or group of persons, other than (A) the H&F Investors and their affiliates or (B) a distribution of IPO Corporation to the unitholders of Holdings as part of an IPO Conversion (as defined in the unitholders agreement) or following an initial public offering, (ii) a merger, reorganization, consolidation or other similar corporate transaction in which the outstanding voting securities of Holdings are exchanged for securities of the successor entity and the holders of the voting securities of Holdings immediately prior to such transaction do not own a majority of the outstanding voting securities of the successor entity immediately upon completion of such transaction or (iii) the direct or indirect sale (whether by sale, merger or otherwise) of all or a majority of the voting securities of Holdings to a person, or group of persons, other than the H&F Investors and their affiliates;

"M. Klein and Company" are to M. Klein and Company, LLC, a Delaware limited liability company, and its affiliates;

"Merger Agreement" are to that certain Agreement and Plan of Merger, dated as of July 12, 2020, by and among Churchill, MultiPlan Parent, Holdings, First Merger Sub and Second Merger Sub, as the same has been or may be amended, modified, supplemented or waived from time to time;

"Mergers" are to, together, (a) the merger of First Merger Sub with and into MultiPlan Parent with MultiPlan Parent being the surviving company in the merger (the "First Merger") and (b) immediately following and as part of the same transaction as the First Merger, the merger of MultiPlan Parent with and into Second Merger Sub, with Second Merger Sub surviving the merger as a wholly owned subsidiary of Churchill (the "Second Merger");

"MPH" are to MPH Acquisition Holdings LLC;

"MultiPlan" are, prior to consummation of the Transactions, to MultiPlan Parent and its consolidated subsidiaries and, following consummation of the Transactions, to MultiPlan Corporation and its consolidated subsidiaries;

"MultiPlan Parent" are to Polaris Parent Corp., a Delaware corporation;

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"NCQA" are to the National Committee for Quality Assurance;

"Non-Employee Director" are to each member of our Board that is not an employee of the Company or any parent or subsidiary of the Company;

"Non-income taxes" includes personal property taxes, real estate taxes, sales and use taxes and franchise taxes which are included in cost of services and general and administrative expenses;

"OCR" are to U.S. Department of Health and Human Services Office for Civil Rights;

"Other expenses" represents miscellaneous expenses, gain or loss on disposal of assets, gain or loss on disposal of leases, tax penalties, non-integration related severance costs, and management fees;

"Payors" are our customers which include large national insurance companies, Blue Cross and Blue Shield plans, provider-sponsored and independent health plans, TPAs, bill review companies, Taft-Hartley plans and other entities that pay medical bills related to the commercial healthcare, government, workers' compensation and auto medical markets

"P&C" are to Property & Casualty;

"PCAOB" are to the Public Company Accounting Oversight Board (United States);

"PSAV" are to percentage of savings;

"PEPM" are to per-employee-per-month;

"PHI" are to Protected Health Information;

"PIK Interest" are to interest paid through an increase in the principal amount of the outstanding Senior Convertible PIK Notes or through the issuance of additional Senior Convertible PIK Notes;

"PIPE Investment" are to, collectively, the Common PIPE Investment and the Convertible PIPE Investment;

"PIPE Warrants" are to the warrants to purchase Churchill's Class A common stock issued in connection with the Common PIPE Investment, on terms identical to the terms of the Private Placement Warrants, other than the exercise period that started on November 7, 2020, the exercise price which is $12.50 per share and the redemption feature that exists for all holders of the PIPE warrants.

"Polaris" is Polaris Parent Corp., a Delaware corporation and direct, wholly owned subsidiary of Holdings and parent company to MultiPlan, Inc.;

"Polaris Agreement" are to a Class B Unit Award Agreement;

"Polaris Plan" are to an incentive plan established by Holdings effective June 7, 2016;

"Polaris Plan Participants" are to directors, officers, employees, consultants and advisors who are eligible for the Polaris Plan;

"PPOs" are to Preferred Provider Organizations;

"Private Placement Warrants" are to warrants issued to the Sponsor in a private placement simultaneously with the closing of the Churchill IPO and the Working Capital Warrants whose terms are identical to the Private Placement Warrants;

"public shares" are to shares of Churchill's Class A common stock sold as part of the units in the Churchill IPO (whether they were purchased in the Churchill IPO or thereafter in the open market);

"public shareholders" are to the holders of the Company's public shares, including the Sponsor and Churchill's officers and directors to the extent the Sponsor and Churchill's officers or directors purchase public shares, provided that each of their status as a "public shareholder" shall only exist with respect to such public shares;

"Public Warrants" are to the Company's warrants sold as part of the units in the Churchill IPO (whether they were purchased in the Churchill IPO or thereafter in the open market);

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"PwC" are to PricewaterhouseCoopers LLP (PCAOB ID 238);

"Qualifying Payment Amount" or "QPA" are, with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage, for an item or service furnished during 2022, the median of contracted rates recognized by the plan or issuer, respectively, as the total maximum payment under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the same geographic region in which the item or service is furnished, consistent with the methodology established by the U.S. Department of Health and Human Services ("HHS") in regulations, and increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021, as described in 42 U.S.C. § 300gg-111 and HHS regulations;

"RBP" are to Reference-Based Pricing formerly referred to as Medical Reimbursement Analysis;

"Refinancing" are to (a) the consummation of the 5.750% Notes offering by MPH and the increase of the revolving credit facility under the senior secured credit facilities from $100.0 million to $450.0 million and (b) the repayment of all outstanding 7.125% Notes and $369.0 million of indebtedness under MPH's term loan facility with the net proceeds of the 5.750% Notes offering, together with cash on hand, which occurred on October 29, 2020;

"Revolver B" are to the revolving credit facility in conjunction with Term Loan B and maturing on August 24, 2026;

"Revolver G" are to the revolving credit facility in conjunction with Term Loan G and replaced by Revolver B on August 24, 2021;

"Revolving credit facility" are to MPH's $450.0 million senior secured revolving credit facility;

"ROU" are to operating lease right-of-use asset;

"SEC" are to the United States Securities and Exchange Commission;

"Second Merger Sub" are to Music Merger Sub II, LLC, a Delaware limited liability company and direct, wholly owned subsidiary of the Company;

"Section 404" are to Section 404 of the Sarbanes-Oxley Act;

"Securities Act" are to the Securities Act of 1933, as amended;

"Senior Convertible PIK Notes" are the 6.00% / 7.00% Convertible Senior PIK Toggle Notes due 2027;

"Senior PIK Notes" are to the 8.500% / 9.250% Senior PIK Toggle Notes due 2022 issued by Polaris Intermediate Corp. on November 21, 2017. All of the outstanding Senior PIK Notes were redeemed on October 8, 2020;

"senior secured credit facilities" are to MPH's senior secured credit facilities which, before August 24, 2021, consist of (a) a $2,341.0 million term loan facility maturing on June 7, 2023 and (b) a $450.0 million revolving credit facility maturing on June 7, 2023, and as of and after August 24, 2021 consist of (a) a $1,325.0 million term loan facility maturing on September 1, 2028 and (b) a $450.0 million revolving credit facility maturing on August 24, 2026;

"Sponsor" are to Churchill Sponsor III, LLC, a Delaware limited liability company and an affiliate of M. Klein and Company in which certain of Churchill's directors and officers hold membership interests;

"Sponsor Agreement" are to the Amended and Restated Sponsor Agreement, dated as of July 12, 2020, by and among the Company, the Sponsor and the Insiders;

"Sponsor Note" are to the unsecured promissory note issued by the Company to the Sponsor in an aggregate principal amount of $1,500,000. The Sponsor converted the unpaid balance of the Sponsor Note into Working Capital Warrants in connection with the Closing;

"Subscription Agreements" are to, collectively, the (a) common stock subscription agreements entered into (i) by and between Churchill and the PIF and (ii) by and among Churchill, Holdings and MultiPlan Parent, on the one hand, and certain investment funds, on the other hand, in each case, dated as of July 12, 2020 and entered into in connection with the Common PIPE Investment and (b) subscription agreements, dated as of July 12, 2020, entered into in connection with the Convertible PIPE Investment;

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"TCJA" are to the Tax Cuts and Jobs Act of 2017;

"Term Loan B" are to a term loan payable borrowed on August 24, 2021 in the amount of $1,325.0 million with a group of lenders due and payable on September 1, 2028;

"Term Loan G" are to a term loan payable borrowed on June 7, 2016 in the amount of $3,500.0 million with a group of lenders and was repaid in full on August 24, 2021;

"TPAs" are to Third Party Administrators;

"Transactions" are to the Mergers, together with the other transactions contemplated by the Merger Agreement and the related agreements;

"Trust Account" are to the Churchill trust account that held the proceeds from the Churchill IPO prior to the consummation of the Transactions;

"Units" are to our stock-based compensation granted to employees in the form of Units and Holdings' Class B Units;

"warrants" are to the Public Warrants, the Private Placement Warrants, the PIPE Warrants and the Working Capital Warrants;

"we," "our" or "us" are to MultiPlan and its consolidated subsidiaries; and

"Working Capital Warrants" are to the warrants to purchase Churchill's Class A common stock pursuant to the terms of the Sponsor Note, on terms identical to the terms of the Private Placement Warrants.

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Cautionary Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K includes statements that express our and our subsidiaries' opinions, expectations, beliefs, plans, objectives, assumptions or projections regarding future events or future results and therefore are, or may be deemed to be, "forward-looking statements" These forward-looking statements can generally be identified by the use of forward-looking terminology, including the terms "believes," "estimates," "anticipates," "expects," "seeks," "projects," "intends," "plans," "may," "will" or "should" or, in each case, their negative or other variations or comparable terminology. These forward-looking statements include all matters that are not historical facts. They appear in a number of places throughout this Annual Report on Form 10-K and these forward-looking statements reflect management's expectations regarding our future growth, results of operations, operational and financial performance and business prospects and opportunities. Such forward-looking statements are based on available current market material and management's expectations, beliefs and forecasts concerning future events impacting our business. Factors that may impact such forward-looking statements include:

- the impact of the ongoing COVID-19 pandemic and its related effects on our results of operations, financial performance, liquidity or other financial metrics;
- loss of our customers, particularly our largest customers;
- inability to preserve or increase our existing market share or the size of our PPO networks;
- effects of competition;
- effects of pricing pressure;
- the inability of our customers to pay for our services;
- decreases in discounts from providers;
- the loss of our existing relationships with providers;
- the loss of key members of our management team or inability to maintain sufficient qualified personnel;
- pressure to limit access to preferred provider networks;
- the ability to achieve the goals of our strategic plans and recognize the anticipated strategic, operational, growth and efficiency benefits when expected;
- our ability to enter new lines of business and broaden the scope of our services;
- our ability to identify, complete and successfully integrate acquisitions;
- our ability to obtain additional financing; changes in our industry and in industry standards and technology; interruptions or security breaches of our information technology systems;
- our ability to protect proprietary information, processes and applications;
- our ability to maintain the licenses or right of use for the software we use;
- our inability to expand our network infrastructure;
- changes in accounting principles or the incurrence of impairment charges;
- our ability to remediate any material weaknesses or maintain effective internal controls over financial reporting;
- changes in our regulatory environment, including healthcare law and regulations;
- the expansion of privacy and security laws;
- heightened enforcement activity by government agencies;
- our ability to pay interest and principal on our notes and other indebtedness;

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- lowering or withdrawal of our credit ratings;
- the possibility that we may be adversely affected by other political, economic, business, and/or competitive factors;
- adverse outcomes related to litigation or governmental proceedings;
- other factors disclosed in this Annual Report on Form 10-K; and
- other factors beyond our control.

The forward-looking statements contained in this Annual Report on Form 10-K are based on our current expectations and beliefs concerning future developments and their potential effects on our business. There can be no assurance that future developments affecting our business will be those that we have anticipated. These forward-looking statements involve a number of risks, uncertainties (some of which are beyond our control) or other assumptions that may cause actual results or performance to be materially different from those expressed or implied by these forward-looking statements. These risks and uncertainties include, but are not limited to, those factors described under the heading *"Risk Factors."* Should one or more of these risks or uncertainties materialize, or should any of the assumptions prove incorrect, actual results may vary in material respects from those projected in these forward-looking statements. We do not undertake any obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise, except as may be required under applicable securities laws.

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Part I

Item 1. Business

Overview

MultiPlan is a leading provider of data analytics and technology-enabled solutions designed to bring affordability, efficiency and fairness to the U.S. healthcare industry. We do so through services focused on reducing medical cost and improving billing and payment accuracy for the payors of healthcare, which are health insurers, self-insured employers and other health plan sponsors (typically through their health plan administrators), and, indirectly, the plan members who are the consumers of healthcare services.

Our predecessor was founded in 1980 as a New York-based hospital network and we have evolved both organically and through acquisition into a national organization offering three categories of services:

- *Analytics-Based Services*: data-driven algorithms which detect claims over-charges and either negotiate or recommend fair reimbursement using a variety of data sources and pricing algorithms;
- *Network-Based Services*: contracted discounts with healthcare providers to form one of the largest independent preferred provider organizations ("PPOs") in the United States with over 1.2 million healthcare providers under contract, as well as outsourced network development and/or management services; and
- *Payment and Revenue Integrity Services*: data, technology, and clinical expertise deployed to identify and remove improper and unnecessary charges before or after claims are paid, or to identify and help restore and preserve underpaid premium dollars.

Although the end beneficiary of our services are employers and other plan sponsors and their health plan members, our direct customers are typically health plan administrators ("Payors"). We offer these Payors a single electronic gateway to a comprehensive set of services in each of the above three categories, which are used in combination or individually to reduce the medical cost burden on their health plan customers and members while fostering independently developed fair and efficient payments to the providers. In essence, we sit in the midst of four constituencies – payors, employers/health plan sponsors, plan members and providers – offering an independent reimbursement solution to reduce healthcare costs in a manner that is orderly, efficient and fair to all parties involved, while also helping them to navigate the highly complex U.S. healthcare system.

These comprehensive offerings have enabled us to maintain long-term relationships with a number of our customers, including relationships of over 25 years with some of the nation's largest Payors. For the year ended December 31, 2021, our services identified approximately $21.7 billion in potential medical cost savings. In addition, because in most instances the fee for our services is directly linked to the savings utilized by our customers, our revenue model is aligned with the interests of our customers.

U.S. Healthcare Industry

According to Centers for Medicare and Medicaid ("CMS"), Americans spent $4.1 trillion, or 19.7% of U.S. GDP, on healthcare in 2020. That equates to about $12,530 per person and is projected to grow by 5.4% annually through 2028. CMS estimates that, at the current rate, healthcare spend will represent $6.2 trillion by 2028. The Census Bureau reports that about 298 million people in the U.S. had health insurance coverage in 2020, of which 177 million were covered under employer-sponsored plans. According to CMS, nearly 22 million people were enrolled in Medicare Advantage plans in 2020, and we conservatively estimate another 54 million were enrolled in managed Medicaid plans based on 2019 CMS figures. This means as many as 85% of those with health insurance coverage could benefit from the value MultiPlan delivers.

Medical spend is a function of both utilization and cost, and there are many factors driving the expected growth in both. Utilization is increasing due to a population that is both aging and experiencing more chronic disease. The advent of new treatments, modalities and technologies also spur utilization. Medical cost is increasing with increases in per-unit prices, driven in part by those same new treatments, modalities and technologies as well as the additional administrative burden of complying with new regulations. Costs also increase with the continued complexities of healthcare billing which lead to unintended billing issues. As expenditures continue to rise, stakeholders – and especially Payors – are becoming increasingly focused on solutions that reduce medical costs and improve billing and payment accuracy.

An estimated $1.2 trillion, or about a third of U.S. healthcare expenditures, are attributed to some form of waste or abuse that leads to overcharges. MultiPlan's services directly address the category of waste/abuse that accounts for about $400 billion of this burden – excessive prices, clinical billing errors, suspect billing schemes and patterns, errors in enrollment data and, in some cases, services provided unnecessarily.

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We believe cost management and billing and payment accuracy will continue to be highly important to Payors across the markets we serve. We expect growth in demand for these services will be driven by two major trends: (i) increasing costs per claim from medical inflation and technology enhancements and (ii) increasing treatment volume from an aging population and increases in the insured population. As medical activity rises as a result of an aging population and a focus on preventative healthcare and technological advances, medical claims volume and costs are expected to increase significantly, which we believe will further increase utilization of our solutions. We see opportunity in trying to counter the accelerating pace of medical cost inflation, leading to more savings for our customers, and associated revenues for the Company.

MultiPlan Solutions

Payors of healthcare have essentially three strategies for reducing medical cost: managing the utilization of medical services, lowering the per-unit cost of medical services incurred, and ensuring the services are reimbursed without error and accepted by the provider. MultiPlan services target the latter two of these approaches, as shown in the value chain from care to payment for healthcare services illustrated below.

Dotted box = addressed by MultiPlan Solutions

Analytics-Based Services.

Our Analytics-Based Services reduce the per-unit cost of claims using data-driven negotiation and/or reference-based pricing methodologies. These services generally are used in a solution hierarchy after network services to reduce claims with no available network contract, but also are used standalone. Value-Driven Health Plan services bundle network and reference-based pricing to enable a blended benefit plan design. All of the services in this category leverage our information technology platform, public data sources, and the billions of claims that we have reviewed and are included in our database reflecting both network and out-of-network priced claims, as well as the results of clinical coding analyses. They feature proprietary algorithms and machine learning/AI to allow claims to be processed quickly and accurately.

Reference-Based Pricing ("RBP"). RBP provides Payors with a recommended payment amount for claims based on a reference point. Most RBP programs in the market uses Medicare as the reference point. We also offer this option, but most customers elect to use our Data iSight program which uses facility cost as the facility reference and median reimbursed amounts as the professional reference. The facility pricing methodology features a patented benchmarking process that determines the cost of a group of like claims from like providers in the same geography. Both methodologies use data from readily-available public and private sources which feed our proprietary automated algorithms to deliver defensible, consistent pricing. RBP recommendations do not incorporate member protection from balance billing, so the service includes optional post-payment negotiation and patient advocacy services to negotiate settlements where needed to eliminate balance billing. Our cost-driven approach was developed with input from healthcare facilities, and was designed to addresses the typical issues providers have with reference-based pricing. As a result, we believe the propensity for providers to balance bill is materially lower than other similar services. Data iSight delivers provider acceptance of over 92% for facility and 96% for professional claims, and for those claims that are appealed, we successfully retain about 75% of savings through education and negotiation. We offer a number of additional choices of reference point, including: median contracted rates (adjusted to the Qualifying Payment Amount for certain surprise bill claims), and usual and customary charges. Our Reference-Based Pricing services are used by all types of Payors, most notably large commercial insurers, Blue Cross and Blue Shield plans, provider-sponsored and independent health plans. They are most commonly priced at a percentage of savings identified.

Value-Driven Health Plan Services ("VDHP"). VDHP is a form of reference-based pricing that bundles member and provider engagement tools to enable employers and other health plan sponsors to offer low-cost health plans. The engagement tools include member shopping based on quality, cost and provider acceptance of the reimbursement; provider education and, where applicable, negotiation in advance or after payment; point-of-service cash payment processing; and other features designed to ensure satisfaction of both members and providers while delivering significant cost reduction. These tools distinguish VDHPs from other plans using RBP because they deliver many of the benefits that plan members and providers expect with a PPO network, and therefore make it feasible to replace the network either in part or in full. Provider acceptance of the reference price is about 98%. Our VDHP service offerings enable a range of VDHP configurations, including a "standard" form of VDHP which integrates our PPO network for professional and select facility services; a "full" VDHP which has no network; and a community-based VDHP which features an agreement with a marquee health system in the area to accept the reference-based price in exchange for preferred steerage of the health plan’s members. VDHP services are sold to employers

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directly using the broker/consultant channel, or through Third-Party Administrators ("TPAs"). Today, they are most in demand in the small and mid-sized group market. They are most commonly priced per-employee/member-per-month ("PEPM").

Financial Negotiation. Our financial negotiation services assist Payors with pricing claims from providers with whom neither they nor MultiPlan have been able to secure a contractual discount. We handle these claims on an individual basis and attempt to negotiate with the provider an acceptable payment amount for a specific claim that includes member protections from balance billing. Negotiation agreements protect the health plan member from balance billing. Approximately half of the successfully negotiated claims are completed in a fully automated manner. These claims include those in which the proposed negotiated amount is generated by algorithms and automatically transmitted to the provider's office, and/or that are electronically accepted and signed by the provider. Certain providers also choose to set up an arrangement with MultiPlan for pre-determined levels of discount to be automatically deducted on claims that would otherwise be individually negotiated. For those claims that are not automatically negotiated, MultiPlan works directly with the provider's office through our negotiations staff, which is aided by extensive workflow and benchmarking tools. Financial negotiation services are used by all types of Payors, most notably Blue Cross and Blue Shield plans, provider-sponsored and independent health plans. They are priced at a percentage of savings identified.

Surprise Billing Services. Introduced in 2021, our surprise billing services enable Payors to comply, or to help their employer/plan sponsor customers to comply, with the federal No Surprises Act ("NSA") which became effective on January 1, 2022. The NSA, and interim final regulations issued on July 13, 2021 and October 7, 2021 ("IFRs") that implemented the NSA, introduces changes to the reimbursement process of certain types of medical claims, increasing what was typically a one to two step reimbursement process to five steps. MultiPlan performs all five steps in an end-to-end service, or makes each step available as components to meet the specific needs of each Payor. The steps require extensive data collection and analysis to identify claims as surprise bills under the law's definition; calculate the new QPA benchmark introduced by the law and append it to the claim; create an initial payment amount for the claim, typically by using the QPA as the reference point; negotiate a settlement as needed; and take claims through an independent dispute resolution process as needed. We leverage existing technology and expertise in data science, claim pricing and negotiation in offering these new services. They are used by all types of Payors that must comply with the NSA, and are priced either at a percentage of savings for the end-to-end service, or on a per-claim basis for individual components.

Network-Based Services

Our Network-Based Services reduce the per-unit cost of claims through contracts with over 1.2 million healthcare providers and facilities that establish discounts with member protection from balance billing in exchange for patient steerage and other provider-friendly terms and conditions. These services generally are used first in a solution hierarchy with members actively steered to participating providers through online and other directories. The services leverage our extensive network development, credentialing and data management capabilities as well as a sophisticated transaction engine that matches rendering provider information on the claim to the correct network contract so the discount can be applied. We offer a variety of network configurations to support all types and sizes of health plans, generally used as either the primary network, or as a complement to another primary network.

Primary Networks. For Payors without their own direct contractual discount arrangements with providers, our primary networks serve as the network for the Payor's commercial or government health plans in a given service area in exchange for a PEPM rate, or as the Payor's out-of-area extended primary network in exchange for a percentage of the savings identified. Our national primary network, branded PHCS Network, has been continuously accredited for credentialing by the National Committee for Quality Assurance ("NCQA") since 2001. We believe this provides assurances to employers/plan sponsors and plan members of the quality of providers in the network. Customers mainly include provider-sponsored and independent health plans; Medicare Advantage plans; Taft-Hartley plans and TPAs, as it is more cost effective for these Payors to outsource this function than to incur the expense of developing and maintaining their own network of thousands of doctors and hospitals. We also offer custom development of primary networks, leveraging our extensive network development team and analytic tools, including a tool combining internal provider data with public sources to enable strategic targeting of providers to be contracted. Customers of this custom build service include Medicare Advantage and Medicaid health plans seeking assistance with expansion plans or help maintaining the required network adequacy.

Complementary Networks. Our complementary networks provide Payor customers with access to our national network of healthcare providers that offer discounts under the health plan's out-of-network benefits, or otherwise can be accessed secondary to another network. Payors use the network to expand provider choice for consumers, and to achieve contracted reductions with member protections on more claims. The service is priced based on a percentage of savings identified. Customers most commonly include large commercial insurers, property and casualty carriers via their bill review vendors, Taft-Hartley plans, provider-sponsored and independent health plans, and some TPAs.

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Payment and Revenue Integrity Services

Our Payment and Revenue Integrity Services improve the accuracy of payments made to providers, leading to a reduction in overall medical cost by minimizing overpayments. They use data, technology and clinical expertise to assist Payors in identifying improper, unnecessary and excessive charges before or after claims are paid, as well as issues with premiums paid by CMS for government health plans caused by discrepancies with enrollment-related data. Payment integrity services can be used before payment, to correct overpayments before they are issued, or after payment to enable the recovery of overpaid dollars. Revenue integrity services identify and correct errors in plan enrollment data that lead to underpayment of CMS premium dollars. The services rely heavily on our internal and other data sources, advanced analysis, machine learning and transaction processing technology, as well as clinical expertise to aid in the identification and selection of issues to be addressed with the least provider abrasion.

Pre-Payment Clinical Reviews. Pre-payment claims are taken through payment integrity analytics, which may include any of the following additional reviews: medical coder, clinician, medical record or itemized bill. Claims are returned with recommended corrections or routed to a negotiator to leverage the billing issues to reach agreement with member protections for a lower reimbursement. The negotiation service targets non-contracted claims; the correction service targets all claims, including a Payor's in-network claims. These services are most commonly used by large commercial and Medicare Advantage/Medicaid insurers, Blue Cross and Blue Shield plans, and provider-sponsored and other independent health plans. Claims are priced based on a percentage of savings identified. The services also are integrated into MultiPlan's network pricing and analytics-based services so the majority of customers benefit from our pre-payment integrity services.

Coordination of Benefits and Subrogation Services (pre- and post-payment). Coordination of Benefits identifies payments that should have been made by a health plan member's other health insurance coverage (for example, if the member's spouse has coverage through another employer-sponsored plan). Subrogation Services identify payments made related to an accident that are the responsibility of another responsible third party. The services use data, technology and highly experienced staff to identify cases, validate coverage status, report or recover dollars paid in error, and assist with root cause correction to avoid future potential overpayments. Subrogation services are also available in a Software-as-a-Service ("SaaS") model. These services are used by commercial, Medicare Advantage and Managed Medicaid Payors and depending on the service are priced based on a percentage of savings identified and/or recovered, per member per year, or per member with primary coverage identified.

Data Mining and Clinical Audits (post-payment). Data Mining deploys payment integrity analytics combining industry-accepted rules and plan-specific policies to identify overpayments associated with claim adjudication errors, billing errors and contract language, as well as their root causes. Findings are returned to the Payor for action. Clinical Audits utilize clinical subject matter experts to review medical records related to a claim to ensure that the claim was billed and coded appropriately. Clinical audits include Diagnosis Related Group validation, medical necessity short stay review, itemized bill review, and hospital bill audit. These services are used by commercial, Medicare Advantage, Managed Medicaid and state Medicaid Payors and are priced based on a percentage of savings identified and/or recovered. Depending on the engagement, some clinical audit programs may be priced based per claim reviewed.

Revenue Integrity Services. Targeting issues unique to Medicare Advantage Payors, these services use data, technology, and clinical expertise to identify and restore underpaid premiums, and to improve accuracy of future premiums paid to Medicare Advantage plans by CMS. There are three services currently offered, typically used in combination: Medicare Secondary Payor interfaces with CMS to confirm member eligibility records for primacy, correct inaccuracies, and help restore and preserve underpaid premium dollars; End Stage Renal Disease ("ESRD") analyzes claim data to identify Medicare Advantage plan members with missing ESRD statuses at CMS and works with dialysis providers and CMS to correct the statuses; and Part D Other Health Insurance ("OHI") leverages analytics to identify Medicare Advantage plan members where the Part D Pharmacy Coverage on file with CMS is inaccurate and effectuates corrections with CMS. The updated Part D information improves compliance, efficiencies and member satisfaction. These services are priced based on a percentage of the CMS premiums restored to the Medicare Advantage Payor. Part D OHI is priced per validated member with other primary Part D coverage.

Mission and Growth Strategy

According to the Peterson-Kaiser Family Foundation Health System Tracker, at an estimated $12,000 per person, the United States has the highest per capita healthcare spend among the 11 high income countries. Yet, in terms of healthcare quality and efficacy, we rank last. Our mission is to deliver fairness, efficiency and affordability to U.S. healthcare, and our services, data, technology, expertise and connectivity are aimed at addressing this dichotomy. We have historically focused on two of the three levers Payors can use to manage medical spend: lowering per-unit costs related to administrative overhead, and improving billing and payment accuracy. For the most part, we also have focused on spend associated with out-of-network utilization although in 2014 we began to offer payment integrity services designed to add value for a Payor's in-network claims.

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Our growth strategy leverages our longstanding relationships with Payors and extensive proprietary data and algorithms to not only accelerate our shift to in-network claims, but also to develop a beachhead for expanding our value to other Payor functions that service their plan members and the providers that service those members. The strategy has three components being executed simultaneously: Enhance, Extend and Expand.

The first part of our strategy is **enhancing** our platform. We do this by improving and innovating upon our existing products to deliver more value on the claim volume we already receive from existing customers. We have and continue to make investments in combining proprietary data with third party data, and in advanced technologies such as artificial intelligence and machine learning to improve service performance. We also have invested in sales resources to heighten cross-selling activity with existing customers.

The second element of the strategy is **extending** our platform. We do this by deepening penetration in customer segments we consider to be large markets where we either develop or acquire capabilities to address an unmet client need. Our initial target segments are a Payor's in-network claims, government programs such as Medicare Advantage and Managed Medicaid, TPAs and the Property and Casualty sector. We leverage sales and product development initiatives, both organic and through acquisition, to execute on this part of the strategy. Our acquisitions of HST in 2020 and Discovery Health Partners in 2021 are two examples of our work on this strategy, both adding new services with HST focused on TPAs and their employer customers and Discovery significantly increasing our footprint with in-network claims for commercial plans as well as Medicare Advantage and Medicaid plans.

The third element of the strategy is to **expand** our platform to new business models that deliver value-added, primarily Payor-centric services for providers and healthcare consumers. We expect to execute on this component through corporate and business development efforts, and believe we are well positioned given the 1.2 million healthcare providers we have under contract and the more than 60 million consumers estimated to have access to MultiPlan's services. Our data, algorithms and service components can be leveraged by us, our Payor customers, and partner software companies to tackle some of providers' and consumers' biggest pain points, such as transparency of patient medical bills and consumer financing of medical expenses.

Markets

We work with healthcare payors in the commercial healthcare, government healthcare and property and casualty markets. Substantially all of MultiPlan's services are available in all 50 U.S. states and the District of Columbia. All services are available to all applicable customers regardless of geographic location, company type or size.

Commercial Health

Commercial healthcare accounted for about 28% of the total $4.1 trillion medical spend in 2020. Commercial health plans are offered either as an insured program where the plan sponsor – typically an employer – and its members pay a monthly premium and the insurer pays the medical costs from those premium dollars, or as self-insured plans funded by the employer/plan sponsor and its members from a pool of funds earmarked for this purpose. Self-insured plans typically are administered by insurance companies or TPAs. Often, particularly for the national insurers, this "Administrative Services Only" ("ASO") business is larger than the at-risk insured business. In the quarter ended September 30, 2021, consistent with MultiPlan's revenue mix, the four largest publicly-held commercial health insurers reported that 80% of their membership was in self-insured plans.

MultiPlan services benefit both fully-insured and self-insured health plans. We work with fully-insured plans directly, including national insurers, Blue Cross and Blue Shield plans, provider-sponsored and independent health plans. Because these entities are responsible for paying for medical claims, they are typically focused primarily on cost management and billing and payment accuracy with member features given less emphasis. These plans favor MultiPlan's Analytics-Based Services, and in particular RBP, over Network-Based Services.

We work with self-insured plans primarily through their plan administrators, which include the same types of companies as well as TPAs and sometimes the employers/plan sponsors themselves. Over 85% of our 2021 revenues are attributed to self-insured plans we service through their payors or directly. According to a Kaiser Family Foundation's Employer Health Benefits survey, healthcare premiums exceeded $22,000 in 2021, with employees paying nearly $6,000 toward their cost of care. Self-insured plan sponsors are responsible for paying medical claims as well as for the satisfaction of their plan members. In a tight employment market, particularly with large employers, choice of benefits and member satisfaction concerns may have equal or more weight than medical cost. This leads to the need for Payors to offer variety in plan designs, and according to Kaiser Family Foundation, over two-thirds of large employers offer at least two benefit plan options to their employees. Consequently, these plans often include Network-Based Services in their service hierarchies and/or use the "standard" VDHP services that integrate the professional PPO network in order to generate savings for both plan and plan member. Larger Payors servicing self-insured plans also have extensive customized processing logic to support plan design variability as the labor market shifts, and one such customer has well over 100,000 such rules in place.

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The commercial health segment also includes individual health plans which are always insured, and may or may not be sold through the Affordable Care Act exchanges. MultiPlan supports individual plans through the insurance companies offering these plans, and does not sell to the individual directly.

Government Programs

This market segment includes Medicare, Medicaid, TRICARE, Federal Employees Health Benefits, Veterans Administration and other federal health programs (state and municipal government health plans typically are managed as commercial plans). Commercial insurers and health plans also participate in this market segment, but there also are Payors that operate government plans exclusively. Most, but not all, of MultiPlan's commercial healthcare services also are of value to Payors of government programs.

Medicare Advantage. Medicare Advantage ("MA") plans serve the Medicare-eligible population in a private plan alternative to traditional Medicare. Kaiser Family Foundation reports that enrollment in MA plans more than doubled over the last decade. As of 2021, an estimated 26 million people were enrolled in MA plans, comprising 37% of the total Medicare population. The population grew from about 21.6 million, or 36% of the total 60 million Medicare enrollees in 2020. MA Payors have a greater need for billing and payment accuracy than they do cost management, because healthcare prices largely are set. With the dramatic growth this segment has and continues to see, there is heightened competition which also drives the need for assistance in building network access. Today, these Payors use MultiPlan's payment and revenue integrity services, and also may outsource some portion of their provider network development to MultiPlan.

Medicaid and Managed Medicaid. An estimated 76.3 million people were enrolled in Medicaid and 6.9 million were enrolled in CHIP (Children's Health Insurance Program) plans as of June 2021. This reflects growth of 12.3% and 3.2%, respectively, over June 2020 figures. At 2019, 83% of Medicaid enrollees were in a managed Medicaid program. Enrollment has been growing as a result of the Medicaid expansion allowed under the Affordable Care Act. To date, 39 states and the District of Columbia have expanded or have committed to expand their Medicaid programs. The most recent growth is likely attributable to Families First Coronavirus Response Act ("FFCRA"), which created a temporary increase in the Medicaid Federal Medical Assistance Percentage ("FMAP"). As with MA, MultiPlan's services in this segment are primarily limited to payment integrity services with some custom network development also of use to bidders winning state Medicaid business under a request for proposal ("RFP").

Other Programs. We have a history of developing custom networks for TRICARE and Veterans Administration programs. These are RFP driven and MultiPlan partners with one or more Payors bidding on the business.

Property and Casualty

This market segment includes payors of the medical services arising from work-related injuries and auto accidents, as well as other types of property and casualty insurance. There is little overlap between the commercial and government Payors and those in this segment. Often the insurers are serviced by third parties that perform bill review services which include access to provider networks. We typically work with these service providers versus the carriers directly.

Workers' Compensation. Workers' compensation insurers must pay both the indemnity costs and the medical costs associated with an injured worker. Recent trends in medical cost inflation have become a major driver in the overall cost growth for workers' compensation insurers. Medical services today constitute about 60% of workers' compensation claims costs, up from 40% in the early 1980s. Rising medical costs have increased focus on cost management measures for the medical portion of workers' compensation insurance claims. We provide network access and pre-payment integrity services to these Payors. Our analytics-based services are used to a lesser extent, primarily because the majority of states have established fee schedules which providers expect to be reimbursed from, in the absence of a network contract that provides other benefits to the Payor.

Auto Medical. Auto insurance carriers face costs from auto damage and medical claims. Economic losses for bodily injury liability claims increased 10% annually from 2012 – 2017, well above the 3% annual medical inflation rate, with medical expenses accounting for 79% of claimed losses. With ongoing medical cost inflation, this trend is expected to continue into the future. MultiPlan's value in this segment is similar to the Workers' Comp segment – network access and payment integrity services primarily, with some interest in analytics-based services where state fee schedules are not in place.

Customers

MultiPlan works directly with Payors to manage medical cost and billing and payment accuracy for their own fully-insured health plans, and for their Administrative Services Only ("ASO"), self-insured employers/plan sponsors. We estimate that in 2021 our Payor customers served over 100,000 employers/plan sponsors actively using our services through the ASO channel, which generated over 85% of our combined Network and Analytics revenues in 2021. Within the ASO channel, the top 10 plan sponsors represent less than 20% of our combined Analytics and Network revenues in 2021. We also indirectly service

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consumers accessing healthcare services through commercial and government health plans or property and casualty policies. An estimated 60 million consumers have access to our services through their health plans. In aggregate, we serve a diverse customer base comprised of national and regional insurance companies, Blue Cross and Blue Shield plans, provider-sponsored and independent health plans, TPAs, self-insured health plans, Property and Casualty bill review companies and other companies involved in the claim adjudication process.

We believe that we have strong relationships with our customers, which include substantially all of the largest health plans. The loss of the business of one or more of our larger customers could have a material adverse effect on our results of operations. Our three largest customers accounted for approximately 34%, 19% and 10%, respectively, of our revenues for the year ended December 31, 2021. Contract terms with larger customers are often three and as many as five years, while mid- to small-sized customer contracts are often annual and typically include automatic one-year renewals. However, we continue to experience high renewal rates and our top ten customers based on full year 2021 revenues have been customers for an average of 25 years. Our customer relationships are further strengthened by high switching costs as MultiPlan is electronically linked to customers in their time-sensitive claims processing functions, and we support highly flexible benefits offerings to an extensive group of customers who often feature a MultiPlan logo on membership cards when networks are used.

Network

As of December 31, 2021, our network includes over 1.2 million healthcare providers. Our team of approximately 100 network development professionals manages these network relationships across our Primary and Complementary PPO Networks. For both networks, the team is responsible for strengthening our existing relationships with these providers. For existing providers, the goal of the network development team is to help providers maintain participation across products as well as increase the discounts the providers extend to our customers that utilize our provider networks.

In addition, the network development team is responsible for executing new contracts with providers that are not currently affiliated with our networks, either under our own contracts or on behalf of a payor that seeks to outsource its network development function. We strategically grow the number of providers that participate across all network product lines so we can continue to increase the value we provide to our customers. The network development team manages a sophisticated program of data mining, profiling, recruiting and ultimately contracting with new providers. An incentive driven pay-for-performance plan measures and rewards the success of our network development team.

Sales and Marketing

Our largest customers are serviced by a team of national account managers and senior executives responsible for continued growth of the relationship. The account team partners strategically with our customers, leveraging our Healthcare Economics unit to mine the customer's data and proactively present opportunities to the customer to improve performance and competitive position. This team also delivers account service, including daily claims management, RFPs, service inquiries and other marketing and operational support functions. The national account managers are compensated with a base salary plus bonus linked to customer retention.

The majority of our customers are serviced by a dedicated team of account managers and account service professionals organized into three market-focused departments — Health Plans (commercial and government), TPA/Employer, and Property and Casualty. These teams also include sales professionals responsible for new customer acquisition. The market-focused account managers are responsible for relationship management as well as for growing revenue through expanded use of services. They are compensated with a base salary plus a bonus and commission based on customer retention and revenue from upselling new products. The sales professionals are compensated with a base salary plus commission based on revenue from new customers. Sales and upselling efforts are supported by a marketing team which generates leads, builds brand awareness, implements and educates customers and develops proposals.

Information Technology

We believe that our IT platform provides us with a substantial competitive advantage. We have made significant investments in upgrading our IT infrastructure enabling us to automatically process significantly more transactions with greater accuracy and greatly improving our capacity to continuously serve our customers. Our IT is certified under HITRUST, NIST and AICPA SOC programs and in May 2020, we were rated at the top of our peer group by BitSight, an IT security rating organization. Our proprietary network repricing application is capable of returning approximately 99% of repriced claims to our Payor customers on the same day. In 2021, our pre-payment integrity and reference-based pricing services returned 99% and 97%, respectively, of claims within one day. Our proprietary negotiation application features portal technology with electronic signature acceptance, sophisticated claim distribution and prioritization algorithms enhanced with machine learning. We have implemented connectivity via EDI or direct integration using web services with all of our top customers. During 2021, nearly all of the claims processed in our system were received via EDI or direct web service integration. As we process more claims

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through EDI and direct web service integration, our substantial back office interconnectivity significantly reduces complexity and the number of processing errors. Because our IT platform is scalable, it is generally able to absorb substantial increases in volume at minimal marginal costs.

In addition to its high levels of security and throughput, our IT platform is enhanced with access to over three petabytes of structured data and 12 petabytes of total structured and unstructured data. The data reflects about one billion claims, growing steadily through the approximately 525,000 claims we process every day. As of December 31, 2021, the Company had the capacity to increase processing capacity three-fold with the current infrastructure.

Competition

Our competitors vary by service as follows.

Analytics-Based Services. MultiPlan competes with a variety of medical cost management companies for negotiation, reference-based pricing and surprise billing services. We compete for these services on the basis of savings effectiveness, provider acceptance, and plan member satisfaction. Our workflow and claim processing technology, user interaction and analytic algorithms are key competitive advantages. MultiPlan's competitors for these services typically are reference-based pricing services. They can be classified as programs intended to partially or fully replace networks, such as 6Degrees, AMPS, ELAP Services and Payer Compass, and those primarily accessed behind a full network, such as Zelis, ClearHealth Strategies and Naviguard.

Network-Based Services. We compete directly with other independent PPO networks, which are primarily regional, and with PPO network aggregators. We compete with independent PPO networks primarily on the basis of network discounts and access, but also on the basis of quality, independence and price. Our nationwide Primary PPO Network is NCQA accredited, which we believe provides assurances to payors and consumers regarding the quality of the providers in our network. Because some independent PPO networks are owned by large commercial payors, our customers may prefer to purchase PPO network services from a fully independent vendor. PPO aggregators offer national access by patching together third-party networks, in some cases including MultiPlan's network. While aggregators rely on third-party networks, MultiPlan's network features direct contracts with 98% of its participating providers. MultiPlan's competitors for these services typically include First Health, TRPN, and Zelis.

Payment and Revenue Integrity Services. We compete with a variety of larger and smaller vendors of payment and revenue integrity services. Our Payment Integrity solutions compete on the basis of analytic breadth and depth, human expertise and scope. Virtually all payment integrity competitors originated as post-payment specialists and to varying degrees have migrated services to a pre-payment modality, while our services were built to focus on examining claims before payment occurs and now, with the recent acquisition of DHP, we have a broader capability to address post-payment integrity. Our Revenue Integrity solutions compete on the basis of identification and assistance in restoration and preservation of underpaid premiums from CMS caused by member eligibility and status errors. Our competitors for these services typically include Change Healthcare Inc., Conduent, Cotiviti, Inc., Optum, SCIO and The Rawlings Group.

Government Regulations

We believe that each of MultiPlan's service offerings bears less risk than other healthcare businesses that bear insurance risk and bill federal healthcare programs or directly provide care. While we support our customers that are regulated entities, we generally are not directly regulated and face significantly lower levels of regulatory complexity. We function as a transaction processor and we believe we have limited risk for services or billing.

MultiPlan does not deliver healthcare services, provide or manage healthcare services, provide care or care management. We do not bear insurance, underwriting, payment, malpractice or reimbursement risks, nor do we adjudicate or pay claims. Our business is compensated directly by private payor customers, not by Medicare, Medicaid or other government healthcare programs. In some instances, we provide services to payors that contract directly with a federal or state agency. In those instances, we may be subject to certain federal and state law requirements associated with those programs as a First Tier, Downstream or Related entity (FDR). As an FDR to these customers, we are subject to requirements which prohibit an individual or entity who has been convicted of program-related crimes or other violations from providing services to, or receiving payment from, government healthcare programs. As an FDR, we are subject to affirmative legal obligations, as well as contractual requirements with our customers, to check the exclusion status of the individuals and entities we employ against lists of excluded individuals and entities prior to entering into employment or contractual relationships with them, and to periodically re-check such lists thereafter, or run the risk of liability under civil monetary penalties laws or a breach of our contractual obligations. We are also required to provide access to contracts, books and records pertaining to services performed in connection with federal or state agency contracts. A failure to comply with FDR requirements or violations of healthcare

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laws could subject us to audits, corrective actions, contract terminations, criminal or civil penalties, debarment or exclusion from government health care programs.

We are, however, subject, either directly or indirectly through our customer relationships, to federal and state laws and regulations governing privacy, security and breaches of patient information and the conduct of certain electronic health care transactions, including, for example, HIPAA, which imposes rules protecting individually identifiable health information and setting national standards for the security of electronic PHI. We are a "Business Associate" (as defined by HIPAA) of our customers. As such, we must comply with all applicable provisions of HIPAA, including the HIPAA Security Rule and applicable provisions of the HIPAA Privacy Rule and the Breach Notification Rule. Violations of such provisions may result in civil monetary penalties, resolution agreements, monitoring agreements, and, in certain circumstances, criminal penalties including fines and/or imprisonment. HIPAA also authorizes state attorneys general to file suit on behalf of their residents. Although HIPAA does not create a private right of action allowing individuals to sue in civil court for violations, the laws and regulations have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of patient information. In addition to HIPAA, there are federal and state laws that protect types of personal information that may be viewed as particularly sensitive, including substance use information, genetic information, HIV/AIDS status, and mental health information. The Federal Trade Commission has also interpreted existing consumer protection laws to impose standards for the collection, storage, processing, use, retention, disclosure, transfer, disposal, and security of information about individuals, including health-related information. State privacy laws are changing rapidly. Massachusetts and New York, for example, have enacted regulations and statutes that require any entity that holds, transmits or collects certain personal information about their residents to adopt a written data security plan meeting the requirements set forth in the statute. In California, the CCPA, as amended by CPRA, provides California residents with a number of privacy-related rights and is more stringent in many respects than other state laws currently in effect in the United States. Further, there currently are also a number of proposals related to data privacy or security pending before federal and state legislative and regulatory bodies, including in a number of states considering consumer protection laws similar to those in California, Colorado and Virginia. These laws are contributing to increased enforcement activity and may also be subject to interpretation by various courts and other governmental authorities.

In addition, we are subject to certain state licensure and/or certification laws and other state and federal laws and regulations governing our operations and our products. Among other examples, contracts governing our relationships with healthcare providers may be subject to the federal Anti-Kickback Statute, federal False Claims Act and comparable state laws, as well as state laws prohibiting fee-splitting and the corporate practice of medicine and state and federal laws regarding transparency. The federal False Claims Act, for example, prohibits knowingly submitting or causing to be submitted false claims or statements to the federal government, including to the Medicare and Medicaid programs. The law contains whistleblower provisions, which allow private individuals to sue on behalf of the federal government, alleging that the defendant has defrauded the federal government. The government has used the FCA to prosecute Medicare and other government healthcare program fraud such as billing for services not provided, coding errors, and providing care that is not medically necessary or that is substandard in quality. In addition, the government may assert that a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the False Claims Act. States have similar false claims act laws. Failure to comply with such laws can result in civil or criminal liability such as penalties, fines, and/or exclusion from federal healthcare programs. Furthermore, we may be subject to some state laws regulating the ability of PPOs to allow broad access to their provider networks. We may directly or indirectly be subject to state and federal regulation regarding the payment of out-of-network claims, including regulations regarding the determination of payment amounts and what data and other factors are permitted to be used by commercial health payors and other payors in making such determinations, as well as regulations targeting surprise billing and requiring transparency.

For example, effective January 1, 2022, the NSA prohibits certain out-of-network providers from charging patients an amount beyond the in-network cost sharing amount for services rendered, subject to limited exceptions. For services for which balance billing is prohibited, the NSA establishes an independent dispute resolution ("IDR") process for providers and payors to handle payment disputes that cannot be resolved through direct negotiation. The law is being implemented through IFRs issued on July 13, 2021 and October 7, 2021 by the U.S. Department of Health and Human Services and other governmental entities. The IFRs provide that, when making a payment determination, the IDR entity must begin with the presumption that the QPA is the appropriate out-of-network rate for the service at issue. The IDR entity must select the offer closest to the QPA unless the provider or payor submits credible evidence that clearly demonstrates the QPA is materially different from the appropriate out-of-network rate. The additional factors that may be considered by the IDR entity are secondary to the QPA. The IFRs are currently subject to several legal challenges, and it is difficult to predict the outcome of efforts to challenge or modify the IFRs or how such challenges may affect our enhancements or offerings within our Analytics-Based Services category.

We may directly or indirectly be subject to regulation in some states governing the submission of true and accurate claims, or regarding the application of payment integrity edits to claims, including regulations impacting what data and other factors are

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permitted to be used by commercial health payors and other payors in making such determinations. Our services may directly or indirectly be subject to state regulations specifically covering certain categories of clients, such as workers compensation insurers and auto medical insurers. We regularly monitor legislative and regulatory activity in all states and at the federal level that could impact any of the products we offer in all relevant market segments. In addition, we are committed to supporting our clients in meeting their regulatory obligations, so we work cooperatively with them in establishing processes and procedures that comply with applicable requirements.

While we believe that we are in compliance with such laws and regulations and we will undertake efforts to comply with new laws and regulations, once effective, a failure to comply with these laws and regulations could adversely affect our contractual relationships and possibly expose us to civil or criminal sanctions by federal or state authorities. Please see the section entitled "*Risk Factors — Risks Related to our Business and Operations*."

Human Capital

Our employees are our most critical assets. Our ability to achieve our strategic objectives, deliver high quality customer service, drive operational excellence and deliver strong financial performance is only achievable through the talent, expertise, and dedication of our team. The long-term success and continued growth of our business depends in large part on our ability to attract, reward, retain, and develop diverse, talented, and high-performing employees at all levels of our organization.

We employed approximately 2,400 people as of December 31, 2021, substantially all of whom are full time employees and none of whom are covered by unions. We believe that we have a good relationship with our employees.

The following are some of the significant investments we make in our employees and their development:

Compensation and Benefits. We offer competitive pay, and a robust benefits package, including healthcare benefits, flexible spending accounts, life insurance, short-term and long-term disability plans, a generous Paid Time Off (PTO) policy, and a 401(k) Plan with employer match. We also offer voluntary wellness programs which can result in reduced benefit premiums, employee assistance programs, tuition assistance programs, voluntary benefits programs (including home & auto insurance, pet insurance, legal services, etc.), summer hours and employee referral programs.

In addition, children of eligible full-time employees may qualify for the MultiPlan scholarship program.

Through our MultiPlan Helping Hands program (formerly named MultiPlan ACTS), we are able to provide financial assistance for employees experiencing hardship; the program is funded 100% from employee donations and is administered by the Helping Hands Committee, comprised of MultiPlan employees.

In response to the COVID-19 pandemic, MultiPlan established the One MultiPlan Fund. Established by MultiPlan and funded in part by employee donations, the One MultiPlan Fund provides direct assistance to colleagues facing financial hardship due to the COVID-19 pandemic.

MultiPlan also continues the PTO Donation Program that enables employees to donate their accrued paid time off to a general pool to be used by fellow colleagues who are experiencing a financial hardship due to a medical emergency or due to a major disaster (as declared by the President of the United States), and who have exhausted all paid leave available to them.

Health and Safety. The physical and mental health of our employees is vital to our success. We sponsor a wellness program designed to enhance physical and mental well-being for all of our employees. Throughout the year, we encourage healthy behaviors through regular communications, educational sessions, voluntary progress tracking, wellness challenges, and other incentives.

As the COVID-19 pandemic unfolded, we responded quickly by enabling our teams to work remotely to ensure the health and safety of our employees, while continuing to provide uninterrupted service to our customers. We implemented a COVID-19 global task force to prioritize our pandemic response, and, in 2021, we began a phased re-opening plan, implementing a number of safety and social distancing measures in our sites to protect the health and safety of our employees who chose to return during the initial phases. With the identification of the Delta and Omnicron variants, our re-opening plans slowed and we generally remain in a voluntary return to work posture. As the pandemic continues, we remain committed to our plan for staged office reentry when safe to do so. Additionally, we are focused on supporting access to COVID-19 vaccines for our employees, including by providing additional paid time off to facilitate employees' ability to receive their vaccinations. We continue to provide communications and information to our employees through an internal Coronavirus Information Center, all with the goal of keeping our employees and communities healthy, safe and informed.

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Diversity Inclusion and Belonging. We strive to create a workplace that fosters mutual respect and collaboration, where talented individuals from all backgrounds, perspectives and abilities can participate and perform their best work. In 2020, we formed a Diversity, Inclusion and Belonging ("DIB") Governance Committee to establish, oversee and advance MultiPlan's DIB program. The committee seeks to champion and foster organizational changes with a dedicated focus on DIB priorities, to facilitate the integration of the DIB program with our corporate objectives and values, to create accountability for program results and to engage and communicate with the MultiPlan community on all DIB efforts.

In 2021, employees completed a survey providing insight on individual perceptions of our commitment and performance on DIB, with the results shared with all employees. As part of the annual training initiatives, employees are asked to complete five hours of DIB training, including a course provided by the Company plus additional hours selected from other DIB educational resources provided by us or other outside opportunities chosen by the employee. In addition, employees were invited to take a pledge to support our efforts to positively impact its employees and local communities, and to foster a culture of mutual respect for individuals from all backgrounds, perspectives, and abilities.

MultiPlan partners with America's Job Exchange, in the recruiting process, to ensure job postings are distributed to diversity websites to expand visibility to individuals seeking employment opportunities from a wide variety of backgrounds. We also partner with local CareerOneStop services for outreach.

Learning and Development. We believe that education is essential to MultiPlan employees' professional growth and our organization's success. To support this belief, our Corporate Education Department offers many learning opportunities beginning with our new employee orientation and continuing with our ongoing operational, compliance and DIB training plus a variety of optional courses to help employees further their career development on topics such as: business management, personal productivity and working with teams.

Talent Management. We also believe that it is important to foster employee feedback and recognition. We utilize our MultiSTAR: MultiPlan Service Talent Achievement & Reward program to allow colleagues an opportunity to acknowledge co-workers for their great work and to recognize their professional accomplishments.

Community Giving. Each MultiPlan office has a Charitable Giving Committee that holds charitable activities throughout the year, and we maintain a MultiPlan Matching Gifts Program. We have continued to focus on our giving efforts even while working remotely during the ongoing COVID-19 pandemic.

Corporate History and Background

Our predecessor was founded in 1980 as a New York-based hospital network, but we are by no means just a network company. We evolved both organically and through acquisitions from that regional network to a leading independent national PPO player, and then to a data- and technology-driven provider of cost management, payment and revenue integrity services company. Other notable acquisitions, in addition to the recent acquisitions of HST and Discovery Health Partners, were BCE Emergis Corporation, in 2004, which extended network access nationally and added a negotiation services platform; Private Healthcare Systems, Inc., in 2006, which added a National Committee for Quality Assurance (NCQA)-accredited, national primary PPO network; Viant, in 2010, which added analytics-based services and additional network access including for Medicare Advantage and Medicaid plans; NCN, in 2011, which added the Data iSight pricing service; and Medical Audit and Review Solutions, in 2014, which added pre-payment integrity services.

Churchill Capital Corp III (formerly known as Butler Acquisition Corp), was incorporated in Delaware on October 30, 2019 for the purpose of effecting a merger, capital stock exchange, asset acquisition, stock purchase, reorganization or similar business combination with one or more businesses.

On July 12, 2020, Churchill entered into the Merger Agreement by and among First Merger Sub, Second Merger Sub, Holdings, and MultiPlan Parent. On October 8, 2020, the Merger was consummated and the Transactions were completed. In connection with the Transactions, Churchill changed its name to MultiPlan Corporation and The New York Stock Exchange ticker symbols for its Class A common stock and warrants to "MPLN" and "MPLN.WS", respectively.

The Transactions were accounted for as a reverse recapitalization, with no goodwill or other intangible assets recorded, in accordance with GAAP. Under this method of accounting, Churchill was treated as the "acquired" company for financial reporting purposes with MultiPlan Parent determined to be the accounting acquirer. This determination was primarily based on the existing MultiPlan Parent stockholders being the majority stockholders and holding majority voting power in the combined company, MultiPlan Parent's senior management comprising the majority of the senior management of the combined company, and the ongoing operations of MultiPlan Parent comprising the ongoing operations of the combined company. Accordingly, for accounting purposes, the Transactions were treated as the equivalent of MultiPlan Parent issuing shares for the net assets of

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Churchill, accompanied by a recapitalization. The net assets of Churchill were recognized at fair value (which were consistent with carrying value), with no goodwill or other intangibles recorded. See Note 4, The Transactions of the Notes to the Consolidated Financial Statements included in this Annual Report on Form 10-K, for further information on the Transactions.

Available Information

Our principal executive offices are located at 115 Fifth Avenue, New York, New York 10003 and our telephone number at that address is (212) 780-2000.

Our website is located at www.multiplan.us, and our investor relations website is located at www.investors.multiplan.us. No information contained on these websites is intended to be included as part of, or incorporated by reference into, this Annual Report on Form 10-K. Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and our Proxy Statements, and any amendments to these reports, are available through our investor relations website, free of charge, after we file them with the SEC. We also provide a link to the section of the SEC's website at www.sec.gov that has all of the reports that we file or furnish with the SEC. Investors and others should note that we routinely announce financial and other material information using our investor relations website, SEC filings, press releases, public conference calls and webcasts. We use these channels of distribution to communicate with our investors and members of the public about our company, our services and other items of interest.

Item 1A. Risk Factors

RISK FACTORS

Our operations and financial results are subject to various risks and uncertainties that could adversely affect our business. You should consider carefully the risks and uncertainties described below, in addition to other information contained in this Annual Report on Form 10-K, including our consolidated financial statements and related notes.

The following risks and uncertainties are not the only ones we face. Additional risks and uncertainties that we are unaware of, or that we currently believe are not material, may also become important factors that adversely affect our business. If any of the following risks or others not specified below materialize, our business, financial condition and results of operations could be materially and adversely affected. In that case, the trading price of our common stock could decline.

Summary of Key Risks

The following summary highlights certain of the principal risks and uncertainties included in the discussion of risk factors below. This is not a complete list of the risks set out in this section and readers are encouraged to review this section in its entirety for a more fulsome understanding of the risks and uncertainties that may impact the Company.

- Business and Operations Risks
  - The impact of the ongoing COVID-19 pandemic and related risks could materially affect our results of operations, financial position and/or liquidity.
  - Our success is dependent on retaining, and the success of, our customers as we depend on a core group of customers for a significant portion of our revenues.
  - If we are unable to preserve or increase our market share or maintain our PPO networks, our results may be adversely affected.
  - The market for our services is fragmented and competitive and we may not be able to maintain our competitive position in the market.
  - If competition or pricing pressures increase, our growth and profits may decline.
  - The inability of our customers to pay for our services could decrease our revenue.
  - Our PPO networks may experience decreases in discounts from providers, thereby adversely affecting our competitive position and revenue.
  - We depend on our providers to maintain the profitability of our business and expand our operations.

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- If we do not continue to attract, motivate and retain members of our senior management team and qualified employees, or if we are unable to maintain sufficient qualified personnel, we may not be able to support our operations.
- Pressure from healthcare providers, and/or changes in state laws, regarding access to preferred provider networks may adversely affect our profitability and ability to expand our operations.
- We may be unable to achieve some or all of the operational, growth and other benefits that we expect to realize through our strategic plans.
- We may not successfully enter new lines of business and broaden the scope of our services.
- If we are unable to identify, complete and successfully integrate acquisitions, our ability to grow our business may be limited and our business, financial position and results of operations may be adversely impacted.
- We may be unable to obtain additional financing to fund our operations or growth.
- Changes in the healthcare industry could adversely affect us.

- Risks Related to Information Technology Systems
  - We depend on uninterrupted computer access for our customers and the reliable operation of our information technology systems; any prolonged delays due to data interruptions or revocation of our software licenses could adversely affect our ability to operate our business and cause our customers to seek alternative service providers.
  - Computer systems like ours could suffer security and privacy breaches or incidents that could negatively impact our business and reputation, harm both us and our customers and create liability.
  - Failure to adequately protect the confidentiality of our trade secrets, know-how, proprietary applications, business processes and other proprietary information could adversely affect the value of our technology and products.
- Other Business and Operations Risks
  - Changes in accounting principles may negatively affect our results of operations.
  - If we fail to maintain an effective system of disclosure controls and internal control over financial reporting, our ability to produce timely and accurate financial statements or comply with applicable regulations could be impaired.
- Risks Related to the Healthcare Industry and other Legal Regulations
  - We operate in an industry that is subject to extensive federal, state and local regulation. Changes in existing health care laws and regulatory interpretations on a state or federal level may adversely affect us.
  - New federal and state laws and regulations could force us to change the conduct of our business or operations or affect our ability to expand our operations into other states or increase costs or delay or prevent the introduction of new or enhanced solutions or impair the function or value of our existing solutions, which could have a material adverse effect on our business, financial condition and results of operations.
  - Our use and disclosure of individually identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or adequately secure the information we hold could result in significant liability or reputational harm.
  - Heightened enforcement activity by federal and state agencies may increase our potential exposure to damaging lawsuits, investigations and other enforcement actions.
- Risks Related to Indebtedness
  - Our level of indebtedness and current leverage may materially adversely affect our ability to raise additional capital to fund our operations and limit our ability to react to changes in the economy or our industry.

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- Despite our current leverage, we and our subsidiaries may still be able to incur substantially more indebtedness, including secured indebtedness.
- Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.
- Our debt agreements contain restrictions that limit our flexibility in operating our business.

- Risks Related to Our Common Stock
  - H&F and the Sponsor beneficially own a significant equity interest in us and their interests may conflict with our or other shareholders' interests.
  - We are currently, and may in the future be, subject to securities or other stockholder litigation, which is expensive and could divert management attention.
  - Our charter designates a state court within the State of Delaware as the sole and exclusive forum for certain types of actions and proceedings that may be initiated by our stockholders, which could limit the ability of our stockholders to obtain a favorable judicial forum for disputes with us and may discourage such claims.

For a more complete discussion of the material risks facing our business, see below.

Business and Operations Risks

The impact of the ongoing COVID-19 pandemic and related risks could materially affect our results of operations, financial position and/or liquidity.

The COVID-19 pandemic has evolved from its emergence in December 2019 and so has its global impact. The global outbreak of COVID-19, including the continued identification of new mutations, has created significant volatility, uncertainty and economic disruption. The extent to which the COVID-19 pandemic impacts our business will depend on future developments, which are highly uncertain and cannot be predicted with confidence, including emergence of mutations of SARS-CoV-2, the virus that causes COVID-19, and new variants of SARS-CoV-2, including any variants of the virus for which currently available vaccines, treatments, and tests may not be effective or authorized; the continued geographic spread and severity of the COVID-19 pandemic; the duration of the pandemic; business closures, travel restrictions, social distancing and other actions taken to contain and treat COVID-19; the effectiveness of actions taken to contain and treat SARS-CoV-2 and mutations thereof; the availability, acceptance and effectiveness of vaccines for COVID-19, other effective treatments for COVID-19, and tests for COVID-19; the impact of the pandemic on economic activity; the extent and duration of the effect on healthcare demand and treatment patterns; the impact of government action on the healthcare industry and the broader economy, including through any future stimulus efforts or vaccine mandates; and any impairment in value of our tangible or intangible assets which could be recorded as a result of weaker economic conditions. For example in the first half of 2020, there was a decrease in patient visits to hospitals and providers due to risk and fear of exposure to COVID-19, as well as decreases in, or temporary moratoriums on, elective procedures, which have been reimposed in some jurisdictions and may be reimposed in the future in other jurisdictions. In addition, if the pandemic continues to create disruptions or turmoil in the credit or financial markets, or impacts our credit ratings, it could adversely affect our ability to access capital on favorable terms and continue to meet our liquidity and any acquisition financing needs, all of which are highly uncertain and cannot be predicted.

As the COVID-19 pandemic and any associated protective or preventative measures continue to spread in the United States and around the world, we may experience disruptions to our business. Risks and uncertainties presented or exacerbated by the ongoing effects of the COVID-19 pandemic, or any future pandemics, include the following:

- impact of the pandemic on our results and financial position due to the significant uncertainty in relation to the duration and challenges that the ongoing pandemic may have on the healthcare industry and us at this time, including increases in unemployment and reductions in participants covered by our customers' plans and related services;
- effects of new laws, including vaccine-or-testing mandates, and pandemic relief and economic stimulus measures on our and our customers' business;
- effects of pricing pressure and/or decreases in discounts from providers on COVID-19 related treatments;
- the inability of our customers to pay for our services;

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- the loss of key members of our management team;
- changes in our regulatory environment, including healthcare law and regulations;
- the ability to implement or expand information systems or network infrastructure, or expand our workforce, while shelter-in-place and other pandemic related restrictions are in effect;
- changes in our industry;
- heightened enforcement activity by government agencies, in particular with respect to government subsidized or funded COVID-19 treatments;
- interruptions or security breaches of our information technology systems, in particular while our and our customers' workforce are working remotely;
- the expansion of privacy and security laws;
- our ability to identify, complete and successfully integrate recent and future acquisitions;
- our ability to pay interest and principal on our notes and other indebtedness;
- our ability to safely and successfully re-open our offices; and
- long-term effects on the nature of the office environment and remote working, which may present new operational challenges.

These risks and uncertainties and other disruptions related to the COVID-19 pandemic could materially and adversely affect our business, financial condition and results of operations.

Our success is dependent on retaining, and the success of, our customers as we depend on a core group of customers for a significant portion of our revenues.

If significant customers terminate or do not renew or extend their contracts with us, our business, financial condition and results of operations could be adversely affected. Our customer contracts generally permit our customers to terminate with relatively short notice, including without cause. Our three largest customers accounted for approximately 34%, 19% and 10%, respectively, of our revenues for the year ended December 31, 2021. While we believe our customer relationships are strong, if we lose any one of our largest customers, one of our largest customers reduces its use of our services, or if any one of our largest customers negotiates less favorable terms with us, then we will lose revenue. Revenue from customers that have accounted for significant revenue in past periods, individually or as a group, may not continue, or if continued, may not reach or exceed historical levels in any period.

Many organizations in the insurance industry are consolidating, which could also result in the loss of one or more of our significant customers. To the extent that these consolidation trends do not cause the loss of customers, we could nevertheless encounter greater customer concentration as our customers become parts of larger organizations. In addition, we could lose significant customers due to competitive pricing pressures or other reasons. Any of the foregoing factors could also result in us receiving a lower ranking in our customer's claims matching process, which would reduce the number of claims we match and as a result would reduce our revenues. Due to the substantial fixed costs in our business, the loss of a significant customer or receiving a lower ranking in our customers' claims matching process could cause a material decline in our profitability and operating performance.

Our success is also dependent on our customers' ability to attract individuals to join their health plans. Many individuals receive their coverage through their employer, and thus employers play a large role in selecting which health plan their employees use. Our customers may also lose members due to competition or if businesses reduce headcount and thus the number of employees who receive health insurance. In addition, our customers may reduce the scope of the health coverage they provide, which may then result in us matching fewer claims. If our customers suffer a decline in the number of members of their health plans or reduce the scope of the insurance coverage they provide, fees from the number of claims we match and the amount of PEPM fees we receive may decrease, which may have a material adverse effect on our business, financial condition and results of operations.

In addition, the majority of our contracts contain payment terms that are based on a percentage of savings to the customer or on the number of covered employees and most contain no minimum requirements for the amount of claims that the customer

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must process through us. As a result, the termination of customer contracts, the material reduction by our customers of claims processed through us or our inability to generate significant savings with respect to customer claims would adversely affect our business, financial condition and results of operations.

If we are unable to preserve or increase our market share or maintain our PPO networks, our results may be adversely affected.

Our business strategy and future success in marketing our services depends in large part on our ability to capture market share as national and regional insurance carriers and large, self-funded employers look for ways to achieve cost savings. We cannot assure you that we will successfully market our services to these insurance carriers and employers or that they will not resort to other means to achieve cost savings, including by in-sourcing or expanding their in-sourcing of such services. Our customers may further disaggregate the services we provide for them generally or in certain geographical areas, such as individual states, and in doing so may create more competitive pricing conditions for such services. Moreover, some of our customers have acquired or may acquire our competitors. If the demand for our services declines or does not increase, our business may be materially and adversely affected.

The market for our services is fragmented and competitive and we may not be able to maintain our competitive position in the market.

We face competition from HMOs, other independent PPOs, insurance companies and other managed healthcare companies and providers of non-network repricing services such as fee negotiation. In addition, some of our competitors have introduced enhanced PPO network products that increase the proportion of contracted in-network provider utilization as compared to out-of-network utilization. These products compromise the market position of our traditional out-of-network lines of business by reducing out-of-network utilization.

Our customers often select PPO providers by specific geography based upon the magnitude of the discount provided or the breadth of the network. Although we are one of the largest independent PPO network providers, regional and local PPO network providers may have deeper discounts or broader networks within their particular region. Our customers may select regional competitors in specific geographies based upon potential deeper discounts and broader networks. Accordingly, we cannot assure you that we will continue to maintain our existing customers or our ranking in their claims matching process. We also cannot assure you that we will be successful in any new markets that we may enter.

Our failure to do any of the foregoing may have a material adverse effect on our business, financial condition and results of operations.

If competition or pricing pressures increase, our growth and profits may decline.

Consolidation among our customers may lead to increased pricing pressures. Pricing is highly competitive across all of our lines of service. PPOs compete on the basis of many factors, including the quality of healthcare services, the breadth of provider networks, the discounts afforded by the provider contracts and the efficiency of the administration of claims. However, we expect that price will continue to be a significant competitive factor. Our customer contracts are subject to negotiation and renegotiation as customers seek to contain their costs, and they may elect to reduce benefits in order to constrain cost increases. Alternatively, customers may purchase different types of products that are less profitable to us or move to competitors to obtain more favorable pricing. Industry consolidation may make it more difficult for us to attract and retain customers and healthcare providers on advantageous terms. In addition, many of our current and potential competitors have greater financial and marketing resources than us and continued consolidation in the industry will likely increase the number of competitors that have greater resources than us. If we do not compete effectively in our markets, our business, financial condition and results of operations may be materially and adversely affected.

The inability of our customers to pay for our services could decrease our revenue.

Our health insurance payor customers may be required to maintain restricted cash reserves and satisfy strict balance sheet ratios promulgated by state regulatory agencies. In addition, the financial stability of our payor customers may be adversely affected by physician groups or associations within their organizations that become subject to costly litigation or become insolvent. Our ability to collect fees for our services may become impaired if our payor customers are unable to pay for our services because they need to maintain cash reserves, if they fail to maintain required balance sheet ratios or if they become insolvent. The potential financial instability of our customers in the future could adversely affect our revenues and cash flows.

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Our PPO networks may experience decreases in discounts from providers, thereby adversely affecting our competitive position and revenue.

Our PPO networks receive discounts from healthcare providers (such as acute care hospitals, practitioners and ancillary facilities) who participate in such networks. These discounts could be reduced by the healthcare providers' desire to increase their net level of reimbursement or to offset reductions, or lack of adequate increases, in reimbursement from payors or from our PPO competitors, any of whom may have greater market penetration and/or the ability to direct more patients to such providers. Any such reductions may reduce our revenues and make our network less attractive to our customers.

We depend on our providers to maintain the profitability of our business and expand our operations.

The healthcare providers that constitute our network are integral to our operations. Our growth depends on our ability to retain our existing providers and to attract additional providers to our network. Typical contracts with our providers have a one-year term, renewable automatically for successive one-year terms (although most such contracts permit early termination without penalty and with short notice periods). These contracts are also subject to negotiation and revisions with respect to the level and amount of price concessions for medical services. Our revenues are based on a percentage of the price concessions from these providers that apply to claims of our payor customers. In addition, our ability to contract at competitive rates with our PPO providers will affect the attractiveness and profitability of our products. Increasing consolidation in the provider sector also may make it more difficult for us to contract at competitive rates and could affect the profitability of our products.

The termination of a significant number of contracts with our high volume providers, the inability to replace such contracts, or the negotiation of contracts with lower discounts resulting in reduced price concessions would reduce the number and value of claims we are able to match and the attractiveness of our network to our customers, each of which could have a material adverse effect on our business, financial condition and results of operations.

If we do not continue to attract, motivate and retain members of our senior management team and qualified employees, or if we are unable to maintain sufficient qualified personnel, we may not be able to support our operations.

The completion and execution of our strategies depend on the continued service and performance of our senior management team. If succession planning is not effectively executed or if we lose key members of our senior management team, our ability to effectively manage our current and future operations may be disrupted and our ability to attract and retain other key executives could be adversely affected.

In addition, our business depends on our ability to continue to attract, motivate and retain a large number of skilled employees across all of our product lines. There is a limited pool of employees who have the requisite skills, training and education. We compete with many businesses and organizations that are seeking skilled individuals, particularly those with experience in healthcare and insurance industries. Attracting and retaining highly skilled employees will be costly as we offer competitive compensation packages to prospective and current employees. If we are unable to maintain sufficient qualified personnel due to employee illness, quarantine, willingness to return to work, vaccine and/or testing mandates, face-covering and other safety requirements, general scarcity of employees, or travel and other restrictions, our ability to support our operations may be adversely affected.

Competition for professionals across our business can be intense, as other companies seek to enhance their positions in the markets we serve. In addition, competition for experienced talent in our faster growing geographic areas, such as Illinois, and Texas, continues to intensify, requiring us to increase our focus on attracting and developing highly skilled employees in these strategically important locations.

Future organizational changes, including the implementation of our cost savings initiatives, could also cause our employee attrition rate to increase. If we are unable to continue to identify or be successful in attracting, motivating and retaining appropriately qualified personnel in sufficient numbers, our business, financial condition and results of operations would be adversely affected.

Pressure from healthcare providers, and/or changes in state laws, regarding access to preferred provider networks may adversely affect our profitability and ability to expand our operations.

A number of healthcare providers have historically sought and in the future may seek to limit access to their contractually negotiated network discounts by, for example, limiting either the type of payor or the type of benefit plan that may access a contractual network discount. In addition, some states have proposed legislation designed to regulate the secondary PPO market by limiting the ability of preferred provider networks to offer broad access to discounted rates negotiated with contracted providers. For example, certain states have proposed or implemented laws limiting access to provider networks by requiring

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that the applicable network be identified on a member's identification card in order for the network discount to apply. Although many of our network offerings are branded, such that members carry identification cards branded with our network logo, we also operate a non-logo business. Where enacted, such laws may adversely affect our non-logo business by limiting our ability to continue this business in existing markets or to expand it into new markets.

We may be unable to achieve some or all of the operational, growth and other benefits that we expect to realize through our strategic plans.

In support of our growth strategy, we have developed, and will continue to develop, new or additional strategic plans which include initiatives across sales and marketing, product development and mergers and acquisitions, and efficiency measures to help self-fund some of the necessary investments to support these initiatives.

We cannot assure you that we will be able to successfully execute our strategic plans in the short term, or at all, or realize the expected benefits of such plans. A variety of risks could cause us not to execute such plans or realize some or all of the expected benefits therefrom. These risks include, among others: higher than expected implementation expenses; delays in the anticipated timing of activities related to such initiatives, in particular with respect to the development and deployment of additional sales and marketing professionals and achievement of certain technology-related product development goals, which will require significant external resources; failure to realize estimated savings from our efficiency measures or, if realized, an inability to sustain such cost savings over time; subsequent regulatory requirements or rulemaking; and the risks and uncertainties inherent in pursuing acquisitions as a portion of our growth strategy in light of our limited acquisition and integration experience. Our ability to successfully manage the organizational changes that may be necessary to implement our strategic plans is important for our future business success. In particular, our reputation and results of operations could be harmed if employee morale, engagement or productivity decline as a result of organizational or other changes we effect as part of our implementation efforts.

Moreover, our implementation of these initiatives may disrupt our operations and performance, and distract management from day-to-day operations and other on-going initiatives, including continuing initiatives relating to becoming a public company, and challenges, such as those presented by the ongoing COVID-19 pandemic. Additional costs associated with executing on our strategic plans, or the failure to achieve the estimated cost savings from efficiency initiatives may adversely impact our results of operations. Some of these expenses, such as the implementation of certain technology-related initiatives, may increase our fixed overhead costs for the foreseeable future and we may be unable to reduce these costs if such initiatives do not progress according to plan.

If, for any reason, the benefits we realize are less than our estimates, or our improvement initiatives adversely affect our operations or cost more or take longer to implement than we project, or if our assumptions prove inaccurate, our results of operations may be materially adversely affected.

We may not successfully enter new lines of business and broaden the scope of our services.

We have entered into new lines of business that are adjacent to our existing lines of business and have broadened the scope of our services, such as the expansion of our Payment and Revenue Integrity Solutions Services and introduction of our Reference-Based Pricing and Value-Driven Health Plan Services Solutions and end-to-end Surprise Billing Services, and may in the future enter into non-adjacent lines of business. We may not achieve our expected growth if we do not successfully enter these new lines of business and continue to broaden the scope of our services. Entering new lines of business and broadening the scope of our services may require significant upfront and ongoing expenditures that we may not be able to recoup in the future. To accommodate our past and anticipated future growth and to compete effectively, we will need to continue to integrate our financial information systems and expand, train, manage and motivate our workforce. Furthermore, focusing our financial resources on the expansion of our operations may negatively impact our financial results. Any failure to implement our operational and financial information systems, or to expand, train, manage or motivate our workforce, may adversely affect our business. These efforts may also divert management's attention and expose us to new risks and regulations. As a result, entering new lines of business and broadening the scope of our services may have material adverse effects on our business, financial condition and results of operations.

If we are unable to identify, complete and successfully integrate acquisitions, our ability to grow our business may be limited and our business, financial position and results of operations may be adversely impacted.

We may not be able to identify, complete and successfully integrate acquisitions in the future and any failure to do so may limit our ability to grow our business. Our acquisition strategy involves a number of risks, including:

- our ability to find suitable businesses to acquire at affordable valuations or on other acceptable terms;

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- competition for acquisition targets may lead to substantial increases in purchase prices or one of our competitors acquiring one of our acquisition targets;
- our continued dependence on access to the credit and capital markets to fund acquisitions;
- prohibition of any of our proposed acquisitions under United States or foreign antitrust laws;
- the diversion of management's attention from existing operations to the integration of acquired companies;
- our inability to realize expected cost savings and synergies;
- expenses, delays and difficulties of integrating acquired businesses into our existing business structure, which risks are heightened for large-scale acquisitions; and
- difficulty in retaining key customers and management personnel.

Our ability to realize the benefits we anticipate from recent and future acquisitions, including anticipated cost savings and additional sales opportunities, will depend in large part upon whether we are able to integrate such businesses efficiently and effectively. Integration is an ongoing process and we may not be able to fully integrate such businesses smoothly or successfully and the process may take longer than expected. Further, the integration of certain operations and the differences in operational culture may require the dedication of significant management resources, which may distract management's attention from day-to-day business operations and from the evaluation of future acquisition targets.

If we are unable to continue to acquire and efficiently integrate suitable acquisition candidates, our ability to increase revenues and fully implement our business strategy may be adversely impacted, which could adversely affect our business, financial position and results of operations. If we are unable to continue to acquire and efficiently integrate suitable acquisition candidates, our ability to increase revenues and fully implement our business strategy may be adversely impacted, which could adversely affect our business, financial position and results of operations.

We may be unable to obtain additional financing to fund our operations or growth.

We may require additional financing to fund our operations or growth. The failure to secure additional financing on acceptable terms and conditions or at all could have a material adverse effect on our continued development or growth. Our access to, and the availability of, financing will be impacted by many factors, including, but not limited to, our financial performance, our credit ratings, our then current level of indebtedness, the liquidity of the overall capital markets and the state of the U.S. and global economy. None of our officers, directors or stockholders will be obligated to provide any financing to us.

Changes in the healthcare industry could adversely affect us.

Our business is dependent on a variety of factors, including our ability to enter into contracts with payors and providers on terms attractive to all parties and the absence of substantial changes in the healthcare industry that would diminish the need for the services we offer. Our ability to continue conducting business in the current manner could be jeopardized if, among other things, a significant number of payors were to seek price concessions directly from providers. In addition, substantial changes in the health-care industry, such as the enactment of laws and the adoption of regulations unfavorable to us or our relationships with payors and providers, including the No Surprises Act and its implementing regulations, as well as other state laws and regulations aimed at addressing "surprise" billing (medical bills that arise when an insured patient receives care from an out-of-network provider, resulting in costs that were not expected by the patient), a substantial trend towards HMOs from PPOs, the adoption of a single payor healthcare system in the United States or changes caused by, or that result from, the ongoing COVID-19 pandemic could have a material adverse effect on our business, financial condition and results of operations and could cause us to substantially alter our business strategy and methods of operation. Furthermore, we may not become aware in a timely manner of changes in regulatory requirements affecting our business, which could result in our taking, or failing to take, actions, resulting in noncompliance with state or federal regulations.

We operate in a litigious environment which may adversely affect our financial results.

We may become involved in legal actions and claims arising in the ordinary course of business, including litigation regarding employment matters, breach of contract, violations of laws and regulations, and other commercial matters. Due to the inherent uncertainty in the litigation process, the resolution of any particular legal proceeding could result in changes to our products and business practices and could have a material adverse effect on our financial position and results of operations.

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Healthcare providers have become more resistant to the use of cost management techniques and are engaging in litigation to avoid application of cost management practices. Litigation brought by healthcare providers has challenged insurers' claims adjudication and reimbursement decisions, and healthcare cost management providers are sometimes made party to such suits or involved in related litigation. We and our subsidiaries have and may, in the future, become involved in such litigation.

New federal and state laws and regulations or other changes that adversely impact healthcare providers or insurers could lead to increased litigation risk to us and other cost management providers and insurers. In addition, many healthcare providers and insurers have greater financial resources than us and other healthcare cost management providers have and may be more willing to engage in, and devote resources to, litigation as a result. In addition, certain of the agreements we enter into include indemnification provisions which may subject us to costs and damages in the event of a claim against an indemnified third party. We maintain insurance coverage for certain types of claims; however, such insurance coverage may be insufficient to cover all losses or all types of claims that may arise.

If lawsuits of this type proliferate, they could materially adversely affect our results. In addition, lawsuits of this type may affect insurers' use of our cost management services.

Evolving industry standards and rapid technological changes could result in reduced demand for our services.

Rapidly changing technology, evolving industry standards and the frequent introduction of new and enhanced services characterize the market for our services. Our success will depend upon our ability to enhance our existing services, introduce new services on a timely and cost-effective basis to meet evolving customer requirements, achieve market acceptance for new services and respond to emerging industry standards and other technological changes. We may not be able to respond effectively to technological changes, new industry standards, or updated regulatory requirements. Moreover, other companies may develop competitive services, or our customers may develop internal solutions, that may result in reduced demand for our services.

Climate change and increased focus on sustainability issues, including those related to climate change, may adversely affect our business and financial results and damage our reputation.

We face risks related to severe natural events which have the potential to disrupt our operations and may increase as a result of climate change. Natural disasters, adverse weather conditions, pandemics, and other business disruptions could seriously harm our revenue and financial condition and increase our costs and expenses by disrupting our operations, or those of our customers or vendors, as a result of potential office closures or damage from severe weather. Any prolonged disruption in the operations of our facilities, whether due to technical difficulties, power failures, break-ins, destruction or damage to the facilities as a result of a natural disaster, fire, or any other reason, could cause service interruptions or reduce the quality level of services that we provide and harm our operating results. Our disaster recovery plan and business interruption insurance may not be sufficient to compensate for losses that may occur. If weather patterns become more volatile as a result of the potential effects of climate change, severe weather events may become more frequent or more widespread. An increase in frequency or severity of natural events may result in greater disruption to our operations and increased cost for, or lack of availability of, property and liability insurance for our offices located in areas subject to such severe weather events.

Risks Related to Information Technology Systems

We depend on uninterrupted computer access for our customers and the reliable operation of our information technology systems; any prolonged delays due to data interruptions or revocation of our software licenses could adversely affect our ability to operate our business and cause our customers to seek alternative service providers.

Many aspects of our business are dependent upon our ability to store, retrieve, process and manage data and to maintain and upgrade our data processing capabilities. Our success is dependent on our ability to deliver high-quality and uninterrupted access for our customers to our computer system, requiring us to protect our computer equipment, software and the information stored in servers against damage by fire, natural disaster, power loss, telecommunications failures, unauthorized intrusion and other catastrophic events. Interruption of data processing capabilities for any extended length of time, loss of stored data, programming errors or other technological problems could impair our ability to provide certain services. A system failure, if prolonged, could result in reduced revenues, loss of customers and damage to our reputation, any of which could cause our business to materially suffer. In addition, due to the highly automated environment in which we operate our computer systems, any undetected error in the operation of our business processes or computer software may cause us to lose revenues or subject us to liabilities for third party claims. While we carry property and business interruption insurance to cover operations, the coverage may not be adequate to compensate us for losses that may occur.

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Computer systems like ours could suffer security and privacy breaches that could negatively impact our business and reputation, harm both us and our customers and create liability.

We currently operate servers and maintain connectivity from multiple facilities, including access by our distributed workforce due to continuing remote working conditions as a result of the ongoing COVID-19 pandemic. Despite our implementation of standard network security measures, our infrastructure may be vulnerable to computer viruses, physical break-ins, attacks by hackers and similar disruptive problems caused by customers or other users. Computer viruses, ransomware and other cyber-attacks, break-ins or other security problems could lead to interruption, delays or cessation in service to our customers. In addition, our safeguards may not prevent incidents of inappropriate and/or unauthorized access to or acquisition of PHI or other personally identifiable information by our employees, contractors, and/or unauthorized actors. Such incidents may result, and on limited occasions in the past have resulted, in unauthorized use, disclosure, modification or deletion of PHI or other personally identifiable information that is transmitted or stored over our networks.

A security or privacy breach may:

- expose us to liability under federal and state laws related to the privacy and security of PHI and other personally identifiable information, including liability to the individuals who are the subject of the information and/or the parties to whom we are contractually obligated, and subject us to fines or penalties;
- increase operating expenses as necessary to investigate security breaches and notify affected individuals, remediate and/or enhance security controls, comply with federal and state regulations, defend against and resolve actual and potential claims, implement and maintain any additional requirements imposed or adopted by reason of such claims or by government action, and take action to manage public relations issues and preserve our reputation; and
- harm our reputation and deter or prevent customers from using our products and services, and/or cause customers to find other means to achieve cost savings, including by switching to a competitor or by in-sourcing such services.

These problems could also potentially jeopardize the security of confidential information stored in the computer systems of our customers, which may deter potential customers from doing business with us and give rise to possible liability to such customers and/or individual users whose security or privacy has been infringed. The security and privacy concerns of existing and potential customers may inhibit the growth of the healthcare information services industry in general, and our customer base and business in particular. A significant customer security breach or incident of this sort could result in loss of customers, loss of revenues, damage to our reputation, direct damages, costs of repair and detection and other unplanned expenses.

While we carry network-security and privacy insurance to cover events of the sort described above, the coverage may not be adequate to compensate us for losses that may occur by reason of such events.

Failure to adequately protect the confidentiality of our trade secrets, know-how, proprietary applications, business processes and other proprietary information could adversely affect the value of our technology and products.

We largely rely on our own security systems and confidentiality procedures, including employee nondisclosure agreements for certain employees, to maintain the confidentiality and security of our trade secrets, know-how, internally developed computer applications, business processes and other proprietary information. If third parties gain unauthorized access to our information systems or if our proprietary information is misappropriated, it may have a material adverse effect on our business, financial condition and results of operations. Trade secrets laws offer limited protection against third party development of competitive products or services. Because we lack the protection of registered copyrights for our internally developed software applications, we may be vulnerable to misappropriation of our proprietary applications by third parties or competitors. Enforcing a claim that a third party illegally obtained and is using any of our proprietary information or technology is expensive and time consuming, and the outcome is unpredictable. The failure to adequately protect our proprietary information could have a material adverse effect on our business, financial condition and results of operations.

We may be sued by third parties for alleged infringement of their proprietary rights.

Our success depends also in part on us not infringing the intellectual property rights of others. Our competitors, as well as a number of other entities and individuals, may own or claim to own intellectual property relating to our industry. In the future, such third parties may claim that we are infringing their intellectual property rights, and we may be found to be infringing such rights. Any claims or litigation could cause us to incur significant expenses and, if successfully asserted against us, could require that we pay substantial damages or ongoing royalty payments, prevent us from offering our services, or require that we comply with other unfavorable terms. Even if we were to prevail in such a dispute, any litigation could be costly and time-consuming and divert the attention of our management and key personnel from our business operations.

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We employ third-party and open source licensed software for use in our business, and the inability to maintain these licenses, errors in the software we license or the terms of open source licenses could result in increased costs, or reduced service levels, which would adversely affect our business.

Our business relies on certain third-party software obtained under licenses from other companies. We anticipate that we will continue to rely on such third-party software in the future. Commercially reasonable alternatives to the third-party software we currently license may not always be available and such alternatives may be difficult or costly to implement. In addition, integration of new third-party software may require significant work and require substantial investment of our time and resources. Our use of additional or alternative third-party software would require us to enter into license agreements with third parties, which may not be available on commercially reasonable terms or at all. Many of the risks associated with the use of third-party software cannot be eliminated, and these risks could negatively affect our business.

Additionally, the software powering our technology systems incorporates software covered by open source licenses. The terms of many open source licenses have not been interpreted by U.S. courts and there is a risk that the licenses could be construed in a manner that imposes unanticipated conditions or restrictions on our ability to operate our systems. In the event that portions of our proprietary software are determined to be subject to an open source license, we could be required to publicly release the affected portions of our source code or re-engineer all or a portion of our technology systems, each of which could reduce or eliminate the value of our technology system. Such risks could be difficult or impossible to eliminate and could adversely affect our business, financial condition and results of operations.

If our ability to expand our network and technology infrastructure is constrained, we could lose customers and that loss could adversely affect our operating results.

The success of our business strategy depends in part on our ability to expand our operations in the future. Our growth has placed, and will continue to place, increased demands on our network and technology infrastructure and other resources and further expansion of our operations will require substantial financial resources. Our growth strategies include the evaluation of opportunities in new geographic markets as well as in adjacent and new market verticals. Any expansions into such markets could significantly increase the demands placed on our network and technology infrastructure. To accommodate such growth, we must continue to expand and adapt our network and technology infrastructure to accommodate additional users, increased transaction volumes, changing customer requirements and current and future growth initiatives. We may not be able to accurately project the rate or timing of increases, if any, in the volume of transactions we process, reprice or otherwise service or be able to expand and upgrade our systems and infrastructure to accommodate such increases. Projecting such needs may be particularly difficult for new solutions and services or for the expansion of existing solutions and services into international or other markets in which we have limited or no prior experience. We may be unable to expand or adapt our network infrastructure to meet additional demand or our customers' changing needs on a timely basis, at a commercially reasonable cost or at all. Our current information technology systems, procedures and controls may not continue to support our operations while maintaining acceptable overall performance and may hinder our ability to exploit the market for healthcare applications and services. Service lapses could cause our users to switch to the services of our competitors or in-source such services.

Other Business and Operational Risks

Changes in accounting principles may negatively affect our results of operations.

We prepare our consolidated financial statements in accordance with U.S. GAAP. These principles are subject to interpretation by the SEC and other organizations that develop and interpret accounting principles. New accounting principles arise regularly, implementation of which can have a significant effect on and may increase the volatility of our reported operating results and may even retroactively affect previously reported operating results. In addition, the implementation of new accounting principles may require changes to our customer and vendor contracts, business processes, accounting systems, and internal controls over financial reporting. The costs and effects of these changes could adversely impact our operating results, and difficulties in implementing new accounting principles could cause us to fail to timely meet our financial reporting obligations.

We may need to recognize impairment charges related to goodwill, identified intangible assets and fixed assets.

We have substantial balances of goodwill and identified intangible assets. We are required to test goodwill and any other intangible assets with an indefinite life for possible impairment on an annual basis, or more frequently when circumstances indicate that impairment may have occurred. We are also required to evaluate amortizable intangible assets and fixed assets for impairment if there are indicators of a possible impairment.

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Based on the results of the annual impairment test as of November 1, 2021, the fair values of our assets exceeded the carrying value, and goodwill was not impaired. The current goodwill impairment analysis incorporates our expectations for moderate sales growth and the overall outlook was consistent with our long-term projections.

There is significant judgment required in the analysis of a potential impairment of goodwill, identified intangible assets and fixed assets. If, as a result of a general economic slowdown, deterioration in one or more of the markets in which we operate or impairment in our financial performance and/or future outlook, the estimated fair value of our long-lived assets decreases, we may determine that one or more of our long-lived assets is impaired. An impairment charge would be recorded if the estimated fair value of the assets is lower than the carrying value and any such impairment charge could have a material adverse effect on our results of operations and financial position.

If we fail to maintain an effective system of disclosure controls and internal control over financial reporting, our ability to produce timely and accurate financial statements or comply with applicable regulations could be impaired.

As a public company, we are subject to the reporting requirements of the Exchange Act, the Sarbanes-Oxley Act, and the rules and regulations of the applicable listing standards of the NYSE. We expect that the requirements of these rules and regulations will continue to increase our legal, accounting and financial compliance costs, make some activities more difficult, time-consuming and costly and place significant strain on our personnel, systems and resources.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective disclosure controls and procedures and internal control over financial reporting. In particular, Section 404 requires us to perform system and process evaluation and testing of our internal control over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, the effectiveness of our internal control over financial reporting. Any failure to maintain effective disclosure controls and internal control over financial reporting could have a material and adverse effect on our business, results of operations and financial condition and could cause a decline in the trading price of our Class A common stock. We are required to be in compliance with the provisions of the Sarbanes-Oxley Act.

We are continuing to refine our disclosure controls and other procedures that are designed to ensure that information required to be disclosed by us in the reports that we will file with the SEC is recorded, processed, summarized and reported within the time periods specified in SEC rules and forms and that information required to be disclosed in reports under the Exchange Act is accumulated and communicated to our principal executive and financial officers. We are also continuing to improve our internal control over financial reporting. In order to develop, maintain and improve the effectiveness of our disclosure controls and procedures and internal control over financial reporting, we have expended, and anticipate that we will continue to expend, significant resources, including accounting-related and audit-related costs and significant management oversight.

During the year, we completed the remediation of two material weaknesses in internal control over financial reporting. These and other controls, including any new controls that we develop, may become inadequate because of changes in conditions in our business. Further, weaknesses in our disclosure controls and internal control over financial reporting may be discovered in the future. Any failure to develop or maintain effective controls or any difficulties encountered in their implementation or improvement could harm our results of operations or cause us to fail to meet our reporting obligations and may result in a restatement of our consolidated financial statements for prior periods. Any failure to implement and maintain effective internal control over financial reporting could also adversely affect the results of periodic management evaluations and annual independent registered public accounting firm attestation reports regarding the effectiveness of our internal control over financial reporting that we will be required to include in our periodic reports that will be filed with the SEC. Ineffective disclosure controls and procedures and internal control over financial reporting could also cause investors to lose confidence in our reported financial and other information, which would likely have a negative effect on the trading price of our Class A common stock. In addition, if we are unable to continue to meet these requirements, we may not be able to remain listed on the NYSE.

Changes in laws, regulations or rules, or a failure to comply with any laws, regulations or rules, may adversely affect our business, investments and results of operations.

We are subject to laws, regulations and rules enacted by national, regional and local governments and the NYSE. In particular, we are required to comply with certain SEC, NYSE and other legal or regulatory requirements. Compliance with, and monitoring of, applicable laws, regulations and rules may be difficult, time consuming and costly. Those laws, regulations or rules and their interpretation and application may also change from time to time and those changes could have a material adverse effect on our business, investments and results of operations. In addition, a failure to comply with applicable laws, regulations or rules, as interpreted and applied, could have a material adverse effect on our business and results of operations.

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Risks Related to the Healthcare Industry and other Legal Regulations

We operate in an industry that is subject to extensive federal, state and local regulation. Changes in existing healthcare laws and regulatory interpretations on a state or federal level may adversely affect us.

The healthcare industry is subject to extensive and evolving federal, state and local regulations, including among other things, laws and regulations relating to:

- health benefit plans subject to ERISA;
- privacy and security of patient information, including HIPAA;
- the conduct of operations, including fraud and abuse, anti-kickback, patient inducement and false claims prohibitions;
- the operation of provider networks, including transparency, access, licensing, certification and credentialing requirements;
- the methods of payment of out-of-network claims, including "surprise" billing subject to the requirements of the No Surprises Act and its implementing regulations, or applicable state law;
- payors subject to the requirements of the Transparency in Coverage Rule;
- health information technology;
- breach of duty, the corporate practice of medicine and fee-splitting prohibitions;
- laws and regulations relating to business corporations in general;
- additional restrictions relating to our ability to utilize the claims data we collect from providers; and
- payors subject to the requirements for health reform under Affordable Care Act.

As a provider of network management services to our customers and as a contractor and/or subcontractor with federal and state governments, we are subject to extensive and increasing regulation by a number of governmental entities at the federal, state and local levels with respect to the above laws. Because of the breadth of these laws and the narrowness of available statutory and regulatory exceptions, it is possible that some of our business activities could be subject to challenge under one or more of such laws from time to time, including in private litigation. Statutory changes to, or changes in the interpretation or enforcement of, the laws and regulations described above may significantly impact or restrict our ability to carry on our business as currently conducted and may have a material adverse impact on our business, financial condition and results of operations. These risks may be exacerbated by our expansion into new geographic markets and, in particular, by any expansion into international markets. The expansion of our operations into new products and services may expose us to additional requirements and potential liabilities under additional statutes and legislative schemes that previously have not been relevant to our business, that may increase demands on our resources for compliance activities, and that may subject us to potential penalties for noncompliance with statutory and regulatory standards. Under our contracts we are also subject to audits by our customers, and are regularly required to attest as to our compliance with our contracts and applicable laws and regulations. We and our healthcare customers may also be subject to investigations and proceedings that seek recovery under laws such as federal and state false claims acts, civil monetary penalties laws, and anti-kickback laws applicable to the business of our customers. Since the services we provide are not reimbursed by government healthcare programs, such fraud and abuse laws generally do not apply to our business, however, some laws may be applicable to us. The laws, regulations, and other requirements in this area are broad and complex and judicial and regulatory interpretations can be inconsistent. We are unable to predict how these laws, regulations or other requirements will be interpreted or the full extent of their application, particularly to services that are not directly reimbursed by government healthcare programs. In addition, private citizens, acting as whistleblowers, can sue on behalf of the government under the qui tam provisions of the federal False Claims Act and similar statutory provisions in many states. Investigations or proceedings could subject us or our customers to various civil and criminal penalties and administrative sanctions, which could include terminations of contracts, fines, and suspension and debarment from doing business with the government. If we are found to be in violation of any applicable law or regulation or are subject to an audit, investigation or proceeding, any resulting negative publicity, penalties or sanctions could have an adverse effect on our reputation in the industry, impair our ability to compete for new contracts and could have a material adverse effect on our business, financial condition and results of operations.

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New federal and state laws and regulations could force us to change the conduct of our business or operations or affect our ability to expand our operations into other states.

Federal Legislation

In recent years, Congress has introduced and, in some cases, passed a number of legislative proposals governing various aspects of the healthcare industry, including initiatives to provide greater government control of health care spending, to broaden access to healthcare services, to prohibit, restrict or address "surprise" billing by out-of-network providers and to change the operating environment for health care providers and payors. In addition, federal and state legislatures periodically have considered programs to reform or amend the U.S. healthcare system at both the federal and state level, such as measures that would modify the Affordable Care Act or expand the role of government-sponsored coverage, including nationalization of the healthcare system and "Medicare for All" proposals, which could have far-reaching implications for the healthcare industry if enacted. Federal and state efforts to reduce healthcare spending may materially adversely affect our business, financial condition, and results of operations. Our failure to anticipate accurately the application of such proposals or future laws and regulations, our failure to adapt our solutions to them or our failure to comply with them may create liability for us, result in adverse publicity, reduce our market share, and may have a material adverse effect on our business, financial condition and results of operations. We are unable to predict the success of such initiatives, but, if passed, these and other efforts may adversely affect our business or operations, may create unexpected liabilities for us, may cause us or our customers to incur additional costs, and may restrict our operations or the operations of our customers.

Healthcare reform laws such as the Affordable Care Act have had a significant impact on the health care industry, including changing the manner in which providers and payors contract for services. In addition, under the Affordable Care Act payors are required to meet certain financial criteria. While these obligations directly affect many of our customers, the obligations may also affect the contract terms and relationships between us and those customers. In addition, the Consolidated Appropriations Act, 2021, included the No Surprises Act, which provides new protections for patients from "surprise" bills, creates new processes for payments to non-participating providers and facilities, and necessitates new compliance efforts by group health plans and health insurance issuers offering group or health insurance coverage, as well as non-participating providers and facilities. While we currently service payor customers that are already subject to certain state-level "surprise" billing laws, we cannot assure you that the No Surprises Act and its implementing interim final rules (IFRs) or any other initiatives aimed at addressing "surprise" billing, if implemented, would not adversely impact our ability to continue certain lines of business in existing markets or expand such business into new markets or adversely affect the contractual terms and relationships between us and our customers or result in additional compliance costs. Current judicial challenges to certain aspects of the No Surprises Act's implementing IFRs could inject further uncertainty or require additional or revised compliance efforts by our customers.

It is uncertain the extent to which any such judicial, legislative, regulatory or administrative changes, if made, may impact our business or financial condition. Although laws such as the Affordable Care Act and the No Surprises Act have not caused us to significantly change our customer contracts or other aspects of our business, it is difficult to quantify the financial impact of such laws and there can be no assurances that we will not be adversely impacted in the future by any amendments to these or other healthcare laws or regulations. Many healthcare laws are complex, subject to frequent change and dependent on interpretation and enforcement decisions from government agencies with broad discretion. The application of these laws to us or our customers or the specific services we deliver and the relationships we have with our customers is not always clear.

Other legislative or regulatory changes that could significantly harm us include, but are not limited to, changes that:

- increase the number of individuals covered by government entitlement programs such as Medicare and Medicaid as opposed to private health insurance plans;
- impact the operation of provider networks, including changes relating to transparency, access, licensing, certification and credentialing;
- limit contractual terms with providers, including audit, payment and termination provisions; and
- impose additional health care information privacy or security requirements.

Renewed calls for health insurance reform could cause significant uncertainty in the U.S. healthcare market, could increase our costs, decrease our revenues or inhibit our business or operations. We cannot predict what impact, if any, U.S. federal and state health reforms or other government proposals and activities, which include efforts to change or reform the administration or interpretation of government health care programs, laws, regulations or policies, might have on us, but such changes could impose new and more stringent regulatory requirements on our activities, which could adversely affect our business, results of

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operations and financial condition. Accordingly, there can be no assurance that such activities will not limit the expansion of our business, impose new compliance requirements on us or have a material adverse effect on our business, financial condition and results of operation. The passage and implementation of new federal laws or regulations that govern the conduct of our business could significantly impact or restrict our ability to carry on our business as currently conducted and could have a material adverse impact on our business, financial condition and results of operations.

State Legislation

State laws and regulations governing our business vary widely among the states in which we operate, and include laws requiring credentialing of all network providers and "any willing provider" laws requiring networks to accept as participating providers any qualified professional who is willing to meet the terms and conditions of the network. There is little regulatory or judicial guidance with respect to the application of such laws and in some cases they may increase the costs of operations in such states. Should a state in which we operate determine that our network does not meet state requirements, we may be subject to administrative penalties or other administrative actions or private litigation.

Several states have implemented legislation mandating certain contract terms in provider contracts for group health plans, preferred provider organizations, HMOs and other third-party payors. Depending on the state, these mandatory contract terms may relate to prompt payment, payment amounts and payment methods. As a result of such legislation and similar future legislative initiatives, we may be required to amend some of our provider contracts and comply with legislative mandates related to payment. Violations of prompt payment laws, which regulate the amount of time that may elapse from when a payor receives a claim for services rendered to when those services are paid, may result in requirements to pay interest in addition to any amounts owed to providers, and may lead to reputational harm or result in a breach of our contractual obligations to certain customers.

Some states have also considered legislation designed to regulate the PPO market by limiting the ability of preferred provider networks to offer broad access to discounted rates negotiated with contracted providers. State laws limiting access to provider networks may affect our ability to continue certain lines of business in existing markets or expand such business into new markets. Some states have considered or enacted legislation designed to regulate the manner in which certain insurers should pay for certain categories of out-of-network claims or aimed at addressing "surprise" billing by out-of-network providers, and it is uncertain how states may react to the recently enacted No Surprises Act. State laws regulating the basis of payment that are not preempted by the No Surprises Act may affect our ability to continue certain lines of business in existing markets or expand such business into new markets and the contractual terms and relationships between us and our customers.

Changes to state laws and regulations or the interpretation and enforcement of such state laws and regulations may adversely impact our existing business in certain states, or restrict our ability to expand our operations in other states, in each case potentially adversely impacting our business, financial condition and results of operations.

Our use and disclosure of individually identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations, including HIPAA, govern the collection, dissemination, use, disclosure, creation, receipt, maintenance, transmission, privacy, confidentiality, security, availability and integrity of individually identifiable information, including PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities such as our clients, and the business associates with whom such entities contract for services, including us. As a business associate, we are also directly liable for compliance with HIPAA. In addition to HIPAA, we must adhere to state patient confidentiality and other laws that are not preempted by HIPAA, including those that are more stringent than HIPAA.

In the event of a breach of our obligations under HIPAA or other state laws, we could be subject to enforcement actions by the U.S. Department for Health and Human Services Office for Civil Rights and state regulators and lawsuits, including class action lawsuits, by private plaintiffs. Mandatory penalties for HIPAA violations can be significant and OCR and state regulators may require businesses to enter into settlement or resolution agreements and corrective action plans that impose ongoing compliance requirements. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. In addition, state Attorneys General are authorized to bring civil actions under HIPAA or relevant state laws. Courts can award damages, costs and attorneys' fees related to violations of HIPAA or state laws in such cases. While we maintain safeguards that we believe are reasonable and appropriate to protect the privacy and security of PHI and other personally identifiable information consistent with applicable law and our contractual obligations, we cannot provide assurance regarding how these laws, regulations, and contracts will be interpreted, enforced or applied to our operations; our systems may be vulnerable to physical break-ins, viruses, hackers, and other potential sources of security breaches or incidents. In addition, we may not be able to prevent incidents of inappropriate use or disclosure or unauthorized access to or acquisition

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of PHI by our employees or contractors. Any such breaches or incidents could result in exposure to liability under federal and state laws and/or under our contractual arrangements and could adversely impact our business.

Numerous other state, federal and foreign laws govern the collection, dissemination, use, disclosure, access to, confidentiality and security of health information and personal data, breaches of such information, and actions that a business must take if it experiences a data breach, such as prompt disclosure to affected customers or individuals. In addition, Congress and some states are considering new laws and regulations that further protect the privacy and security of medical information and personal data and that address data breaches. The Federal Trade Commission, or FTC, and states' Attorneys General have also brought enforcement actions and prosecuted some data breach cases as unfair and/or deceptive acts or practices under the FTC Act. In addition to data breach notification laws, some states have enacted statutes and rules requiring businesses to reasonably protect certain types of personal information they hold or to otherwise comply with certain specified data security requirements for personal information, such as, the California Consumer Privacy Act and the California Privacy Rights Act. As with HIPAA, these laws may apply directly to our business or indirectly by contract when we provide services to other companies. We are currently evaluating potential growth opportunities, including opportunities that involve the processing and analysis of third-party data which may include PHI or other protected personal information, which could increase our compliance obligations and may subject us to state, foreign, federal or other laws that we are not currently subject. In the event that we are found out of compliance with applicable state, federal and foreign laws and regulations, we could potentially be subject to civil or criminal sanctions, which could have a material adverse effect on our business, financial condition and results of operations.

Heightened enforcement activity by federal and state agencies may increase our potential exposure to damaging lawsuits, investigations and other enforcement actions.

In recent years, both federal and state government agencies have increased civil and criminal enforcement efforts relating to the healthcare industry. This heightened enforcement activity increases our potential exposure to damaging lawsuits, investigations and other enforcement actions. Any such investigation or action could force us to expend considerable resources to respond to or defend against such investigation or action and could adversely affect our reputation or profitability and could be disruptive to normal business operations. Moreover, the results of complex legal proceedings and governmental inquiries are difficult to predict. Unfavorable outcomes from these claims, lawsuits and governmental inquiries could adversely affect our business, financial condition and results of operations and we could incur substantial monetary liability and/or be required to change our business practices. Any claims made against us, regardless of their merit or eventual outcome, could damage our reputation and business and our ability to attract and retain customers and employees.

By way of example, the Affordable Care Act increased the penalties applied under the Federal Sentencing Guidelines for federal health care offenses that affect a governmental program. The fraud enforcement would apply to us to the extent we are deemed a government contractor for a federal health care program.

A number of laws bear on our relationships with physicians. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. Judicial and regulatory interpretation or other guidance regarding the application of these types of laws to businesses such as ours is limited. These laws regarding fee-splitting and the corporate practice of medicine could also be invoked by litigants in a breach of contract dispute against us or in an action to find our contracts to be legally invalid or unenforceable. In addition, patients may seek to hold us responsible for third parties' recommendations regarding the appropriateness of providers' medical treatment plans for patients. We could be subject to claims or investigations under certain state laws were such laws interpreted to apply to our provision of such recommendations.

A number of laws could impact our out-of-network products. Federal and state regulators may investigate us or our clients with respect to the payment of out-of-network claims, including the determination of payment amounts and what data and other factors are permitted to be used by commercial health payors and other payors in making such determinations, or the calculation of required amounts under the No Surprises Act, as well as investigations related to regulations requiring transparency.

We can provide no assurance that state or federal regulators will not take the position that our current and planned activities and the conduct of our business constitute illegal fee-splitting, the unlawful practice of medicine or a breach of any legal duty, or do not comply with laws and regulations relating to determination of payment amounts, surprise billing or transparency. Moreover, we can provide no assurance that future interpretations or applications of these laws will not require us to make material changes to our operations or business, including with respect to our existing contractual arrangements with providers and payors. If regulatory authorities assert or determine that we have violated any of these laws, we could be subject to

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significant penalties and/or restructuring requirements that could have a material adverse impact on our business, financial condition and results of operations.

Risks Related to Indebtedness

Our level of indebtedness and current leverage may materially adversely affect our ability to raise additional capital to fund our operations and limit our ability to react to changes in the economy or our industry.

As of December 31, 2021, we had total indebtedness (excluding an aggregate of $1.8 million of letters of credit) of $4,971.8 million, which is comprised of $1,300.0 million in aggregate principal amount of Senior Convertible PIK Notes, $1,321.7 million in outstanding term loans under the term loan facility, $1,300.0 million in aggregate principal amount of 5.750% Notes, $1,050.0 million in aggregate principal amount of 5.50% Senior Secured Notes and $0.1 million in non-current finance lease obligations. In addition, we would have had an additional $450.0 million available for borrowing under the revolving credit facility (without giving effect to the $1.8 million of outstanding letters of credit referred to above). Our substantial level of indebtedness increases the possibility that we may be unable to generate cash sufficient to pay, when due, the principal of, interest on or other amounts due in respect of our indebtedness. Our substantial indebtedness, combined with our other financial obligations and contractual commitments, may have a material adverse impact on us and our business. For example, it could:

- make it more difficult for us to satisfy obligations with respect our indebtedness and any repurchase obligations that may arise thereunder;
- require us to dedicate a substantial portion of cash flow from operations to payments on our indebtedness, thereby reducing funds available for working capital, capital expenditures, acquisitions, research and development and other purposes;
- increase our vulnerability to adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- expose us to the risk of increased interest rates as certain of our borrowings are at variable rates of interest;
- limit our flexibility to adjust to changing market conditions and our ability to withstand competitive pressures, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy;
- limit our ability to borrow additional funds or to dispose of assets to raise funds, if needed, for working capital, capital expenditures, acquisitions, research and development and other corporate purposes; and
- limit our ability to compete with others who are not as highly-leveraged.

Despite our current leverage, we and our subsidiaries may still be able to incur substantially more indebtedness, including secured indebtedness. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur significant additional indebtedness in the future. Although certain of our subsidiaries are subject to restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us or such subsidiaries from incurring obligations that do not constitute indebtedness. We may also seek to increase the borrowing availability under the senior secured credit facilities through incremental term loans or an increase to the revolving credit facility commitments under the senior secured credit facilities under certain circumstances.

Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

All of the borrowings under the senior secured credit facilities bear interest at variable rates. As a result, an increase in interest rates, whether due to an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt even though the amount borrowed remained the same, and our net income and cash flows, including cash available for servicing our indebtedness, will correspondingly decrease. A 0.25% increase in interest rates under the senior secured credit facilities (assuming the revolving credit facility was fully drawn) would increase our annual interest expense by approximately $4.4 million. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt. In the future, we may enter into interest rate swaps that involve the exchange

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of floating for fixed rate interest payments in order to reduce interest rate volatility. However, we may not maintain interest rate swaps with respect to all of our variable rate indebtedness, and any swaps we enter into may not fully mitigate our interest rate risk.

In addition, interest on our Term Loan B and Revolver B is calculated in reference to LIBOR, the publication of which is expected to be discontinued in mid-2023. We are currently assessing the impact that the discontinuation of LIBOR may have on us. It is possible that the transition from LIBOR will result in interest rates and/or payments that result in higher borrowing costs over time than would have been our obligations if LIBOR continued to be available in its current form. See "Item 7A. Quantitative and Qualitative Disclosures About Market Risk" in this Annual Report for more information.

Our debt agreements contain restrictions that limit our flexibility in operating our business.

We are subject to certain affirmative and negative debt covenants under the debt agreements governing our indebtedness that limit our and/or certain of our subsidiaries' ability to engage in specific types of transactions. These covenants limit our and/or certain of our subsidiaries' ability to, among other things:

- incur additional indebtedness or issue disqualified or preferred stock;
- pay certain dividends or make certain distributions on capital stock or repurchase or redeem capital stock;
- make certain loans, investments or other restricted payments;
- transfer or sell certain assets;
- incur certain liens;
- place restrictions on the ability of its subsidiaries to pay dividends or make other payments to us;
- guarantee indebtedness or incur other contingent obligations;
- prepay junior debt and make certain investments;
- consummate any merger, consolidation or amalgamation, or liquidate, wind up or dissolve ourself or itself (or suffer any liquidation or dissolution), or dispose of all or substantially all of our or such subsidiary's business units, assets or other properties; and
- engage in transactions with our affiliates.

In addition, under the senior secured credit facilities, in certain circumstances, MPH is required to satisfy specified financial ratios, including a first-lien secured debt leverage ratio. MPH's ability to meet those financial ratios can be affected by events beyond our control, and MPH may not be able to meet those ratios and tests.

The restrictions and specified financial ratios could limit our ability to plan for or react to market or economic conditions or meet capital needs or otherwise restrict our activities or business plans and could adversely affect our ability to finance operations, acquisitions, investments or strategic alliances or other capital needs or to engage in other business activities that would be in our interest.

The debt agreements governing the new senior secured credit facilities, Term Loan B, the Revolver B, the 5.750% Notes and the 5.50% Senior Secured Notes contain customary events of default, subject to grace periods and exceptions, which include, among others, payment defaults, cross-defaults to certain material indebtedness, certain events of bankruptcy, material judgments, in the case of the debt agreements governing the new senior secured credit facilities and the 5.50% Senior Secured Notes, failure of a guarantee on the liens on material collateral to remain in effect, in the case of the debt agreements governing the new senior secured credit facilities, Term Loan B and Revolver B any change of control. Upon the occurrence of an event of default under such debt agreements, the lenders and holders of such debt will be permitted to accelerate the loans and terminate the commitments, as applicable, thereunder and exercise other specified remedies available to the lenders and holders thereunder. These actions by lenders could cause cross-acceleration under the indentures that govern the Senior Convertible PIK Notes and the indentures that govern the 5.750% Notes and the 5.50% Senior Secured Notes. A significant portion of our indebtedness then may become immediately due and payable. We cannot be certain whether we would have, or would be able to obtain, sufficient funds to make these accelerated payments. If any such indebtedness is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

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We may not be able to generate sufficient cash to service all of our indebtedness, and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which in turn are subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we could face substantial liquidity problems and may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which could harm our ability to incur additional indebtedness. In the absence of such cash flows and resources, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. The agreement that governs the senior secured credit facilities and the indenture that governs the 5.750% Notes restrict us, MPH and our restricted subsidiaries' ability to dispose of assets and use the proceeds from the disposition. We may not be able to consummate those dispositions or to obtain the proceeds that we could realize from them and these proceeds may not be adequate to meet any debt service obligations then due. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt instruments by rating agencies may increase our future borrowing costs and reduce our access to capital.

Any rating assigned to our debt instruments could be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes in our performance under assorted financial metrics and other measures of financial strength, our business and financial risk, our industry or other factors determined by such rating agency, so warrant. There can be no assurances that our credit ratings or outlook will not be lowered in the future in response to adverse changes in these metrics and factors caused by our operating results or by actions that we take, that reduce our profitability, or that require us to incur additional indebtedness for items such as substantial acquisitions, significant increases in costs and capital spending in security and IT systems, significant costs related to settlements of litigation or regulatory requirements, or by returning excess cash to shareholders through dividends. Consequently, real or anticipated changes in our credit rating will generally affect the market value of our indebtedness. Additionally, credit ratings may not reflect the potential effect of risks relating to the structure of our indebtedness. Any future lowering of our ratings likely would make it more difficult or more expensive for us to obtain additional debt financing and may reduce our profitability.

Risks Related to Our Common Stock

H&F and the Sponsor beneficially own a significant equity interest in us and their interests may conflict with us or other shareholders' interests.

H&F and the Sponsor collectively control approximately 42% of our voting equity. As a result, they have significant influence over our decisions to enter into any corporate transaction. In addition, H&F and the Sponsor are each in the business of making investments in companies and may acquire and hold interests in businesses that compete directly or indirectly with us. H&F and the Sponsor, and their respective affiliates, may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. Our second amended and restated certificate of incorporation provides that certain parties may engage in competitive businesses and renounces any entitlement to certain corporate opportunities offered to the private placement investors or any of their managers, officers, directors, equity holders, members, principals, affiliates and subsidiaries (other than us and our subsidiaries) that are not expressly offered to them in their capacities as our directors or officers. The second amended and restated certificate of incorporation also provides that certain parties or any of their managers, officers, directors, equity holders, members, principals, affiliates and subsidiaries (other than us and our subsidiaries) do not have any fiduciary duty to refrain from engaging directly or indirectly in the same or similar business activities or lines of business as us or any of our subsidiaries.

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We are currently and may in the future be subject to securities or other stockholder litigation, which is expensive and could divert management attention.

In the past, following periods of volatility in the overall market and the market prices of particular companies' securities, securities class action or state stockholder litigations have often been instituted against publicly traded companies. We are currently, and may in the future be, the target of this type of litigation and regulatory proceedings. For example, we were previously named as a defendant in two putative class action lawsuits relating to the Transactions that have since been consolidated under the caption In Re MultiPlan Corp. Stockholders Litigation, Consolidated C.A. No. 2021-0300-LWW (Del.Ch) ("Delaware Stockholder Litigation"). While we have been dismissed from the Delaware Stockholder Litigation, that consolidated lawsuit is proceeding against other defendants affiliated with Churchill Capital III Corp.

The existence of litigation, claims, investigations and proceedings may harm our reputation, limit our ability to conduct our business in the affected areas and adversely affect the trading prices of our stock and/or other securities. The outcome of any claims, investigations and proceedings is inherently uncertain, and in any event defending against these claims could result in substantial costs and divert our management's attention and resources from other business concerns, which could seriously harm our business. Any adverse determination in any such litigation or any amounts paid to settle any such actual or threatened litigation could require that we make significant payments incur legal and other costs, limit our ability to conduct business or require us to change the manner in which we operate.

Our board of directors will be authorized to issue and designate shares of our preferred stock in additional series without stockholder approval.

Our second amended and restated certificate of incorporation authorizes our board of directors, without the approval of our stockholders, to issue 10,000,000 shares of our preferred stock, subject to limitations prescribed by applicable law, rules and regulations and the provisions of our second amended and restated certificate of incorporation, as shares of preferred stock in series, to establish from time to time the number of shares to be included in each such series and to fix the designation, powers, preferences and rights of the shares of each such series and the qualifications, limitations or restrictions thereof. The powers, preferences and rights of these additional series of preferred stock may be senior to, or on parity with, our common stock, which may reduce its value.

Our charter designates a state court within the State of Delaware, to the fullest extent permitted by law, as the sole and exclusive forum for certain types of actions and proceedings that may be initiated by our stockholders, which could limit the ability of our stockholders to obtain a favorable judicial forum for disputes with us or with our directors, officers or employees and may discourage stockholders from bringing such claims.

Under our charter, unless we consent in writing to the selection of an alternative forum, the sole and exclusive forum will be a state court within the State of Delaware for:

- any derivative action or proceeding brought on our behalf;
- any action asserting a claim of breach of a fiduciary duty owed by, or any wrongdoing by, any director, officer or employee of ours to us or our stockholders;
- any action asserting a claim against us or any director or officer or other employee of ours arising pursuant to any provision of the DGCL or our charter or bylaws (as either may be amended, restated, modified, supplemented or waived from time to time);
- any action asserting a claim against us or any director or officer or other employee of ours governed by the internal affairs doctrine; or any action asserting an "internal corporate claim" as that term is defined in Section 115 of the DGCL, shall be a state court located within the State of Delaware (or, if no state court located within the State of Delaware has jurisdiction, the federal district court for the District of Delaware).

For the avoidance of doubt, the foregoing provisions of our charter will not apply to any action or proceeding asserting a claim under the Securities Act or the Exchange Act. These provisions of our charter could limit the ability of our stockholders to obtain a favorable judicial forum for certain disputes with us or with our directors, officers or other employees, which may discourage such lawsuits against us and our directors, officers and employees. Alternatively, if a court were to find these provisions of our charter inapplicable to, or unenforceable in respect of, one or more of the types of actions or proceedings listed above, we may incur additional costs associated with resolving such matters in other jurisdictions, which could adversely affect our business, financial condition and results of operations.

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Provisions in our organizational documents and stockholders agreement could delay or prevent a change of control.

Certain provisions of our second amended and restated certificate of incorporation, amended and restated bylaws and Investor Rights Agreement may have the effect of delaying or preventing a merger, acquisition, tender offer, takeover attempt or other change of control transaction that a stockholder might consider to be in its best interest, including attempts that might result in a premium over the market price of our common stock.

These provisions provide for, among other things:

- the division of our board of directors into three classes, as nearly equal in size as possible, with directors in each class serving three-year terms and with terms of the directors of only one class expiring in any given year;
- that directors may only be removed for cause, and only by the affirmative vote of the holders of at least two-thirds in voting power of all the then-outstanding shares of stock entitled to vote thereon, voting together as a single class;
- the ability of our board of directors to issue one or more series of preferred stock with voting or other rights or preferences that could have the effect of impeding the success of an attempt to acquire us or otherwise effect a change of control;
- advance notice for nominations of directors by stockholders and for stockholders to include matters to be considered at stockholder meetings;
- the right of H&F and Sponsor and certain of their respective affiliates to nominate a number of the members of our board of directors and the obligation of certain of our the other parties to the Investor Rights Agreement to support such nominees;
- certain limitations on convening special stockholder meetings; and
- that certain provisions of our second amended and restated certificate of incorporation and amended and restated bylaws may be amended only by the affirmative vote of the holders of at least two-thirds in voting power of all the then-outstanding shares of our stock entitled to vote thereon, voting together as a single class.

These provisions could make it more difficult for a third-party to acquire us, even if the third-party's offer may be considered beneficial by many of our stockholders. As a result, our stockholders may be limited in their ability to obtain a premium for their shares.

We currently do not intend to declare dividends on our common stock in the foreseeable future and, as a result, your only opportunity to achieve a return on your investment is if the price of our common stock appreciates.

We currently do not expect to declare any dividends on our common stock in the foreseeable future. Any determination to declare or pay dividends in the future will be at the discretion of our board of directors, subject to applicable laws and dependent upon a number of factors, including our earnings, capital requirements, debt service obligations, overall financial condition and other factors that our board of directors deems relevant. In addition, our ability to pay dividends on our common stock is currently limited by the covenants contained in the agreements governing our debt instruments, and may be further restricted by the terms of any future debt or preferred securities. We cannot guarantee that we will pay, or if commenced continue to pay, a dividend in the future. Accordingly, your only opportunity to achieve a return on your investment in our company may be if the market price of our common stock appreciates and you sell your shares at a profit. The market price for our common stock may never exceed, and may fall below, the price that you pay for such common stock.

A significant portion of our Class A common stock is restricted from immediate resale, but may be sold into the market in the future. This could cause the market price of our Class A common stock to drop significantly, even if our business is doing well.

The market price of shares of our Class A common stock could decline as a result of substantial sales of our Class A common stock, particularly by our significant stockholders, a large number of shares of our Class A common stock becoming available for sale or the perception in the market that holders of a large number of shares intend to sell their shares. Sales of a substantial number of shares of common stock in the public market could occur at any time.

In connection with the Merger Agreement, we, the Sponsor, Holdings, H&F and certain other parties thereto entered into the Investor Rights Agreement, pursuant to which such stockholders are entitled to, among other things, certain registration rights, including demand, piggy-back and shelf registration rights, subject to cut-back provisions. Certain parties to the Investor

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Rights Agreement, including H&F and the Sponsor, have agreed not to sell, transfer, pledge or otherwise dispose of shares of our Class A common stock and warrants they hold or receive for certain time periods specified therein, however, upon expiration of their respective lock-up periods, the sale of shares of our Class A common stock and warrants or the perception that such sales may occur, could cause the market price of our securities to drop significantly.

Our Private Placement Warrants and unvested founder shares are accounted for as derivative liabilities and changes in fair value for each period are reported in earnings, which may have an adverse effect on the market price of our Class A common stock.

As of December 31, 2021, we had Private Placement Warrants exercisable for an aggregate of 24,500,000 shares of our Class A common stock and unvested founder shares contingently issuable for an aggregate of 12,404,080 shares of our Class A common stock outstanding. We account for the Private Placement Warrants and unvested founder shares as liabilities. At each reporting period (i) the accounting treatment of the Private Placement Warrants and unvested founder shares will be re-evaluated for proper accounting treatment as a liability or equity and (ii) the fair value of the liability of the Private Placement Warrants and unvested founder shares will be remeasured and the change in the fair value of the liability will be recorded as Change in fair value of Private Placement Warrants and unvested founder shares in our consolidated statements of income (loss) and comprehensive income (loss). Changes in the inputs and assumptions for the valuation model we use to determine the fair value of such liability may have a material impact on the estimated fair value of the embedded derivative liability. The share price of our Class A common stock represents the primary underlying variable that impacts the value of the derivative instruments. Additional factors that impact the value of the derivative instruments include the volatility of our stock price, risk-free rate and discount for lack of marketability. As a result, our consolidated financial statements and results of operations may fluctuate quarterly, based on various factors, such as the share price of our Class A common stock, many of which are outside of our control. In addition, we may change the underlying assumptions used in our valuation model, which could result in significant fluctuations in our results of operations. If our stock price is volatile, we expect that we will recognize non-cash gains or losses on the outstanding Private Placement Warrants, unvested founder shares or any other similar derivative instruments each reporting period and that the amount of such gains or losses could be material. The impact of changes in fair value on earnings may have an adverse effect on the market price of our Class A common stock.

The price of our securities may be volatile.

The trading price of our securities may fluctuate substantially. This may be especially true for companies like ours with a small public float. The trading price of our securities will depend on many factors, including those described in this *"Risk Factors"* section, many of which are beyond our control and may not be related to our operating performance. Any of the factors listed below could have a material adverse effect on your investment in our securities. In such circumstances, the trading price of our securities may experience a decline.

The price of our securities may fluctuate due to a variety of factors, including:

- actual or anticipated fluctuations in our quarterly and annual results and those of other public companies in our industry;
- changes in the market's expectations about our operating results;
- the public's reaction to our press releases, other public announcements and filings with the SEC;
- speculation in the press or investment community;
- short seller reports and negative public commentary;
- actual or anticipated developments in our business, competitors' businesses or the competitive landscape generally;
- the operating results failing to meet the expectation of securities analysts or investors in a particular period;
- our ability to execute on our strategic plans and amount of costs we incur in connection therewith;
- changes in financial estimates and recommendations by securities analysts concerning us or the market in general;
- the failure of securities analysts to publish research about us, or shortfalls in our operating results compared to levels forecast by securities analysts;
- operating and stock price performance of other companies that investors deem comparable to ours;

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- changes in laws and regulations affecting our business;
- commencement of, or involvement in, litigation involving us;
- changes in our capital structure, such as future issuances of securities or the incurrence of additional debt;
- the volume of our Class A common stock available for public sale;
- any major change in our board of directors or management;
- sales of substantial amounts of our common stock by our directors, officers or significant stockholders or the perception that such sales could occur;
- mergers and strategic alliances in the industry in which we operate;
- market prices and conditions in the industry in which we operate;
- general economic and political conditions such as recessions, interest rates and "trade wars," inflation, pandemics (such as COVID-19), natural disasters, potential or actual military conflicts or acts of terrorism;
- the general state of the securities markets; and
- other risk factors listed under *"Risk Factors."*

Broad market and industry factors may materially harm the market price of our securities irrespective of our operating performance. The stock market in general and the NYSE have experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of the particular companies affected. The trading prices and valuations of these stocks, and of our securities, may not be predictable. A loss of investor confidence in the market for the stocks of other companies which investors perceive to be similar to us could depress our stock price regardless of our business, prospects, financial conditions or results of operations. Broad market and industry factors, including, most recently, the impact of the novel coronavirus, COVID-19, and any other global pandemics, as well as general economic, political and market conditions such as recessions or interest rate changes, may seriously affect the market price of our securities, regardless of our actual operating performance. A decline in the market price of our securities also could adversely affect our ability to issue additional securities and our ability to obtain additional financing in the future.

Item 1B. Unresolved Staff Comments

None

Item 2. Properties

We lease all of our properties, which are located in 15 states. Our corporate headquarters are located in New York, New York. Our primary data center is hosted by a leading provider of co-location hosting services in Texas. Our redundant data center is hosted by a leading provider of co-location hosting services within a facility located in Illinois.

Item 3. Legal Proceedings

We are a defendant in various lawsuits and other pending and threatened litigation and other adversarial matters which have arisen in the ordinary course of business as well as regulatory investigations, all which have arisen in the ordinary course of business. While the ultimate outcome with respect to such proceedings cannot be predicted with certainty, we believe they will not have a material adverse effect on our financial condition or results of operations.

On March 25, 2021 and April 9, 2021, we were named as a defendant in two putative class action lawsuits relating to the Transactions that have since been consolidated under the caption In Re MultiPlan Corp. Stockholders Litigation, Consolidated C.A. No. 2021-0300-LWW (Del.Ch) ("Delaware Stockholder Litigation"). The Delaware Stockholder Litigation asserts breach of fiduciary duty claims and aiding and abetting breach of fiduciary duty claims against the former directors of the Churchill board, the Sponsor, KG and M. Klein (collectively, the "Churchill Defendants") and the Company. The Delaware Stockholder Litigation complaint alleges that the Transactions were a product of an unfair process by Churchill, which was allegedly impacted by conflicts of interest, resulting in mispricing of the Transactions. The complaint seeks, among other things, damages, certain equitable relief including the reopening of redemptions, and attorneys' fees and costs. The Company and the Churchill Defendants filed motions to dismiss the complaint. On January 3, 2022, the Chancery Court issued a ruling granting

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in part the Company's motion to dismiss and denying the motion to dismiss filed by the Churchill Defendants. The Company is therefore dismissed from the Delaware Stockholder Litigation, which will proceed against the Churchill Defendants. Certain of the Churchill Defendants have contractual indemnification rights to the Company.

Item 4. Mine Safety Disclosures

N/A

Part II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Price and Ticker Symbols

Our Class A common stock and Public Warrants are currently listed on NYSE under the symbols "MPLN" and "MPLN.WS," respectively.

Holders

As of February 21, 2022, there were 88 holders of record of our Class A common stock. Such numbers do not include beneficial owners holding our securities through nominee names.

Dividend Policy

We have not paid any cash dividends on our Class A common stock to date. The payment of cash dividends in the future will be dependent upon, among other things, our revenues and earnings, capital requirements and general financial condition and the terms of any outstanding indebtedness. The payment of any cash dividends will be within the discretion of the Board at such time.

Securities Authorized for Issuance Under Equity Compensation Plans

See Item 12, Security Ownership of Certain Beneficial Owner and Management and related Stockholder Matters, for information related to securities authorized for issuance under the Company's equity compensation plans.

Recent Sales of Unregistered Securities

None.

Issuer Purchases of Equity Securities

(in thousands, except share and per share data) Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased[1]
October 1 - 31, 2021	7,143,639	$ 5.13	7,143,639	$ 152,257
November 1 - 30, 2021	510,240	4.42	510,240	150,000
December 1 - 31, 2021	—	—	—	150,000
Total	7,653,879	$ 5.09	7,653,879	$ 150,000

(1) On August 27, 2021, the Company announced a share repurchase program approved by its board of directors, authorizing, but not obligating, the repurchase of up to an aggregate amount of $250,000,000 of its Class A common stock from time to time through December 31, 2022. Repurchases under the share repurchase program may be made in amounts and at prices the Company deems appropriate and may be made pursuant to a trading plan intended to qualify under Rule 10b5-1 of the Exchange Act. Repurchases by the Company under the share repurchase program will be subject to general market and economic conditions, applicable legal requirements and other considerations, and the share repurchase program may be suspended, modified or discontinued at any time without prior notice at the Company's discretion.

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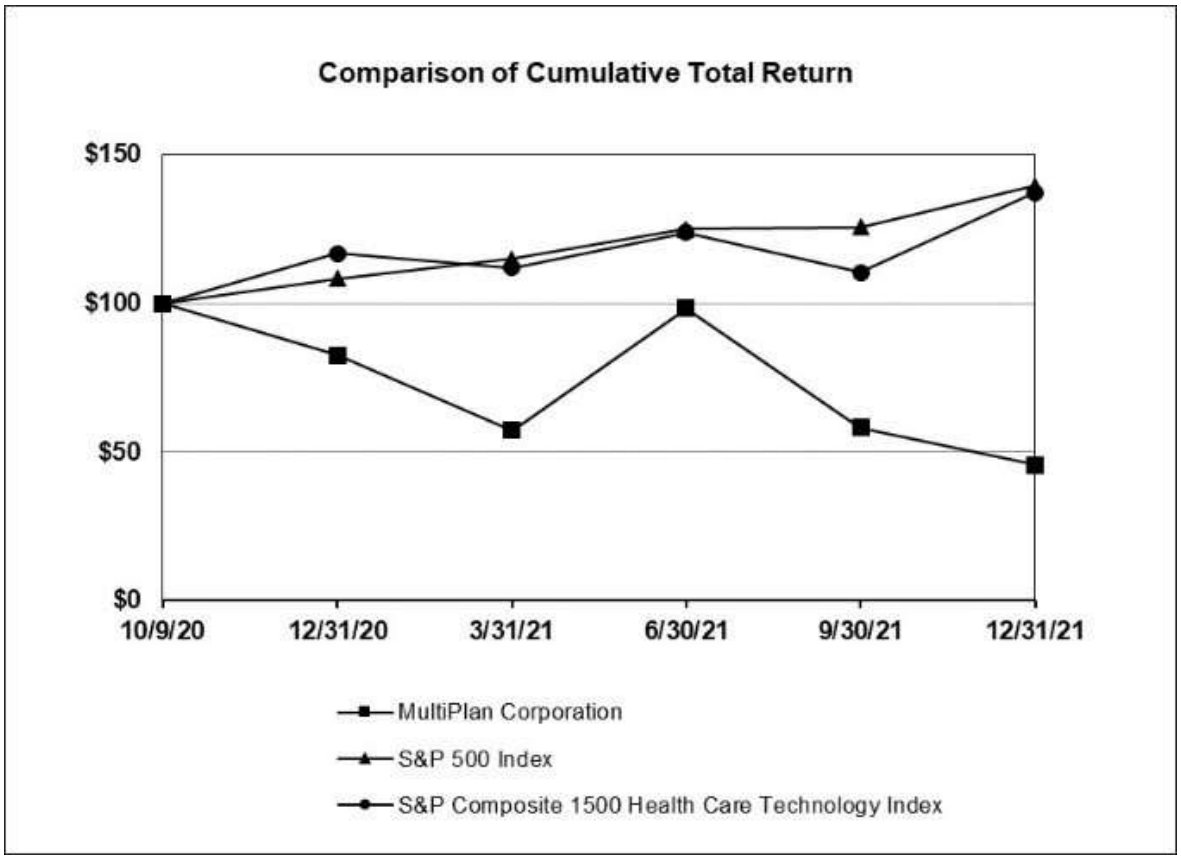
Performance Graph

The following Performance Graph and related information shall not be deemed "soliciting material" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Securities Act or the Securities Exchange Act, except to the extent that the Company specifically incorporates it by reference into such filing.

The following graph compares, as of each of the dates indicated, the percentage change in the Company's cumulative total shareholder return on its Class A common stock with the cumulative total return of the S&P 500 Index and the S&P Composite 1500 Health Care Technology Index.

The graph assumes that the value of the investment in our Class A common stock and each index was $100 at October 9, 2020, which was the first day the Class A common stock was traded on the New York Stock Exchange, and that all dividends paid by those companies included in the indices were reinvested. The graph is based on historical data and is not necessarily indicative of future performance.



	October 9, 2020 ($)	December 31, 2020 ($)	March 31, 2021 ($)	June 30, 2021 ($)	September 30, 2021 ($)	December 3 2021 ($)
MultiPlan Corporation	100.00	82.54	57.33	98.35	58.16	45.
S&P 500 Index	100.00	108.40	115.10	124.94	125.66	139.
S&P Composite 1500 Health Care Technology Index	100.00	116.75	112.04	123.84	110.48	137.

Item 6. [Reserved]

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Item 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read in conjunction with the consolidated financial statements and the notes accompanying those statements appearing elsewhere in this Annual Report on Form 10-K. The results described below are not necessarily indicative of the results to be expected in any future periods.

Company Overview

MultiPlan is a leading provider of data analytics and technology-enabled solutions designed to bring affordability, efficiency and fairness to the United States healthcare industry. We do so through services focused on reducing medical cost and improving payment accuracy for the payors of healthcare, which are health insurers, self-insured employers and other health plan sponsors (typically through their health plan administrators), and, indirectly, the plan members who are the consumers of healthcare services.

Founded initially in 1980 as a New York-based hospital network, MultiPlan has evolved both organically and through acquisition into a national organization offering three categories of services:

- Analytics-Based Services: data-driven algorithms which detect claims over-charges and either negotiate or recommend fair reimbursement using a variety of data sources and pricing algorithms;
- Network-Based Services: contracted discounts with healthcare providers to form one of the largest independent preferred provider organizations ("PPO") in the United States with over 1.2 million under contract, as well as outsourced network development and/or management services; and
- Payment and Revenue Integrity Services: data, technology, and clinical expertise deployed to identify and remove improper and unnecessary charges before or after claims are paid, or to identify and help restore and preserve underpaid premium dollars.

Although the end beneficiary of our services are employers and other plan sponsors and their health plan members, our direct customers are mostly health plan administrators ("Payors"). We offer these Payors a single electronic gateway to a comprehensive set of services in each of the above three categories, which are used in combination or individually to reduce the medical cost burden on their health plan customers and members while fostering fair and efficient payments to the providers. These comprehensive offerings have enabled us to maintain long-term relationships with a number of our customers, including relationships of over 25 years with some of the nation's largest Payors. For the year ended December 31, 2021, our services identified approximately $21.7 billion in potential medical cost savings.

We believe our solutions provide a strong value proposition to Payors, their health plan customers and healthcare consumers, as well as to providers. Overall, our service offerings aim to reduce healthcare costs in a manner that is orderly, efficient and fair to all parties. In addition, because in most instances the fee for our services is directly linked to the savings we identify, our revenue model is aligned with the interests of our customers.

The Transactions

On July 12, 2020, Churchill entered into the Merger Agreement by and among First Merger Sub, Second Merger Sub, Holdings, and MultiPlan Parent. On October 8, 2020, the Merger Agreement was consummated and the Transactions were completed.

The Transactions were accounted for as a reverse recapitalization, with no goodwill or other intangible assets recorded, in accordance with GAAP. Under this method of accounting, Churchill was treated as the "acquired" company for financial reporting purposes with MultiPlan Parent determined to be the accounting acquiror. This determination was primarily based on the existing MultiPlan Parent stockholders being the majority stockholders and holding majority voting power in the combined company, MultiPlan Parent's senior management comprising the majority of senior management of the combined company, and the ongoing operations of MultiPlan Parent comprising the ongoing operations of the combined company. Accordingly, for accounting purposes, the Transactions were treated as the equivalent of MultiPlan Parent issuing shares for the net assets of Churchill, accompanied by a recapitalization. The net assets of Churchill were recognized at fair value (which were consistent with carrying value), with no goodwill or other intangible assets recorded. See Note 4 The Transactions of the Notes to the Consolidated Financial Statements included in this Annual Report on Form 10-K for further information on the Transactions.

As a consequence of the Transactions, we became the successor to an SEC-registered and NYSE-listed company.

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HST Acquisition

On November 9, 2020, the Company acquired HST, a healthcare technology company that enables value-driven health benefit plan designs featuring reference-based pricing and tools to engage health plan members and providers in making the best use of available benefits both before and after care delivery. The Company acquired 100 percent of the voting equity interests of HST.

The results of operations and financial condition of HST have been included in the Company's consolidated results from the date of acquisition. In connection with the HST acquisition, the Company incurred transaction costs. The transaction costs have been expensed as incurred and these amounts, totaling $0.1 million and $0.9 million for the years ended December 31, 2021 and 2020, respectively, are included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

DHP Acquisition

On February 26, 2021, the Company completed the acquisition of DHP, an analytics and technology company offering healthcare payment and revenue integrity services. The Company acquired 100 percent of the voting equity interest of DHP. The acquisition strengthens MultiPlan's service offering in the payment integrity market with new and complementary services to help its payor customers manage the overall cost of care and improve their competitiveness. It also adds revenue integrity services for plans that receive premiums from the Centers for Medicare and Medicaid Services.

The results of operations and financial condition of DHP have been included in the Company's consolidated results from the date of acquisition. In connection with the DHP acquisition, the Company incurred transaction-related expenses of $4.9 million and $0.6 million for the years ended December 31, 2021 and 2020, respectively. The transaction-related expenses have been expensed as incurred and are included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

Uncertainty Relating to the Ongoing COVID-19 Pandemic

As discussed in Note 1 General Information and Basis of Accounting of the Notes to Consolidated Financial Statements included in this Annual Report, the COVID-19 pandemic has negatively impacted our business, results of operations and financial condition during the years ended December 31, 2021 and 2020.

We temporarily closed all of our offices and restricted travel due to concern for our employees' health and safety and also in compliance with state orders. Most of our approximately 2,400 employees continue to work remotely. Other than these modifications, we have not experienced any material changes to our operations including receiving and processing transactions with our customers as a result of the COVID-19 pandemic.

Effects from COVID-19 began to impact our business in first quarter 2020 with various federal, state, and local governments and private entities mandating restrictions on travel, restrictions on public gatherings, closure of non-essential commerce, and shelter in place orders. The Company experienced an approximately 4.6% decline in revenues for the year ended December 31, 2020 as compared to 2019 primarily due to reduced volume from customers as a result of restrictions on elective medical procedures and non-essential medical services. Although the revenues for the year ended December 31, 2021, exceeded revenues for the year ended December 31, 2020 and the pre-COVID revenues for the year ended December 31, 2019, the Company's revenues continue to be negatively impacted by the ongoing COVID-19 pandemic, but to a lesser extent compared to 2020 as vaccination rates have increased and restrictions on medical services have been lifted. The extent of the ultimate impact of COVID-19 will depend on the severity and duration of the pandemic. Future developments remain uncertain, including the number of confirmed cases, the emergence of highly contagious variants, and any actions taken by federal, state and local governments such as economic relief efforts, as well as U.S. and global economies, consumer behavior and healthcare utilization patterns.

In connection with the COVID-19 pandemic, the CARES Act was enacted on March 27, 2020 and included certain changes to corporate income taxes. Specifically, the CARES Act provided numerous tax provisions and other stimulus measures, including temporary changes regarding the prior and future utilization of net operating losses, temporary changes to the prior and future limitations on interest deductions, temporary suspension of certain payment requirements for the employer portion of Social Security taxes, technical corrections from prior tax legislation for tax depreciation of certain qualified improvement property, and the creation of certain payroll tax credits associated with the retention of employees. We assessed these impacts and noted the largest impact is due to the tax law change related to the interest disallowance rules retroactive to 2019. The other aspects of the CARES Act did not have a material effect on us.

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Factors Affecting Our Results of Operations

Key Technology

Our strength as a company is our ability to use data and analytics to develop new service opportunities to enhance our customer relationships and to increase revenues. We use technology, data and analytics to transform healthcare transactions into multiple opportunities for savings and recurring revenues by leveraging data and analytics to inform our transaction processing systems (i.e., our claims processing systems). The transaction processing systems generate savings for our customers, revenues for us, and each transaction adds more data to our intelligence engine and data warehouse. The intelligence engine drives our analytics and development of new saving opportunities and revenue growth through service enhancement or new product development.

Our technology also contributes to our ability to efficiently process our transactions through EDI batch files, real-time web services and online through customer and provider portals. We believe our current infrastructure can support significantly more than the current transaction volume giving us room for growth and increased volume. Our application platforms are architected and built with redundancy to eliminate downtime. All of the claims processed in our system are received via EDI or direct web service integration. As we process more claims through EDI and direct service integration, our electronic integration with customers results in substantial back office interconnectivity and considerably reduces complexity and processing failures. Because we believe our transaction processing systems are scalable, we should be able to absorb significant increases in volume at minimal marginal costs. Our integration into our customers' systems and processes is an important component of our business model.

Medical Cost Savings

Our business and revenues are driven by the ability to lower medical costs through claims savings for our customers. The medical charges of those claims can influence our ability to generate claim savings.

The following table presents the medical charges processed and the potential savings identified for the periods presented:

	Year Ended December 31,		
(in billions)	**2021**	**2020**	**2019**
Medical charges processed[1][3]	$ 120.7	$ 101.7	$ 107.1
Potential medical cost savings[2][3]	$ 21.7	$ 18.6	$ 18.1

(1) Medical charges processed represent the aggregate dollar amount of claims processed by our cost management solutions in the period presented. The dollar amount of the claim for purposes of this calculation is the dollar amount of the claim prior to any reductions that may be made as a result of the claim being processed by our cost management solutions. Medical charges processed include medical charges processed on HST acquired claims of $1.9 billion for the year ended December 31, 2021. No medical charges processed by HST were included for 2020 and 2019. Medical charges processed exclude medical charges processed by DHP in all time periods.

(2) Potential medical cost savings represent the aggregate amount of potential savings in dollars identified by our cost management solutions in the period presented. Since certain of our fees are based on the amount of savings achieved by our customers and our customers are the final adjudicator of the claims and may choose not to reduce claims or reduce claims by only a portion of the potential savings identified, potential medical cost savings may not directly correlate with the amount of fees earned in connection with the processing of such claims. Potential medical cost savings include potential medical cost savings identified on HST acquired claims of $1.5 billion for the year ended December 31, 2021. No potential medical cost savings for HST were included for 2020 and 2019. Potential medical cost savings exclude potential medical cost savings identified by DHP in all time periods.

(3) Changes to previously reported medical charges processed and potential medical cost savings are due to client claim resubmissions or cancellation of claims. Examples of these changes include, but are not limited to, adjudication changes, billing changes, and elimination of claims that were later determined to be invalid.

Our medical charges processed and potential medical cost savings figures may not be directly comparable from period to period due to the completion and integration of acquisitions made in a particular period.

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Business Model

Our business model avoids reimbursement, underwriting and malpractice risk and exposure. We do not provide or manage healthcare services or provide medical care. This reduces our exposure to state and federal regulations that are imposed on insurers and medical services providers.

Healthcare Industry Exposure

According to CMS, healthcare expenditures will grow from $3.8 trillion, or 17.8% of U.S. GDP, in 2019 to represent 19.7% of GDP by 2028, representing a compounded annual growth rate of 5.5%. There are a multitude of factors driving this expected growth, including recent regulations and ongoing secular trends, such as the aging population and other demographic factors, which are driving expanded healthcare coverage and increased utilization. Additional growth in healthcare costs are driven by availability of new medical technologies, therapies and modalities. As expenditures continue to rise, stakeholders and especially payors, are becoming increasingly focused on solutions that reduce medical costs and improve payment accuracy.

Components of Results of Operations

Revenues

We generate revenues from several sources including: (i) Analytics-Based Services that use our leading and proprietary information technology platform to offer customers solutions to reduce medical costs, (ii) Network-Based Services that process claims at a discount compared to billed fee-for-service rates and by using an extensive network and (iii) Payment and Revenue Integrity Services that use data, technology, and clinical expertise to identify improper, unnecessary and excessive charges. Payors typically compensate us through either a PSAV achieved or a PEPM rate. Approximately 93% of revenues for the year ended December 31, 2021 were based on a PSAV achieved rate.

Costs of Services (exclusive of depreciation and amortization of intangible assets)

Costs of services (exclusive of depreciation and amortization of intangible assets) consist of all costs specifically associated with claims processing activities for customers, sales and marketing, and the development and maintenance of our networks, analytics-based services, and payment and revenue integrity services. Two of the largest components in costs of services are personnel expenses and access and bill review fees. Access and bill review fees include fees for accessing non-owned third-party provider networks, expenses associated with vendor fees for database access and systems technology used to reprice claims, and outsourced services. Third-party network expenses are fees paid to non-owned provider networks used to supplement our owned network assets to provide more network claim savings to our customers.

General and Administrative Expenses

General and administrative expenses include corporate management and governance functions composed of general management, legal, treasury, tax, real estate, financial reporting, auditing, benefits and human resource administration, communications, public relations, billing and information management. In addition, general and administrative expenses include taxes, insurance, advertising, transaction costs, and other general expenses.

Depreciation Expense

Depreciation expense consists of depreciation and amortization of property and equipment related to our investments in leasehold improvements, furniture and equipment, computer hardware and software, and internally generated capitalized software development costs. We provide for depreciation and amortization on property and equipment using the straight-line method to allocate the cost of depreciable assets over their estimated useful lives.

Amortization of Intangible Assets

Amortization of intangible assets includes amortization of the value of our customer relationships, provider network, technology, and trademarks which were identified in valuing the intangible assets in connection with the June 6, 2016 acquisition by H&F, as well as recent acquisitions by the Company.

Interest Expense

Interest expense consists of accrued interest and related interest payments on our outstanding long-term debt and amortization of debt issuance costs, discounts and premiums.

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Loss (Gain) on Extinguishment of Debt

The Company recognizes a loss (gain) on extinguishment of debt for the difference between the net carrying amount of the extinguished debt immediately before the refinancing and the fair value of the new debt instruments, and fees associated with the issuance of the new debt under the refinancing.

(Gain) Loss on Investments

(Gain) loss on investments consists of the changes in the fair value of the Company's investments.

Change in fair value of Private Placement Warrants and unvested founder shares

The Company remeasures the fair value of the Private Placement Warrants and unvested founder shares at each reporting period. The changes in fair value are primarily due to the change in the stock price of the Company's Class A common stock over the reporting period.

Income Tax Expense (Benefit)

Income tax expense (benefit) consists of federal, state, and local income taxes. Due to the variability of our taxable income as compared to net income, stock-based compensation and the variability of the jurisdictions where income is earned, our effective tax rate can vary significantly from one period to the next depending on relative changes in net income.

Non-GAAP Financial Measures

We use EBITDA, Adjusted EBITDA and Adjusted EPS to evaluate our financial performance. EBITDA, Adjusted EBITDA and adjusted earnings per share are financial measures that are not presented in accordance with GAAP. We believe the presentation of these non-GAAP financial measures provides useful information to investors in assessing our financial condition and results of operations across reporting periods on a consistent basis by excluding items that we do not believe are indicative of our financial operating results of our core business.

These measurements of financial performance have important limitations as analytical tools and should not be considered in isolation or as a substitute for analysis of our results as reported under GAAP. Additionally, they may not be comparable to other similarly titled measures of other companies. Some of these limitations are:

- such measures do not reflect our cash expenditures or future requirements for capital expenditures or contractual commitments;
- such measures do not reflect changes in, or cash requirements for, our working capital needs;
- such measures do not reflect the significant interest expense, or cash requirements necessary to service interest or principal payments on our debt;
- such measures do not reflect any cash requirements for any future replacement of depreciated assets;
- such measures do not reflect the impact of stock-based compensation upon our results of operations;
- such measures do not reflect our income tax (benefit) expense or the cash requirements to pay our income taxes;
- such measures do not reflect the impact of certain cash charges resulting from matters we consider not to be indicative of our ongoing operations; and
- other companies in our industry may calculate these measures differently from how we do, limiting their usefulness as a comparative measure.

In evaluating EBITDA, Adjusted EBITDA and Adjusted EPS, you should be aware that in the future we may incur expenses similar to those eliminated in the presentation.

EBITDA, Adjusted EBITDA, and Adjusted EPS are widely used measures of corporate profitability eliminating the effects of financing and capital expenditures from the operating results. We define EBITDA as net income adjusted for interest expense, interest income, income tax expense (benefit) , depreciation, amortization of intangible assets, and non-income taxes. We define Adjusted EBITDA as EBITDA further adjusted to eliminate the impact of certain items that we do not consider to be indicative of our core business, including other expense, change in fair value of Private Placement Warrants and unvested

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founder shares, transaction related expenses, loss (gain) on the debt extinguishment, (gain) loss on investments and stock-based compensation. See our consolidated financial statements for more information regarding these adjustments. Adjusted EBITDA is used in our agreements governing our outstanding indebtedness for debt covenant compliance purposes. Our Adjusted EBITDA calculation is consistent with the definition of Adjusted EBITDA used in our debt instruments.

Adjusted EPS is used in reporting to our Board and executive management and as a component of the measurement of our performance. We believe that this measure provides useful information to investors because it is the profitability measure we use to evaluate earnings performance on a comparable year-to-year basis. Adjusted EPS is defined as net income (loss) adjusted for amortization of intangible assets, stock-based compensation, transaction related expenses, (gain) loss on investments, loss (gain) on debt extinguishment, other expense, change in fair value of Private Placement Warrants and unvested founder shares and tax effect of adjustments to arrive at Adjusted net income divided by our weighted average number of shares outstanding.

The following table presents a reconciliation of net income (loss) to EBITDA and Adjusted EBITDA for the periods presented:

	Year Ended December 31,		
(in thousands)	**2021**	**2020**	**2019**
Net income (loss)	$ 102,080	$ (520,564)	$ 9,710
Adjustments:			
Interest expense	267,475	335,638	376,346
Interest income	(30)	(288)	(196)
Income tax provision (benefit)	33,373	(26,343)	799
Depreciation	64,885	60,577	55,807
Amortization of intangible assets	340,210	334,697	334,053
Non-income taxes	1,698	3,221	1,944
EBITDA	$ 809,691	$ 186,938	$ 778,463
Adjustments:			
Other expenses	8,295	1,095	1,947
Integration expenses	9,460	801	—
Change in fair value of Private Placement Warrants and unvested founder shares	(32,596)	(35,422)	—
Transaction-related expenses	9,647	31,689	3,270
(Gain) loss on investments	(25)	12,165	—
Loss (gain) on extinguishment of debt	15,843	102,993	(18,450)
Stock-based compensation	18,010	406,054	(14,880)
Adjusted EBITDA	$ 838,325	$ 706,313	$ 750,350

Material differences between MultiPlan Corporation and MPH for the years ended December 31, 2021 and 2020 include differences in interest expense, change in fair value of Private Placement Warrants and unvested founder shares, stock-based compensation, and net insurance premiums associated with our captive insurance company, which are eliminated in the consolidated financial reporting of MultiPlan Corporation. For the years ended December 31, 2021, 2020 and 2019 interest expense for MultiPlan Corporation was $82.1 million, $107.2 million, and $112.0 million higher than interest expense, respectively, for MPH due to interest expense incurred by MultiPlan Corporation on the Senior Convertible Notes (issued on October 8, 2020) and Senior PIK Notes (redeemed October 8, 2020) including amortization of discount on Senior PIK Notes, net of debt issue costs. For the years ended December 31, 2021 and 2020, the change in fair value of Private Placement Warrants and unvested founder shares, and stock-based compensation are recorded in the parent company MultiPlan Corporation and not in the MPH operating company and therefore represent differences between MultiPlan Corporation and MPH. In the year ended December 31, 2021, MPH had higher EBITDA expenses than MultiPlan Corporation of $0.4 million due to insurance premiums paid to our captive insurance company, net of related captive insurance company costs which are eliminated in the consolidated financial reporting of MultiPlan Corporation.

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The following table presents a reconciliation of net income (loss) to Adjusted EPS for the periods presented:

($ in thousands, except share and per share amounts)	Year Ended December 31, 2021	2020	2019
Net income (loss)	$ 102,080	$ (520,564)	$ 9,710
Adjustments:			
Amortization of intangible assets	340,210	334,697	334,053
Stock-based compensation	18,010	406,054	(14,880)
Transaction-related expenses	9,647	31,689	3,270
(Gain) loss on investments	(25)	12,165	—
Loss (gain) on extinguishment of debt	15,843	102,993	(18,450)
Integration expenses	9,460	801	—
Other expenses	8,295	1,095	1,947
Change in fair value of Private Placement Warrants and unvested founder shares	(32,596)	(35,422)	—
Estimated tax effect of adjustments	(98,671)	(106,989)	(76,992)
Adjusted net income	$ 372,253	$ 226,519	$ 238,658
Weighted average shares outstanding – Basic[1]	651,006,567	470,785,192	415,700,000
Net income (loss) per share – basic	$ 0.16	$ (1.11)	$ 0.02
Adjusted earnings per share	$ 0.57	$ 0.48	$ 0.57

(1) The shares of the Company's common stock, prior to the Transactions, have been retroactively restated as shares reflecting the exchange ratio established in the Transactions.

Factors Affecting the Comparability of our Results of Operations

As a result of a number of factors, our historical results of operations may not be comparable to our results of operations in future periods and may not be directly comparable from period to period. Set forth below is a brief discussion of the key factors impacting the comparability of our results of operations.

The Transactions

On July 12, 2020, Churchill entered into the Merger Agreement by and among First Merger Sub, Second Merger Sub, Holdings, and Polaris. On October 8, 2020, the Merger Agreement was consummated and the Transactions were completed.

HST Acquisition

On November 9, 2020, the Company completed the acquisition of HST, a healthcare technology company that enables value-driven health benefit plan designs featuring reference-based pricing and tools to engage health plan members and providers in making the best use of available benefits both before and after care delivery.

The results of operations and financial condition of HST have been included in the Company's consolidated results from the date of acquisition.

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DHP Acquisition

On February 26, 2021, the Company completed the acquisition of DHP, an analytics and technology company offering healthcare payment and revenue integrity services. The Company acquired 100 percent of the voting equity interest of DHP. The acquisition strengthens MultiPlan's service offering in the payment integrity market with new and complementary services to help its payor customers manage the overall cost of care and improve their competitiveness. It also adds revenue integrity services for plans that receive premiums from the Centers for Medicare and Medicaid Services.

The results of operations and financial condition of DHP have been included in the Company's consolidated results from the date of acquisition. In connection with the DHP acquisition, the Company incurred transaction-related expenses of $4.9 million and $0.6 million for the years ended December 31, 2021 and 2020, respectively. The transaction-related expenses have been expensed as incurred and are included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

Debt Refinancings, Repayments and Repricing

During August and September of 2019, the Company repurchased and cancelled $121.3 million of the Senior PIK Notes, resulting in the recognition of a gain on debt extinguishment of $18.5 million in the year ended December 31, 2019.

On October 8, 2020, the Senior PIK notes were redeemed in full for a total redemption price of $1,237.6 million, resulting in the recognition of a loss on debt extinguishment of $35.7 million in the year ended December 31, 2020.

On October 29, 2020, the Company (a) issued 5.750% Notes under MPH and increased the revolving credit facility under the senior secured credit facilities from $100.0 million to $450.0 million and (b) repaid all outstanding 7.125% Notes and $369.0 million of indebtedness under Term Loan G with the net proceeds of the 5.750% Notes, together with $715.0 million of cash on hand. As a result, we recognized a loss on debt extinguishment of $67.2 million in the year ended December 31, 2020.

On August 24, 2021, MPH issued new senior secured credit facilities composed of $1,325.0 million of Term Loan B and $450.0 million of a Revolver B, and $1,050.0 million in aggregate principal amount of 5.50% Senior Secured Notes. MPH used the net proceeds from Term Loan B, and the 5.50% Senior Secured Notes to repay all of the outstanding balance of its Term Loan G of $2,341.0 million, and pay fees and expenses in connection therewith. As a result, we recognized a loss on debt extinguishment of $15.8 million in the year ended December 31, 2021.

Interest on Term Loan B and Revolver B is calculated, at MPH's option, as (a) LIBOR (or, with respect to the term loan facility only, 0.50%, whichever is higher), plus the applicable margin, or (b) the highest rate of (1) prime rate, (2) the federal funds effective rate, plus 0.50%, (3) the LIBOR for an interest period of one month, plus 1.00% and (4) 0.50% for Term Loan B and 1.00% for Revolver B, in each case, plus an applicable margin of 4.25% for Term Loan B and between 3.50% and 4.00% for Revolver B, depending on MPH's first lien debt to consolidated EBITDA ratio. The interest rate in effect for Term Loan B was 4.75% as of December 31, 2021.

The Company is obligated to pay a commitment fee on the average daily unused amount of Revolver B. The annual commitment fee can range from an annual rate of 0.25% to 0.50% based on the Company's first lien debt to consolidated EBITDA ratio, as defined in the agreement.

In connection with the issuance of our debt instruments, the Company incurred specific expenses related to raising the debt, including commissions, fees and expenses of investment bankers and underwriters, registration and listing fees, accounting and legal fees pertaining to the financing and other external, incremental expenses paid to advisors that were directly attributable to realizing the proceeds of the debt issues. These costs were capitalized and are being amortized over the term of the related debt using the effective interest method. The amortization of the debt issuance costs, premiums and discounts are included in interest expense in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

In the years ended December 31, 2019, 2018, and 2017, we did not recognize expense for the portions of debt issuance costs related to the amounts of the principal loan prepayments of Term Loan G made in each year, which resulted in an understatement of long-term debt of $2.3 million as of December 31, 2019. We corrected this error as an out-of-period adjustment resulting in an overstatement of interest expense of $2.3 million in the year ended December 31, 2020.

Stock-Based Compensation

Prior to the consummation of the Transactions, we were a wholly-owned subsidiary of Holdings and our stock-based compensation was granted to employees in the form of Units via a Class B Unit Award Agreement. The fair value of the Units was remeasured at each reporting period. The consummation of the Transactions constituted a definitive Liquidity Event under the agreements governing the Unit awards and as a result the incentive plan was liquidated. For the year ended December 31,

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2020, the Company recorded stock-based compensation expense under the Class B Unit Award Agreement of $405.8 million in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

Since the consummation of the Transactions, the Company has operated under the 2020 Omnibus Incentive Plan effective October 8, 2020. To date, awards granted under the 2020 Omnibus Incentive Plan have been in the form of Employee RS, Employee RSUs, Fixed Value RSUs, Employee NQSOs and Director RSUs. Stock-based compensation is measured at the grant date based on the fair value of the award.

For the year ended December 31, 2021, the Company has granted 4.2 million Employee NQSOs, 2.9 million Employee RSUs, 0.1 million Employee RS, 0.5 million Fixed Value RSUs and 0.1 million Director RSUs under the 2020 Omnibus Incentive Plan. For the years ended December 31, 2021 and 2020, the Company recorded stock-based compensation expense under the 2020 Omnibus Incentive Plan of 18.0 million and 0.2 million, respectively, in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

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Results of Operations for the Years Ended December 31, 2021 and 2020

The following table provides the results of operations for the periods indicated:

($ in thousands)	Year Ended December 31, 2021	2020	Change $	Change %
Revenues				
Network-Based Services	$ 278,457	$ 271,262	$ 7,195	2.
Analytics-Based Services	709,272	564,661	144,611	25.
Payment and Revenue Integrity Services	129,873	101,840	28,033	27.
Total Revenues	$ 1,117,602	$ 937,763	$ 179,839	19.
Costs of services (exclusive of depreciation and amortization of intangible assets shown below)				
Personnel expenses excluding stock-based compensation	147,342	128,222	19,120	14.
Stock-based compensation	2,618	163,025	(160,407)	(98.
Personnel expenses including stock-based compensation	149,960	291,247	(141,287)	(48.
Access and bill review fees	13,526	13,794	(268)	(1.
Other cost of services expenses	11,806	13,634	(1,828)	(13.
Total costs of services (exclusive of depreciation and amortization of intangible assets shown below)	175,292	318,675	(143,383)	(45.
General and administrative expenses excluding stock-based compensation and transaction-related expenses	126,056	80,917	45,139	55.
Stock-based compensation	15,392	243,029	(227,637)	(93.
Transaction-related expenses	9,647	31,689	(22,042)	(69.
Total general and administrative expenses	151,095	355,635	(204,540)	(57.
Depreciation expense	64,885	60,577	4,308	7.
Amortization of intangible assets	340,210	334,697	5,513	1.
Operating income (loss)	386,120	(131,821)	517,941	
Interest expense	267,475	335,638	(68,163)	(20.
Interest income	(30)	(288)	258	89.
Loss on extinguishment of debt	15,843	102,993	(87,150)	(84.
(Gain) loss on investments	(25)	12,165	(12,190)	
Change in fair value of Private Placement Warrants and unvested founder shares	(32,596)	(35,422)	2,826	8.
Net income (loss) before taxes	135,453	(546,907)	682,360	
Provision (benefit) for income taxes	33,373	(26,343)	59,716	
Net income (loss)	$ 102,080	$ (520,564)	$ 622,644	

NM = Not meaningful

Revenues

The increase in revenues for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was primarily due to increased claims volumes from customers, higher savings rates per unit of billed charges on processed claims, favorable changes in the mix of claims toward higher charge medical services as the effects of the COVID-19 pandemic subsided, and revenues from the acquisitions of DHP and HST. Acquired revenues related to the acquisitions of DHP and HST were $44.4 million and $2.0 million for the years ended December 31, 2021 and 2020, respectively. The increase in revenues, excluding acquired revenues, was $137.4 million or 14.7% for the year ended December 31, 2021 as compared to the year ended December 31, 2020.

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Network-Based Services revenues increased in the year ended December 31, 2021 as compared to the year ended December 31, 2020 primarily due to increases in claims volumes from customers, higher savings rates on processed claims, and reduced effects of the COVID-19 pandemic on claim mix, partially offset by certain client adoptions of our Analytics-Based Services in lieu of our Network-Based Services.

Analytics-Based Services revenues increased for the year ended December 31, 2021 as compared to the year ended December 31, 2020 primarily due to increases in claim volumes from customers, higher savings rates, reduced effects of the COVID-19 pandemic on claim mix, certain client adoptions of our Analytics-Based Services in lieu of our Network-Based Services and revenues from the acquisition of HST. Within Analytics-Based Services, revenue increased across all major product categories: Reference-Based Pricing, which includes our Data iSight program, Financial Negotiation, and Value-Driven Health Plan Services.

Payment and Revenue Integrity Services revenues increased for the year ended December 31, 2021 as compared to the year ended December 31, 2020 primarily due to revenues from the acquisition of DHP, increases in claims volumes from customers, and reduced effects of the COVID-19 pandemic on claim mix. The acquisition of DHP contributed to revenues from our Data Mining and Clinical Auditing Services and added revenues from new product categories, including Revenue Integrity Services and Coordination of Benefits and Subrogation Services.

Costs of Services (exclusive of depreciation and amortization of intangible assets)

	Year Ended December 31,		Change	
($ in thousands)	**2021**	**2020**	**$**	**%**
Cost of services (exclusive of depreciation and amortization of intangible assets)	$ 175,292	$ 318,675	$ (143,383)	(45.
Less: stock-based compensation	2,618	163,025	(160,407)	(98.
Costs of services excluding stock-based compensation	$ 172,674	$ 155,650	$ 17,024	10.

The decrease in cost of services for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was due to decreases in personnel expenses primarily related to stock-based compensation as explained below.

The decrease in personnel expenses, including contract labor, for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was primarily due to decreases in stock-based compensation of $160.4 million partially offset by increases in other compensation-related expenses, including salaries, bonus, commissions, fringe benefits and contract labor of $19.1 million for the year ended December 31, 2021 as compared to the year ended December 31, 2020. The increase in other compensation-related expenses was primarily due to increased headcount related to organic growth, the full year impact of the HST acquisition in fourth quarter 2020, and the acquisition of DHP in first quarter 2021. The change in stock-based compensation expense over these time periods was primarily the result of changes in the stock-based compensation plans as described above in the Factors Affecting the Comparability of our Results of Operations.

General and Administrative Expenses

	Year Ended December 31,		Change	
($ in thousands)	**2021**	**2020**	**$**	**%**
General and administrative expenses	$ 151,095	$ 355,635	$ (204,540)	(57.
Less: stock-based compensation	15,392	243,029	(227,637)	(93.
Less: transaction-related expenses	9,647	31,689	(22,042)	(69.
Less: integration expenses	9,460	801	8,659	
General and administrative expenses excluding stock-based compensation, transaction-related expenses, and integration expenses	$ 116,596	$ 80,116	$ 36,480	45.

The decrease in general and administrative expenses for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was primarily due to a decrease in personnel expenses of $202.0 million, a decrease in transaction-related expenses of $22.0 million, and an increase in capitalized development costs of $10.5 million, partially offset by an increase in professional fees of $8.6 million including higher legal, audit, and consulting fees, an increase in insurance premiums of $6.5 million primarily related to higher errors and omissions liability and directors and officers liability insurance, an increase in integration expenses of $8.7 million primarily related to integrating HST and DHP, an increase in equipment lease and

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maintenance expenses of $2.8 million, an increase in the loss on disposal of assets of $2.6 million based on a periodic review of capitalized computer hardware and software, and an increase in other general and administrative expenses of $0.8 million.

The decrease in personnel expenses of $202.0 million was due to a decrease in stock-based compensation of $227.6 million, partially offset by an increase in other compensation related expenses, including salaries, bonus, fringe benefits, and contract labor of $25.6 million due to increased headcount through organic growth, non-integration related severance costs of $5.0 million, the full year impact of the acquisition of HST in fourth quarter of 2020, and the acquisition of DHP in first quarter of 2021. The decrease in transactions costs of $22.0 million was primarily due to higher costs associated with the Transactions on October 8, 2020 and acquisition of HST on November 9, 2020 as compared to the costs associated with the acquisition of DHP on February 26, 2021. See Note 5 Business Combinations and Note 4 The Transactions of the Notes to Consolidated Financial Statements for additional information.

Depreciation Expense

The increase in depreciation expense for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was due to purchases of property and equipment, including internally generated capitalized software in the years ended December 31, 2021 and 2020, partially offset by assets that were written-off or became fully depreciated in the period.

Amortization of Intangible Assets

The increase in the amortization of intangible assets for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was primarily due to the acquisitions of HST and DHP. This expense represents the amortization of intangible assets, as explained above and in the Notes to Consolidated Financial Statements.

Interest Expense and Interest Income

The decrease in interest expense for the year ended December 31, 2021 as compared to the year ended December 31, 2020 was due to the effect of (i) the Transactions on October 8, 2020 when we redeemed our Senior PIK Notes (8.500% interest rate) and issued Convertible PIK Notes (6.000% interest rate), (ii) the Refinancing on October 29, 2020 when we prepaid $369.0 million of principal balance on Term Loan G and we redeemed the 7.125% Notes and issued 5.750% Notes, and (iii) the refinancing on August 24, 2021 when MPH issued new senior secured credit facilities composed of Term Loan B and Revolver B, and issued the 5.50% Senior Secured Notes, using the net proceeds to repay all of the outstanding balance of Term Loan G.

In the years ended December 31, 2017, 2018 and 2019, we did not recognize expense for the portions of debt issuance costs related to the amounts of the principal loan prepayments made in each year, which resulted in an understatement of long-term debt of $2.3 million as of December 31, 2019. We corrected this error as an out-of-period adjustment resulting in an overstatement of interest expense of $2.3 million in the year ended December 31, 2020.

As of December 31, 2021, our long-term debt was $4,879.1 million and included (i) $1,308.4 million Term Loan B, discount on Term Loan B of $12.9 million, (ii) $1,050.0 million of 5.50% Senior Secured Notes, (iii) $1,300.0 million of 5.750% Senior Notes, (iv) $1,300.0 million of Senior Convertible PIK Notes, discount on Senior Convertible PIK Notes of $27.7 million (reduction in discount on Senior Convertible PIK Notes from December 30, 2020 relates to the adoption of ASU 2020-06 effective January 1, 2021), and (v) $0.1 million of long-term finance lease obligations, net of (vi) debt issue costs of $38.8 million. As of December 31, 2021, our total debt had an annualized weighted average cash interest rate of 4.6%.

As of December 31, 2020, our long-term debt was $4,578.5 million and included (i) $2,341.0 million Term Loan G, discount on Term Loan G of $3.8 million, (ii) $1,300.0 million of 5.750% Senior Notes, (iii) $1,300.0 million of Senior Convertible PIK Notes, discount on Senior Convertible PIK Notes of $329.5 million, and (iv) $0.1 million of long-term finance lease obligations, net of (v) debt issue costs of $29.3 million. As of December 31, 2020, our total debt had a weighted average cash interest rate of 4.9%

Loss (gain) on extinguishment of debt

As a result of the refinancing transactions of August 24, 2021, the Company recognized a loss on debt extinguishment of $15.8 million representing the difference between Term Loan G's net carrying amount immediately before the refinancing and the fair value of the new debt instruments, and fees associated with the issuance of the new debt under the refinancing.

The loss on extinguishment of debt for the year ended December 31, 2020 was the result of the redemption in full of the 7.125% Notes, redemption in full of the Senior PIK Notes, and the repayment of $369.0 million of indebtedness under our term loan facility.

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Change in fair value of Private Placement Warrants and unvested founder shares

The Company measures at each reporting period the fair values of the Private Placement Warrants and unvested founder shares. For the year ended December 31, 2021, the fair values of the Private Placement Warrants and the unvested founder shares decreased by $6.5 million and $26.1 million, respectively. The decrease was primarily due to the variations in the stock price of the Company's Class A common stock over that period.

Provision (Benefit) for Income Taxes

Net income before income taxes for the year ended December 31, 2021 of $135.5 million generated a provision for income taxes of $33.4 million with an effective tax rate of 24.6%. Net loss before income taxes for the year ended December 31, 2020 of $546.9 million generated a benefit for income taxes of $26.3 million with an effective tax rate of 4.8%. Our effective tax rate for the years ended December 31, 2021 and December 31, 2020 differed from the statutory rate primarily due to non-deductible stock-based compensation expense, non-deductible mark-to-market liability, limitations on executive compensation, changes in the Company's deferred state tax rate due to operations, and state tax expense.

Results of Operations for the Years Ended December 31, 2020 and December 31, 2019

For a discussion comparing our consolidated operating results from the year ended December 31, 2020 with the year ended December 31, 2019, refer to Part II, Item 7. "Management’s Discussion and Analysis of Financial Condition and Results of Operations – Results of Operations for the Years Ended December 31, 2020 and December 31, 2019" in our Annual Report on Form 10-K for the year ended December 31, 2020, which was filed with the Commission on March 16, 2021.

Liquidity and Capital Resources

As of December 31, 2021, we had cash, cash equivalents, and restricted cash of $188.4 million, which includes restricted cash of $3.1 million, and $450.0 million of loan availability under the revolving credit facility. In connection with the Refinancing, the capacity of the revolving credit facility was increased from $100.0 million to $450.0 million and $369.0 million of indebtedness under the Term Loan G was repaid. On August 24, 2021, the maturity of the revolving credit facility was extended from June 7, 2023 to August 24, 2026. As of December 31, 2021, we had three letters of credit that reduce the capacity of the revolver by $1.8 million and are used to satisfy real estate lease agreements for three of our offices in lieu of security deposits. See Note 3 Long-Term Debt of the Notes to Consolidated Financial Statements for further information on the August 24, 2021 refinancing.

On August 27, 2021, the Company's Board of Directors approved a share repurchase program authorizing the Company to repurchase up to $250.0 million of its Class A common stock from time to time in open market transactions. The repurchase program was effective immediately and expires on December 31, 2022. As of December 31, 2021, the Company has repurchased approximately $100.0 million of its Class A common stock as part of this program using cash on hand.

Our primary sources of liquidity are internally generated funds combined with our borrowing capacity under our revolving credit facility. We believe that these sources will provide sufficient liquidity for us to meet our working capital, capital expenditure and other cash requirements for the next twelve months and for the long term. We may from time to time at our sole discretion, purchase, redeem or retire our long-term debt, through tender offers, in privately negotiated or open market transactions or otherwise. We plan to finance our capital expenditures with cash from operations. Furthermore, our future liquidity and future ability to fund capital expenditures, working capital and debt requirements are also dependent upon our future financial performance, which is subject to many economic, commercial, financial and other factors that are beyond our control, including the ability of financial institutions to meet their lending obligations to us. If those factors significantly change, our business may not be able to generate sufficient cash flow from operations or future borrowings may not be available to meet our liquidity needs. We anticipate that to the extent we require additional liquidity as a result of these factors or in order to execute our strategy, it would be financed either by borrowings under our senior secured credit facilities, by other indebtedness, additional equity financings or a combination of the foregoing. We may be unable to obtain any such additional financing on reasonable terms or at all.

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Cash Flow Summary

The following table is derived from our consolidated statements of cash flows:

(in thousands)	For the Year Ended December 31, 2021	2020
Net cash flows provided by (used in):		
Operating activities	$ 404,687	$ 377,1
Investing activities	$ (228,379)	$ (210,8
Financing activities	$ (114,684)	$ (61,5

For the year ended December 31, 2021 as compared to the year ended December 31, 2020

Cash Flows from Operating Activities

Cash flows from operating activities provided $404.7 million for the year ended December 31, 2021 and $377.4 million for the year ended December 31, 2020. This $27.3 million, or 7.2%, increase in cash flows from operating activities was primarily the result of increase in net income of $622.6 million, after adjusting for non-cash items of $521.3 million, offset by changes in net working capital of $74.0 million.

The $521.3 million decrease in non-cash items was primarily due to a decrease in stock-based compensation of $388.0 million, decrease in loss on extinguishment of debt of $87.2 million, change in the deferred tax benefit of $36.9 million, decrease in loss on investments of $12.2 million, decrease in the amortization of right-of-use-asset of $1.4 million, and the decrease in non-cash interest costs of $10.6 million, offset by increases in depreciation expense of $4.3 million, increase in amortization of intangible assets of $5.5 million, increases in loss on disposal of assets of $2.4 million, and the change in fair value of Private Placement Warrants and unvested founder shares of $2.8 million.

The increase in net income of $622.6 million was primarily the result of increases in revenues and reductions in costs of services, general and administrative expenses, interest expense, loss on extinguishment of debt, and decreases in the change in fair value of Private placement Warrants and unvested founder shares, offset by increases in depreciation expense, increases in amortization expense, increases in change in fair value of Private Placement Warrants and unvested founder shares, increases in the provision for income taxes, and decreases in interest income as explained above.

During the year ended December 31, 2021, $44.0 million was used by changes in working capital including increases in net accounts receivable of $33.8 million primarily due to increases in year-over-year revenues and timing of collections, increases in prepaid expenses and other assets of $7.0 million, increases in prepaid taxes of $5.1 million, and decreases in operating lease obligations of $5.9 million, offset by increases in accounts payable and accrued expenses of $7.7 million.

During the year ended December 31, 2020, $30.0 million was provided by changes in working capital including decreases in net accounts receivable of $14.8 million primarily due to declines in year-over-year revenues and timing of collections, decreases in prepaid taxes of $2.1 million primarily due to a retrospective change in the tax law, and increases in accounts payable and accrued expenses of $29.1 million, offset by increases in prepaid expenses and other assets of $7.5 million and decreases in operating lease obligations of $8.5 million. The increase in accounts payable and accrued expenses is primarily due to an increase in accrued interest of $13.6 million and accrued taxes of $9.8 million.

Cash Flows from Investing Activities

For the year ended December 31, 2021, net cash of $228.4 million was used in investing activities including $149.7 million for the acquisition of DHP and $84.6 million for purchases of property and equipment and capitalization of software development, offset by proceeds from the sale of investment of $5.6 million. For the year ended December 31, 2020, net cash of $210.8 million was used in investing activities including $140.0 million for the acquisition of HST and $70.8 million for purchases of property and equipment and capitalization of software development. This increase in purchases of property and equipment and capitalization of software development of $13.8 million was primarily due to increased capitalization of software development on capital projects primarily to enhance our information technology infrastructure and platforms to increase efficiencies, data security, and service line capabilities.

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Cash Flows from Financing Activities

Cash flows used in financing activities for the year ended December 31, 2021 were $114.7 million primarily consisting of repayments of Term Loan G of $2,341.0 million, $100.0 million of purchases of treasury stock, and $3.8 million of taxes paid on net settlement of vested share awards and repayments of Term Loan B of $3.3 million, offset by the issuance of Term Loan B of $1,298.9 million and the issuance of $1,034.5 million of the 5.50% Senior Secured Notes.

Cash flows used in financing activities for the year ended December 31, 2020 were $61.6 million primarily consisting of $369.0 million of prepayments on our Term Loan G, $1,615.6 million for the extinguishment of the 7.125% Notes, $1,202.3 million for extinguishment of the Senior PIK Notes, $101.1 million for the purchase of treasury stock, and $23.5 million for the payment of debt issuance costs, offset by $682.4 million for the effect of the Transactions, $1,267.5 million of cash provided by the issuance of Senior Convertible PIK Notes and $1,300.0 million of cash provided by the issuance of the 5.750% Notes. In addition, there was $98.0 million of borrowings on and repayments of our Revolver G.

For the year ended December 31, 2020 as compared to the year ended December 31, 2019

For a discussion comparing our cash flows from operating activities, investing activities, and financing activities from the year ended December 31, 2020 with the year ended December 31, 2019, refer to Part II, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations – Cash Flow Summary – For the year ended December 31, 2020 as compared to the year ended December 31, 2019" in our Annual Report on Form 10-K for the year ended December 31, 2020, which was filed with the Commission on March 16, 2021.

Term Loans and Revolvers

On August 24, 2021, MPH issued new senior secured credit facilities composed of $1,325.0 million of Term Loan B and $450.0 million of Revolver B, and $1,050.0 million in aggregate principal amount of 5.50% Senior Secured Notes. MPH used the net proceeds from Term Loan B, issued with a discount of 1.00%, and the 5.50% Senior Secured Notes to repay all of the outstanding balance of its Term Loan G of $2,341.0 million, and pay fees and expenses in connection therewith.

Interest on Term Loan B and Revolver B is calculated, at MPH's option, as (a) LIBOR (or, with respect to the term loan facility only, 0.50%, whichever is higher), plus the applicable margin, or (b) the highest rate of (1) prime rate, (2) the federal funds effective rate, plus 0.50%, (3) the LIBOR for an interest period of one month, plus 1.00% and (4) 0.50% for Term Loan B and 1.00% for Revolver B, in each case, plus an applicable margin of 4.25% for Term Loan B and between 3.50% and 4.00% for Revolver B, depending on MPH's first lien debt to consolidated EBITDA ratio. The interest rate in effect for Term Loan B was 4.75% as of December 31, 2021.

Term Loan B matures on September 1, 2028 and Revolver B matures on August 24, 2026.

For all our debt agreements with an interest rate dependent on LIBOR, we are currently assessing and monitoring how transitioning from LIBOR to an alternative reference rate may affect us past 2023.

We are obligated to pay a commitment fee on the average daily unused amount of our revolving credit facility. The annual commitment fee rate was 0.50% at December 31, 2021 and 0.25% at December 31, 2020. The fee can range from an annual rate of 0.25% to 0.50% based on our consolidated first lien debt to consolidated EBITDA ratio, as defined in the agreement.

Senior Notes

On October 8, 2020, the Senior PIK notes were redeemed in full for a total redemption price of $1,237.6 million, which included a redemption premium and accrued interest. The interest rate on the Senior PIK Notes was fixed at 8.5% and was payable semi-annually on June 1 and December 1 of each year.

On October 8, 2020, the Company issued $1,300.0 million in aggregate principal amount of Senior Convertible PIK Notes. The Senior Convertible PIK Notes were issued with a 2.5% discount with a maturity date of October 15, 2027. Prior to the adoption of ASU 2020-06 on January 1, 2021, the nature of the notes required management to separate the Senior Convertible PIK Notes into liability and equity components. ASU 2020-06's elimination of the beneficial conversion guidance resulted in "recombining" the equity and debt components of the Senior Convertible PIK Notes into a single liability. As a result, $297.9 million of the discount on the liability created by recognition of a component of the convertible debt in equity was eliminated on January 1, 2021. See Note 3 New Accounting Pronouncements and Note 9 Long-Term Debt of the Notes to the Consolidated Financial Statements for further detail.

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The Senior Convertible PIK Notes are convertible into shares of Class A common stock based on a $13.0 conversion price, subject to customary anti-dilution adjustments. The interest rate on the Senior Convertible PIK Notes is fixed at 6% in cash and 7% in kind, and is payable semi-annually on April 15 and October 15 of each year.

On October 29, 2020, the 7.125% Notes were redeemed in full for a total redemption price of $1,661.3 million, which included a redemption premium and accrued interest. The interest rate on the 7.125% Notes was fixed at 7.125% and was payable semi-annually on June 1 and December 1 of each year.

On October 29, 2020, the Company issued $1,300.0 million in aggregate principal amount of the 5.750% Notes. The 5.750% Notes are guaranteed on a senior unsecured basis jointly and severally by the Company and its subsidiaries and have a maturation date of November 1, 2028. The 5.750% Notes were issued at par. The interest rate on the 5.750% Notes is fixed at 5.750%, and is payable semi-annually on May 1 and November 1 of each year.

On August 24, 2021 MPH issued $1,050.0 million in aggregate principal amount of 5.50% Senior Secured Notes with a maturation date of September 1, 2028. The interest rate on the 5.50% Senior Secured Notes is fixed at 5.50%, and is payable semi-annually on March 1 and September 1 of each year. The 5.50% Senior Secured Notes are guaranteed and secured as described below under "—Guarantees and Security."

Debt Covenants and Events of Default

We are subject to certain affirmative and negative debt covenants under the debt agreements governing our indebtedness that limit our and/or certain of our subsidiaries' ability to engage in specific types of transactions. These covenants limit our and/or certain of our subsidiaries' ability to, among other things:

- incur additional indebtedness or issue disqualified or preferred stock;
- pay certain dividends or make certain distributions on capital stock or repurchase or redeem capital stock;
- make certain loans, investments or other restricted payments;
- transfer or sell certain assets;
- incur certain liens;
- place restrictions on the ability of its subsidiaries to pay dividends or make other payments to us;
- guarantee indebtedness or incur other contingent obligations;
- prepay junior debt and make certain investments;
- consummate any merger, consolidation or amalgamation, or liquidate, wind up or dissolve itself (or suffer any liquidation or dissolution), or dispose of all or substantially all of its business units, assets or other properties; and
- engage in transactions with our affiliates.

Certain covenants related to the 5.50% Senior Secured Notes will cease to apply to the 5.50% Senior Secured Notes for so long as such notes have investment grade ratings from both Moody’s Investors Service, Inc. and S&P Global Ratings.

In connection with the Refinancing, the Revolver Ratio was amended such that, if, as of the last day of any fiscal quarter of MPH, the aggregate amount of loans under the revolving credit facility, letters of credit issued under the revolving credit facility (to the extent not cash collateralized or backstopped or, in the aggregate, in excess of $10.0 million) and swingline loans are outstanding and/or issued in an aggregate amount greater than 35% of the total commitments in respect of the revolving credit facility at such time, the revolving credit facility will require MPH to maintain a maximum first lien secured leverage ratio of 6.75 to 1.00. Our consolidated first lien debt to consolidated EBITDA ratio was 2.61 times and 3.14 times as of December 31, 2021 and 2020, respectively.

As of December 31, 2021 and 2020 we were in compliance with all of the debt covenants.

The debt agreements governing the new senior secured credit facilities, Term Loan G, the Revolver G, the 5.750% Notes and the 5.50% Senior Secured Notes contain customary events of default, subject to grace periods and exceptions, which include, among others, payment defaults, cross-defaults to certain material indebtedness, certain events of bankruptcy, material

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judgments, in the case of the debt agreements governing the new senior secured credit facilities and the 5.50% Senior Secured Notes, failure of a guarantee on the liens on material collateral to remain in effect, in the case of the debt agreements governing the new senior secured credit facilities, Term Loan G and the Revolver G, and any change of control. Upon the occurrence of an event of default under such debt agreements, the lenders and holders of such debt will be permitted to accelerate the loans and terminate the commitments, as applicable, thereunder and exercise other specified remedies available to the lenders and holders thereunder.

See the footnotes to the EBITDA and Adjusted EBITDA reconciliation table provided above under "*Non-GAAP Financial Measures*" for material differences between the financial information of MultiPlan and MPH.

Guarantees and Security

All obligations under the debt agreements governing Term Loan B, Revolver B and the 5.50% Senior Secured Notes are unconditionally guaranteed by MPH Acquisition Corp. 1, the direct holding company parent of MPH, and each existing and subsequently acquired or organized direct or indirect wholly owned U.S. organized restricted subsidiary of MPH (subject to certain exceptions). All such obligations, and the guarantees of such obligations, are secured, subject to permitted liens and other exceptions, by a first priority lien shared between the senior secured credit facilities and the 5.50% Senior Secured Notes on substantially all of MPH's and the subsidiary guarantors' tangible and intangible property, and a pledge of all of the capital stock of each of their respective subsidiaries.

Critical Accounting Policies

A critical accounting policy is one that is both important to the portrayal of a company's financial condition and results and requires management's most difficult, subjective, or complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. Our financial statements and accompanying notes are prepared in accordance with GAAP. Preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses. We base these determinations upon the best information available to us during the period in which we account for our financial condition and results. Our estimates and assumptions could change materially as conditions within and beyond our control change or as further information becomes available. We record changes in our estimates in the period the change occurs.

The following is a discussion of our critical accounting policies and the related management estimates and assumptions necessary in determining the value of related assets, liabilities, revenues and expenses.

Revenue Recognition

We derive revenues from contracts with customers by selling various cost management services and solutions. Variable consideration is estimated using the expected value method based on our historical experience and best judgment at the time. Due to the nature of our arrangements, certain estimates may be constrained if it is probable that a significant reversal of revenues will occur when the uncertainty is resolved. For our PSAV contracts, portions of revenues that are recognized and collected in a reporting period may be returned or credited in subsequent periods. These credits are the result of payors not utilizing the discounts that were initially calculated, or differences between our estimates of savings achieved for a customer and the amounts self-reported in the following month by that same customer. Significant judgment is used in constraining estimates of variable consideration, and these estimates are based upon both client-specific and aggregated factors that include historical billing and adjustment data, client contract terms, and performance guarantees. We update our estimates at the end of each reporting period as additional information becomes available.

See Note 2 Summary of Significant Accounting Policies of the Notes to Consolidated Financial Statements for additional information.

Goodwill

Goodwill is calculated as the excess of the purchase price in an acquisition over the fair value of identifiable net assets acquired. Acquired intangible assets are separately recognized if the benefit of the intangible asset is obtained through contractual or other legal rights, or if the intangible asset can be sold, transferred, licensed, rented, or exchanged, regardless of the Company's intent to do so.

We assess the impairment of our goodwill at least annually and whenever events or changes in circumstances indicate that the carrying value may not be recoverable. We performed our 2021 impairment assessment of goodwill and indefinite-lived intangible assets and determined that no impairment existed as of November 1, 2021. The Company's management is not aware

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of any triggering events subsequent to the impairment review, and management believes no impairments exist as of December 31, 2021 that need to be disclosed.

The goodwill arose from the acquisition of the Company in 2016 by Holdings, the HST acquisition in 2020 and the DHP acquisition in 2021. The carrying value of goodwill was $4,363.1 million and $4,257.3 million as of December 31, 2021 and 2020, respectively and no impairment has been recognized to date.

Stock-Based Compensation

Prior to the Transactions

Stock-based compensation expense includes costs associated with Units awarded to certain members of key management. Stock-based compensation is measured at the grant date based on the fair value of the Unit and is recognized as compensation expense, net of forfeitures, over the applicable requisite service period of the Unit. The fair value of the Units is remeasured at each reporting period. Based on the put right available to the employee participants, stock-based compensation Units have been accounted for as a liability classified within Holdings' consolidated financial statements and we recorded these Units within shareholders' equity as an equity contribution from Holdings based on the fair value of the outstanding Units at each reporting period.

Each individual award was composed of time vesting units and performance vesting units. Time vesting units and performance vesting units vest based on the vesting dates and the achievement of certain performance measures as defined in each award agreement. We amortize the time vesting units on a straight line basis, and the performance vesting units on a graded vesting basis.

We determined the fair value of our awards based on (i) the customized payout structure of the subject Units, (ii) liquidity timing, and (iii) vesting hurdles, as applicable, based on the output of Monte Carlo simulations. The simulation was based on a risk neutral framework which is a common technique for valuing financial derivatives that possess optionality.

Changes in the assumptions made on (i) liquidity dates, (ii) volatility, (iii) discount rates and (iv) the risk-free rate can materially affect the estimate of fair value and ultimately how much stock-based compensation expense is recognized. The Company has historically been a private company and lacked company-specific historical and implied volatility information. Therefore, it estimated its expected stock volatility based on the historical volatility of a publicly traded set of peer companies. The risk-free interest rate is based on U.S. Treasury constant maturity yields commensurate with the remaining term for each liquidity date assumption. These inputs are subjective and generally require significant analysis and judgment to develop.

The consummation of the Transactions constituted a definitive Liquidity Event under the agreements governing the Unit awards and as a result the valuation as of October 7, 2020 used the cumulative exit value of the Company, corresponding to the transaction value and prior distributions, and removed the discount for lack of marketability.

After the consummation of the Transactions

The fair value of the awards under the 2020 Omnibus Incentive Plan is measured on the grant date. We determine the fair value of the Employee RS, Employee RSUs and Director RSUs with time based vesting using the value on our common stock on the date of the grant. We determine the fair value of Employee NQSOs with an exercise price equal to the price of the Company's Class A common stock on the grant date ("at-the-money") using a Black-Scholes option pricing model while taking into consideration the price of the Company's Class A common stock, vesting conditions, and the expected term obtained using the simplified method of averaging the vesting term and the original contractual term of the options. The fair value of Employee NQSOs with an exercise price higher than the Company's Class A common stock on the grant date is estimated on the date of grant using a binomial-lattice option pricing model while taking into consideration the price of the Company's Class A common stock, vesting conditions, and a sub optimal exercise factor calibrated to the valuation obtained from the Black-Scholes options model used for a hypothetical at-the-money option with the same vesting schedules. We determine the fair value of the Fixed Value RSUs using the fixed dollar amount of the award. The Fixed Value RSUs are classified as liabilities.

We amortize the value of these awards to expense over the vesting period on a straight line basis for employees, and in the same period(s) and in the same manner as if the Company had paid cash in exchange for the goods or services instead of a share-based award for non-employees. The Company recognizes forfeitures as they occur.

See Note 15 Stock-Based Compensation of the Notes to Consolidated Financial Statements for additional information.

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Private Placement Warrants and unvested founder shares

The Company classifies the Private Placement Warrants and unvested founder shares as a long-term liability on its consolidated balance sheets. Each Private Placement Warrant and unvested founder share is initially recorded at fair value on the date of consummation of the Transactions using an option pricing model, and it is re-measured to fair value at each subsequent reporting date. The Company will continue to adjust the liability for changes in fair value for the founder shares until the earlier of the re-vesting or forfeiture of these instruments. The Company will continue to adjust the liability for changes in fair value for the private placement warrants until the warrant is equity classified.

We determine the fair value of the Private Placement Warrants and unvested founder shares using an option pricing model while taking into consideration (i) the price of the Company's Class A common stock, (ii) transfer restrictions, and (iii) vesting hurdles, as applicable. The simulation was based on a risk neutral framework which is a common technique for valuing financial derivatives that possess optionality.

Certain assumptions used in the model are subjective and require significant management judgment, and include the (i) the risk-free rate, (ii) volatility, and (iii) the discount for lack of marketability. Changes in these assumptions can materially affect the estimate of the fair value of these instruments and ultimately change in fair value of Private Placement Warrants and unvested founder shares and expenses. The Company has historically been a private company and lacked sufficient company-specific historical and implied volatility information. Therefore, it estimated its expected stock volatility based on the implied volatility of our publicly traded financial instruments and the historical volatility of a publicly traded set of peer companies. The risk-free interest rate is based on the 5 year U.S. Treasury constant maturity yields. The discount for lack of marketability for privately held securities is based on the average rate protective put method that estimates the discount based on the average price over the restriction period rather than based on the final price.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under the asset and liability method, deferred income tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred income tax assets and liabilities are measured using the enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. Deferred income tax assets are recognized for deductible temporary differences, net operating loss carryforwards, and tax credit carryforwards if it is more likely than not that the tax benefits will be realized. The ultimate realization of deferred income tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. We evaluate a variety of factors on a regular basis to determine the amount of deferred income tax assets to recognize in our financial statements, including our recent earnings history, current and projected future taxable income, the number of years our net operating loss and tax credits can be carried forward, the existence of taxable temporary differences, any changes in current tax law, such as the CARES Act, the TCJA and available tax planning strategies.

Customer Concentration

Three customers individually accounted for 34%, 19% and 10% of revenues for the year ended December 31, 2021 and 35%, 20% and 9% of revenues for each of the years ended December 31, 2020 and December 31, 2019. The loss of the business of one or more of our larger customers could have a material adverse effect on our results of operations.

Recent Accounting Pronouncements

See Note 3 New Accounting Pronouncements of the Notes to Consolidated Financial Statements for additional information.

Quantitative and Qualitative Disclosure about Market Risk

See Item 7A. Quantitative and Qualitative Disclosure about Market Risk below.

Internal Controls of Financial Reporting

See Item 9A. Controls and Procedures below.

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Item 7A. Quantitative and Qualitative Disclosures About Market Risk

As a result of our financing activities, we are exposed to market risks that may affect our consolidated results of operations and financial position. These market risks include fluctuations in interest rates, which impact the amount of interest we must pay on our variable-rate debt. Other than the interest rate swaps described below, financial instruments that potentially subject us to significant concentrations of credit risk consist principally of cash investments and trade accounts receivable.

Trade accounts receivable include amounts billed and currently due from customers, amounts currently due but unbilled, certain estimated contract changes, claims in negotiation that are probable of recovery, and amounts retained by the customer pending contract completion. We continuously monitor collections and payments from customers. Based upon historical experience and any specific customer collection issues that have been identified, we record a provision for estimated credit losses, as deemed appropriate.

While such credit losses have historically been within our expectations, we cannot guarantee that we will continue to experience the same credit loss rates in the future.

Interest Rate Risks. We are exposed to changes in interest rates. Borrowings under our senior secured credit facilities are variable rate debt. Interest rate changes generally impact the amount of our interest payments and, therefore, our future earnings and cash flows, assuming other factors are held constant. A 100-basis point increase (decrease) in the variable interest rates under Term Loan B would result in a $13.2 million increase (decrease) in interest expense, per annum on our borrowings.

We may manage our exposure to fluctuations in interest rates with respect to our senior secured credit facilities by entering into interest rate swap or cap agreements. From time to time, we have entered into interest rate swap and cap agreements or other financial instruments in the normal course of business for purposes other than trading. These financial instruments were used to mitigate interest rate or other risks, although to some extent they exposed us to market risks and credit risks. We currently have no derivative instruments and had no derivatives in 2021, 2020 and 2019.

We controlled the credit risks associated with these instruments through the evaluation of the creditworthiness of the counterparties. In the event that the counterparty failed to meet the terms of a contract or agreement then our exposure would have been limited to the current value, at that time, of the interest rate differential, not the full notional or contract amount. Management believes that such contracts and agreements were executed with creditworthy financial institutions. As such, we considered the risk of nonperformance to be remote.

In July 2017, the United Kingdom Financial Conduct Authority announced its intention to phase out LIBOR rates by the end of 2021, some of which have recently been extended to June 30, 2023. The effect of any changes in the methods by which LIBOR is determined, or any other reforms to LIBOR that may be enacted in the United Kingdom or elsewhere cannot be predicted. Such developments may cause LIBOR to perform differently from the past, including sudden or prolonged increases or decreases in LIBOR, or LIBOR may cease to exist resulting in the application of a successor base rate under our credit facilities. Either development could have unpredictable effects on our interest payment obligations, including an increase in interest payments under our credit facilities. See above for our sensitivity to an increase or decrease in the variable interest rates under Term Loan B.

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Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of MultiPlan Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of MultiPlan Corporation and its subsidiaries (the "Company") as of December 31, 2021 and 2020, and the related consolidated statements of income (loss) and comprehensive income (loss), of shareholders' equity and of cash flows for each of the three years in the period ended December 31, 2021, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the COSO.

Change in Accounting Principle

As discussed in Note 3 to the consolidated financial statements, the Company changed the manner in which it accounts for convertible instruments and contracts in an entity's own equity in 2021.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management’s Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company’s consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company’s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company’s internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the

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company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

PSAV Revenue – Variable Consideration

As described in Note 2 to the consolidated financial statements, the Company's revenue is generated from the compensation received from healthcare cost payors in exchange for various cost management services and solutions. Compensation from payors includes commissions received for each claim based on the percentage of savings ("PSAV") achieved compared to the providers' billed fee-for service rates. Revenue under a PSAV arrangement is entirely variable and variable consideration is estimated using the expected value method based on the Company's historical experience and management's best judgment at the time. Management uses significant judgment when assessing whether estimates of variable consideration are constrained and these estimates are calculated based on both client-specific and aggregated factors that include historical billing and adjustment data, client contractual terms, and performance guarantees. When assessing the estimate of variable consideration, the period of historical experience considered as part of the expected value method requires significant management judgment. For the year ended December 31, 2021, revenue from PSAV arrangements was $1,037.8 million.

The principal considerations for our determination that performing procedures relating to the PSAV revenue variable consideration, is a critical audit matter are (i) the significant judgment by management due to the measurement uncertainty involved in developing the estimates of variable consideration, as the estimates are based on assumptions developed using both client-specific and aggregated factors related to historical billing and adjustment data, including the period of historical experience utilized in determining the estimate of variable consideration, and (ii) a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating audit evidence related to management's significant assumption related to the period of historical experience.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the PSAV revenue recognition process, including controls over management's estimation of variable consideration. These procedures also included, among others, (i) testing management's process for developing the estimate of PSAV variable consideration, (ii) evaluating the appropriateness of the expected value method, (iii) testing the completeness and accuracy of underlying data used in the method, and (iv) evaluating the reasonableness of management's significant assumption related to the period of historical experience. Evaluating the reasonableness of the assumption related to the period of historical experience involved considering the historical relationships of revenue recognized and collected and amounts returned or credited in subsequent periods, and whether this assumption was consistent with evidence obtained in other areas of the audit.

Valuation of Private Placement Warrants and Unvested Founder Shares

As described in Notes 2 and 10 to the consolidated financial statements, the Company classifies the private placement warrants and unvested founder shares as a liability on its consolidated balance sheets as these instruments are precluded from being indexed to the Company's own stock given the terms allow for a settlement adjustment that does not meet the scope of the fixed-for-fixed exception in the relevant accounting guidance. The private placement warrants and unvested founder shares were initially recorded at fair value on the date of consummation of the transactions using option pricing models, and subsequently remeasured to fair value at each subsequent reporting date. Changes in these assumptions can materially affect the estimate of the fair value of these instruments and ultimately other income and expenses. Management determines the fair value of the private placement warrants and unvested founder shares using an option pricing model while taking into consideration (i) the price of the Company's Class A common stock, (ii) transfer restrictions, and (iii) vesting hurdles, as applicable. Assumptions used in the model are subjective and require significant management judgment, and include (i) the risk-free rate, (ii) volatility, and (iii) the discount for lack of marketability. Changes in these assumptions can materially affect the estimate of

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the fair value of the private placement warrants and unvested founder shares. As of December 31, 2021, the fair values of the private placement warrants and unvested founder shares were $38.0 million and $36.0 million, respectively.

The principal considerations for our determination that performing procedures relating to the valuation of the private placement warrants and unvested founder shares is a critical audit matter are (i) the significant judgment by management in determining the fair value of the private placement warrants and unvested founder shares which included the significant assumptions related to the volatility and discount for lack of marketability; (ii) the high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating audit evidence related to the valuation of the private placement warrants and unvested founder shares, and (iii) the audit effort involved the use of professionals with specialized skill and knowledge.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of private placement warrants and unvested founder shares, including controls over management's review of the significant assumptions related to the volatility and discount for lack of marketability. These procedures also included, among others, testing management’s process for determining the fair value of the private placement warrants and unvested founder shares as of the balance sheet date. Testing management’s process included (i) evaluating the methodology used by management to determine the fair value of the private placement warrants and unvested founder shares, (ii) testing the mathematical accuracy of management’s model, (iii) assessing the reasonableness of management’s significant assumptions related to the volatility and discount for lack of marketability, and (iv) testing the completeness and accuracy of data used in the model. Professionals with specialized skill and knowledge were used to assist in evaluating the methodology to determine the fair value of the private placement warrants and unvested founder shares, testing the mathematical accuracy of the model, and evaluating whether the significant assumptions related to the volatility and discount for lack of marketability used by management were reasonable considering consistency with external market data.

/s/ PricewaterhouseCoopers LLP

Chicago, Illinois
February 25, 2022

We have served as the Company’s auditor since 2009.

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MULTIPLAN CORPORATION

Consolidated Balance Sheets

(in thousands, except share and per share data)

	December 31,	
	2021	2020
Assets		
Current assets:		
Cash and cash equivalents	$ 185,328	$ 126,7
Restricted cash	3,051	
Trade accounts receivable, net	99,905	63,1
Prepaid expenses	24,910	17,7
Prepaid taxes	5,064	
Other current assets, net	999	1,1
Total current assets	319,257	208,8
Property and equipment, net	213,238	187,6
Operating lease right-of-use assets	30,104	31,3
Goodwill	4,363,070	4,257,3
Other intangibles, net	3,285,037	3,584,1
Other assets	9,701	14,2
Total assets	$ 8,220,407	$ 8,283,5
Liabilities and Shareholders' Equity		
Current liabilities:		
Accounts payable	$ 13,005	$ 15,2
Accrued interest	55,685	31,5
Accrued taxes	—	10,1
Operating lease obligation, short-term	6,883	6,4
Current portion of long-term debt	13,250	
Accrued compensation	25,419	21,8
Other accrued expenses	27,666	27,2
Total current liabilities	141,908	112,4
Long-term debt	4,879,144	4,578,4
Operating lease obligation, long-term	26,725	27,4
Private Placement Warrants and unvested founder shares	74,000	106,5
Deferred income taxes	753,825	900,6
Other liabilities	135	
Total liabilities	5,875,737	5,725,7
Commitments and contingencies (Note 13)		
Shareholders' equity:		
Shareholder interests		
Preferred stock, $0.0001 par value — 10,000,000 shares authorized; no shares issued	—	
Common stock, $0.0001 par value — 1,500,000,000 shares authorized; 665,456,180 and 664,183,318 issued; 638,338,774 and 655,075,355 shares outstanding	67	
Additional paid-in capital	2,311,660	2,530,4
Retained earnings	225,112	116,9
Treasury stock — 27,117,406 and 9,107,963 shares	(192,169)	(89,6
Total shareholders' equity	2,344,670	2,557,8
Total liabilities and shareholders' equity	$ 8,220,407	$ 8,283,5

The accompanying notes are an integral part of these consolidated financial statements

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MULTIPLAN CORPORATION

Consolidated Statements of Income (Loss) and Comprehensive Income (Loss)

(in thousands, except share and per share data)

	Years Ended December 31,		
	2021	2020	2019
Revenues	$ 1,117,602	$ 937,763	$ 982,90
Costs of services (exclusive of depreciation and amortization of intangible assets shown below)	175,292	318,675	149,60
General and administrative expenses	151,095	355,635	75,22
Depreciation	64,885	60,577	55,80
Amortization of intangible assets	340,210	334,697	334,05
Total expenses	731,482	1,069,584	614,69
Operating income (loss)	386,120	(131,821)	368,20
Interest expense	267,475	335,638	376,34
Interest income	(30)	(288)	(19
Loss (gain) on extinguishment of debt	15,843	102,993	(18,45
(Gain) loss on investments	(25)	12,165	-
Change in fair value of Private Placement Warrants and unvested founder shares	(32,596)	(35,422)	-
Net income (loss) before taxes	135,453	(546,907)	10,50
Provision (benefit) for income taxes	33,373	(26,343)	79
Net income (loss)	$ 102,080	$ (520,564)	$ 9,71
Weighted average shares outstanding – Basic	651,006,567	470,785,192	415,700,00
Weighted average shares outstanding – Diluted	651,525,791	470,785,192	415,700,00
Net income (loss) per share – Basic	*$ 0.16*	*$ (1.11)*	*$ 0.0*
Net income (loss) per share – Diluted	*$ 0.16*	*$ (1.11)*	*$ 0.0*
Comprehensive income (loss)	$ 102,080	$ (520,564)	$ 9,71

The accompanying notes are an integral part of these consolidated financial statements

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MULTIPLAN CORPORATION

Consolidated Statements of Shareholders' Equity

(in thousands, except share data)

	Common Stock Issued		Additional Paid-in Capital	Retained Earnings	Treasury stock		Total Shareholders' Equity
	Shares	Amount			Shares	Amount	
Balance as of December 31, 2018 [1]	415,700,000	$ 42	$ 1,362,493	$ 627,853	—	$ —	$ 1,990,388
Class B Unit expense	—	—	(14,880)	—	—	—	(14,880)
Net income	—	—	—	9,710	—	—	9,710
Balance as of December 31, 2019 [1]	415,700,000	$ 42	$ 1,347,613	$ 637,563	—	$ —	$ 1,985,218
Class B Unit expense (Note 15)	—	—	405,843	—	—	—	405,843
2020 Omnibus Incentive Plan (Note 15)	31,250	—	211	—	(13,087)	(117)	94
Effect of the Mergers (Note 4)	128,806,148	13	(548,636)	—	—	—	(548,623)
Private Placement Warrants and unvested founder shares (Note 10)	(12,404,080)	(2)	(142,017)	—	—	—	(142,019)
PIPE Investment, net of costs (Note 4)	132,050,000	13	1,467,396	—	—	—	1,467,409
Treasury stock purchases	—	—	—	—	(9,094,876)	(89,493)	(89,493)
Net loss	—	—	—	(520,564)	—	—	(520,564)
Balance as of December 31, 2020	664,183,318	$ 66	$ 2,530,410	$ 116,999	(9,107,963)	$ (89,610)	$ 2,557,865
Effect of ASU 2020-06 (Note 3)	—	—	(233,874)	6,033	—	—	(227,841)
2020 Omnibus Incentive Plan (Note 15)	1,272,862	1	16,354	—	—	—	16,355
Tax withholding related to vesting of equity awards	—	—	(1,230)	—	(345,733)	(2,559)	(3,789)
Repurchase of common stock	—	—	—	—	(17,663,710)	(100,000)	(100,000)
Net income	—	—	—	102,080	—	—	102,080
Balance as of December 31, 2021	665,456,180	$ 67	$ 2,311,660	$ 225,112	(27,117,406)	$ (192,169)	$ 2,344,670

[1] The shares of the Company's common stock, prior to the Transactions, have been retroactively restated as shares reflecting the exchange ratio established in the Transactions.

The accompanying notes are an integral part of these consolidated financial statements

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MULTIPLAN CORPORATION

Consolidated Statements of Cash Flows

(in thousands)

	Years Ended December 31,		
	2021	2020	2019
Operating activities:			
Net income (loss)	$ 102,080	$ (520,564)	$ 9,710
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation	64,885	60,577	55,807
Amortization of intangible assets	340,210	334,697	334,053
Amortization of the right-of-use asset	6,963	8,405	9,594
Stock-based compensation	18,010	406,054	(14,880)
Deferred income taxes	(81,929)	(45,041)	(111,404)
Non-cash interest costs	12,259	22,888	13,368
Loss on extinguishment of debt	15,843	102,993	(18,450)
Loss on equity investments	—	12,165	—
Loss on disposal of property and equipment	2,991	610	163
Change in fair value of Private Placement Warrants and unvested founder shares	(32,596)	(35,422)	—
Changes in assets and liabilities, net of assets acquired and liabilities assumed from acquisitions:			
Accounts receivable, net	(33,826)	14,758	5,279
Prepaid expenses and other assets	(6,952)	(7,480)	(8,822)
Prepaid taxes	(5,064)	2,130	(1,426)
Operating lease obligation	(5,900)	(8,461)	(9,462)
Accounts payable and accrued expenses and other	7,713	29,065	20,783
Net cash provided by operating activities	404,687	377,374	284,313
Investing activities:			
Purchases of property and equipment	(84,590)	(70,813)	(66,414)
Proceeds from sale of investment	5,641	—	—
HST Acquisition, net of cash acquired	246	(140,032)	—
DHP Acquisition, net of cash acquired	(149,676)	—	—
Net cash used in investing activities	(228,379)	(210,845)	(66,414)
Financing activities:			
Repayments of Term Loan G	(2,341,000)	(369,000)	(100,000)
Extinguishment of 7.125% Notes	—	(1,615,583)	—
Extinguishment of Senior PIK Notes	—	(1,202,302)	(101,013)
Issuance of Senior Convertible PIK Notes	—	1,267,500	—
Issuance of 5.750% Notes	—	1,300,000	—
Repayments of Term Loan B	(3,313)	—	—
Issuance of Term Loan B	1,298,930	—	—
Issuance of 5.50% Senior Secured Notes	1,034,520	—	—
Taxes paid on settlement of vested share awards	(3,789)	—	—
Borrowings on revolving credit facility	—	98,000	—
Repayment of revolving credit facility	—	(98,000)	—
Effect of the Transactions	—	682,408	—
Purchase of treasury stock	(100,000)	(101,123)	—
Payment of debt issuance costs	—	(23,489)	—

MULTIPLAN CORPORATION

Consolidated Statements of Cash Flows Continued

(in thousands)

	Years Ended December 31,		
	2021	2020	2019
Borrowings on finance leases, net	(32)	(10)	(
Net cash used in financing activities	(114,684)	(61,599)	(201,0
Net increase in cash, cash equivalents and restricted cash	61,624	104,930	16,8
Cash, cash equivalents and restricted cash at beginning of period	126,755	21,825	5,0
Cash, cash equivalents and restricted cash at end of period	$ 188,379	$ 126,755	$ 21,8
Cash and cash equivalents	$ 185,328	$ 126,755	$ 21,8

Restricted cash	3,051	—	
Cash, cash equivalents and restricted cash at end of period	$ 188,379	$ 126,755	$ 21,8
Noncash investing and financing activities:			
Purchases of property and equipment not yet paid	$ 5,930	$ 4,334	$ 3,7
Operating lease right-of-use assets obtained in exchange for operating lease liabilities	$ 6,880	$ 10,210	$ 4,0
Supplemental disclosure of cash flow information:			
Cash paid during the period for:			
Interest	$ (231,049)	$ (312,349)	$ (363,9
Income taxes, net of refunds	$ (131,517)	$ (3,917)	$ (114,5

The accompanying notes are an integral part of these consolidated financial statements

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MULTIPLAN CORPORATION

Notes to Consolidated Financial Statements

1. General Information and Business

General Information

MultiPlan Corporation, formerly known as Churchill Capital Corp III, was incorporated in Delaware on October 30, 2019 for the purpose of effecting a merger, capital stock exchange, asset acquisition, stock purchase, reorganization or similar business combination with one or more businesses.

On July 12, 2020, Churchill entered into the Merger Agreement by and among First Merger Sub, Second Merger Sub, Holdings, and MultiPlan Parent. On October 8, 2020, the Merger Agreement was consummated and the Transactions were completed. In connection with the Transactions, Churchill changed its name to MultiPlan Corporation and The New York Stock Exchange ticker symbols for its Class A common stock and warrants to "MPLN" and "MPLN.WS", respectively.

The Transactions were accounted for as a reverse recapitalization. Under this method of accounting, Churchill has been treated as the acquired company for financial reporting purposes. This determination was primarily based on our existing stockholders being the majority stockholders and holding majority voting power in the combined company, our senior management comprising the majority of the senior management of the combined company, and our ongoing operations comprising the ongoing operations of the combined company. Accordingly, for accounting purposes, the Transactions were treated as the equivalent of MultiPlan issuing shares for the net assets of Churchill, accompanied by a recapitalization. The net assets of Churchill were recognized at fair value (which were consistent with carrying value), with no goodwill or other intangible assets recorded. Operations prior to the Transactions in these financial statements are those of Polaris and the retained earnings of Polaris has been carried forward after the Transactions. Earnings per share calculations for all periods prior to the Transactions have been retrospectively adjusted for the equivalent number of shares reflecting the exchange ratio established in the Transactions.

Throughout the Notes to Consolidated Financial Statements, unless otherwise noted, "we," "us," "our", "MultiPlan", and the "Company" and similar terms refer to Polaris and its subsidiaries prior to the consummation of the Transactions, and MultiPlan and its subsidiaries after the Transactions.

Business

We are a provider of data analytics and technology-enabled solutions designed to bring affordability, efficiency and fairness to the U.S. healthcare industry. We do so through services focused on reducing medical cost and improving payment accuracy for the payors of healthcare, which are health insurers, self-insured employers and other health plan sponsors (typically through their health plan administrators), and, indirectly, the plan members who are the consumers of healthcare services. The Company, through its operating subsidiary, MultiPlan, Inc., offers these solutions nationally through its Analytics-Based Services, which reduce medical cost through data-driven algorithms which detect claims over-charges and either negotiate or recommend fair reimbursement using a variety of data sources and pricing algorithms, its Network-Based Services, which reduce medical cost through contracted discounts to form one of the largest independent preferred provider organizations in the United States, and outsourced network development and/or management services; and its Payment and Revenue Integrity Services, which reduce medical cost through data, technology, and clinical expertise deployed to identify and remove improper and unnecessary charges before or after claims are paid, or to identify and help restore and preserve underpaid premium dollars. We are a technology-enabled service provider and transaction processor and do not deliver health-care services, bear insurance risk, underwrite risk, provide or manage healthcare services, provide care or care management, or adjudicate or pay claims.

Although the end beneficiary of our services are employers and other plan sponsors and their health plan members, for the most part our customers are payors. We offer these payors a single electronic gateway to a highly-integrated and comprehensive set of services in each of the above three categories, which are used in combination or individually to reduce the medical cost burden on their health plan customers and members while fostering fair and efficient payments to the providers. For the year ended December 31, 2021, our expansive network included access to over 1.2 million healthcare providers.

Payors generally aim to pay provider claims at a discount to reduce cost, to eliminate any improperly billed charges before payment is made, and to recover any incorrectly paid charges after payment is made. Our Analytics-Based Services discount claims using data-driven negotiation and/or re-pricing methodologies to support payments to providers with whom contractual discounts are not possible and are generally priced based on a percentage of savings achieved. Also included in this category are services that enable lower cost health plans that feature reference-based pricing either in conjunction with or in place of a provider network. These services are generally priced at a bundled PEPM rate. Our Network-Based Services offer payors a

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broad network of discounted rates for providers with whom payors do not have a contractual relationship, and are priced based on either a percentage of savings achieved or at a per employee/member per month fee. This service category also includes customized network development and management services for payors seeking to expand their network footprint using outsourced services. These build services are generally priced on a per contract or other project-based price. Our Payment and Revenue Integrity Services use data, technology and clinical expertise to assist payors in identifying improper, unnecessary and excessive charges before or after claims are paid, as well as issues with premiums paid by CMS for government health plans caused by discrepancies with enrollment-related data. Payment and Revenue Integrity Services are generally priced based on a percentage of savings achieved.

2. Summary of Significant Accounting Policies

Basis of Presentation and Consolidation

The accompanying consolidated financial statements have been prepared in accordance with GAAP. The consolidated financial statements include the accounts of all subsidiaries, all of which are wholly owned.

The consolidated financial statements include the accounts of the Company and its subsidiaries for the years ended December 31, 2021, December 31, 2020 and December 31, 2019. Intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of the consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenues and expenses during the reporting periods. Actual results could differ from the Company's estimates. Estimates are periodically reviewed in light of changes in circumstances, facts and experience. Changes in estimates are recorded in the period in which they become known. Significant estimates and assumptions reflected in these consolidated financial statements include, but are not limited to revenue recognition, recoverability of long-lived assets, goodwill, valuation of debt instruments, valuation of stock-based compensation awards and income taxes.

COVID-19

COVID-19 has negatively impacted our business, results of operations, and financial condition during the years ended December 31, 2021 and 2020. Effects from COVID-19 began to impact our business in first quarter 2020 with various federal, state, and local governments and private entities mandating restrictions on travel, restrictions on public gatherings, closure of non-essential commerce, and shelter in place orders. The Company experienced an approximately 4.6% decline in revenues for the year ended December 31, 2020 compared to 2019 primarily due to reduced volume from customers as a result of restrictions on elective medical procedures and non-essential medical services. For the year ended December 31, 2021, the Company's revenues continue to be negatively impacted, but to a lesser extent compared to 2020 as vaccination rates have increased and restrictions on medical services have been lifted. The extent of the ultimate impact of COVID-19 will depend on the severity and duration of the pandemic. Future developments remain uncertain, including the number of confirmed cases, the emergence of highly contagious variants, and any actions taken by federal, state and local governments such as economic relief efforts, as well as U.S. and global economies, consumer behavior and healthcare utilization patterns.

Segment Reporting

Operating segments are defined as components of an entity for which separate financial information is available and regularly reviewed by the chief operating decision maker. The Company manages its operations as a single segment for the purposes of assessing performance and making decisions. The Company's singular focus is being a leading value-added provider of data analytics and technology-enabled end-to-end cost management, payment and revenue integrity solutions to the U.S. healthcare industry.

In addition, all of the Company's revenues and long-lived assets are attributable to operations in the United States for all periods presented.

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MULTIPLAN CORPORATION

Notes to Consolidated Financial Statements

Business Combinations

The Company determines whether substantially all the fair value of the gross assets acquired is concentrated in a single identifiable asset or group of similar identifiable assets. If this threshold is met, the set is not a business. If it is not met, the Company then evaluates whether the set meets the requirement that a business include, at a minimum, an input and a substantive process that together significantly contribute to the ability to create outputs.

Business combinations are accounted for using the acquisition method at the acquisition date, which is when control is obtained. The consideration transferred is generally measured at fair value, as are the identifiable assets acquired and liabilities assumed. During the one-year period following the acquisition date, if an adjustment is identified based on new information about facts and circumstances that existed as of the acquisition date, the Company will record measurement-period adjustments related to the acquisitions in the period in which the adjustment is identified.

Goodwill is measured at the acquisition date as the fair value of the consideration transferred (including, if applicable, the fair value of any previously held equity interest and any non-controlling interests) less the net recognized amount (which is generally the fair value) of the identifiable assets acquired and liabilities assumed.

Transaction costs, other than those associated with the issuance of debt or equity securities incurred in connection with a business combination, are expensed as incurred and included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

Cash and Cash Equivalents

The Company considers all highly liquid investments purchased with original maturities of three months or less to be cash equivalents. The carrying amount of these investments approximates fair value due to the short maturity of those investments. The Company had deposits in a major financial institution that exceeded Federal Deposit Insurance Corporation insurance limits. Management believes the credit risk related to these deposits is minimal.

Restricted Cash

In accordance with local insurance regulations, our insurance captive is required to meet and maintain minimum solvency capital requirements. The cash and cash equivalents held by our insurance captive have been classified in the line item restricted cash in our consolidated balance sheets because the assets are not available to satisfy our current obligations. See the Insurance section of this footnote for additional information on our captive insurance company.

Accounts Receivable

Accounts receivable are stated at the net amount expected to be collected, using an expected loss methodology that is referred to as the CECL.

Allowance for Doubtful Accounts

The Company is paid for virtually all of its services by insurance companies, third-party administrators and employers. Management estimates constraints on variable consideration for anticipated contractual billing adjustments that its clients or the Company may make to invoiced amounts; refer to *Revenue Recognition* accounting policies for additional detail. Management also maintains allowances for doubtful accounts for estimated losses resulting from the Company's clients' inability to make required payments. The Company establishes an allowance for doubtful accounts based upon a specific customer's credit risk.

The following table details the changes in the allowance for doubtful accounts:

(in thousands)	2021	2020	2019
Allowance as of January 1,	$ 466	$ 408	$ 529
Provision for doubtful accounts	—	58	—
Write-offs of uncollectible receivables	(51)	—	(121)
Allowance as of December 31,	$ 415	$ 466	$ 408

Management regularly evaluates the adequacy of the assumptions used in determining these allowances and adjusts as necessary. Changes in estimates are recognized in the period in which they are determined. Management writes off accounts

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after all substantial collection efforts have failed and any resulting losses are included in general and administrative expenses within our consolidated statements of income (loss) and comprehensive income (loss).

Property and Equipment

Property and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses, if any. Major expenditures for property and equipment and those that substantially increase useful lives are capitalized. Direct internal and external costs of developing software for internal use, including programming and enhancements, are capitalized and amortized over the estimated useful lives once the software is ready for its intended use. Software training costs, maintenance and repairs are expensed as incurred. When assets are sold or otherwise disposed of, costs and related accumulated depreciation are removed from the financial statements and any resulting gains or losses are included in costs of goods sold and general and administrative expenses within our consolidated statements of income (loss) and comprehensive income (loss).

The Company provides for depreciation and amortization on property and equipment using the straight-line method to allocate the cost of depreciable assets over their estimated lives as follows:

Asset Classification	Estimated Useful Life
Leasehold improvements	The shorter of the life of lease or asset life, 5 – 15 years
Furniture and equipment	5 – 7 years
Computer hardware	3 – 5 years
Computer software	3 – 5 years

Internal-use software development costs incurred in the preliminary project stage are expensed as incurred; costs incurred in the application and development stage, that meet the capitalization criteria, are capitalized and amortized on a straight-line basis over the estimated useful life of the asset, generally five years; and costs incurred in the post-implementation/operations stage are expensed as incurred.

Leases

Substantially all of our operating leases are related to office space we lease in various buildings for our own use. The terms of these non-cancelable operating leases typically require us to pay rent and a share of operating expenses and real estate taxes. We also lease equipment under both operating and finance lease arrangements. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

ROU assets represent the Company's right to control the use of the underlying assets for the lease term and lease liabilities represent the Company's obligations to make lease payments arising from the Company's portfolio of leases. Operating lease ROU assets and operating lease liabilities are recognized based on the present value of the future lease payments over the lease term beginning at the lease commencement date. The lease term is the non-cancelable period of the lease, and includes any renewal and termination options we are reasonably certain to exercise. The reasonably certain threshold is evaluated at lease commencement and is typically met if substantial economic incentives or termination penalties are identified. The operating lease ROU assets are adjusted for lease incentives, any lease payments made prior to the commencement date and initial direct costs, if incurred. Our leases generally do not include an implicit rate; therefore, we use an incremental borrowing rate based on information available at the lease commencement date in determining the present value of future lease payments. The incremental borrowing rate is determined using an approach based on the rate of interest that the lessee would pay to borrow on a collateralized basis over a similar term at an amount equal to the lease payments in a similar economic environment. We utilized a market-based approach to estimate the incremental borrowing rate for each individual lease. The lease expense for our operating leases is recognized on a straight-line basis over the lease term and is included in cost of services or general and administrative expenses in our consolidated statements of income (loss) and comprehensive income (loss).

Finance leases are included in property and equipment, net and in long-term debt on our consolidated balance sheets. Our finance leases are not material to the financial statements as a whole.

Leases with an initial term of 12 months or less are not recorded on the balance sheet; lease expense is recognized for these short-term leases on a straight-line basis over the lease term.

See Note 7 Leases for additional information on leases.

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Goodwill and Other Intangible Assets

Goodwill is calculated as the excess of the purchase price in an acquisition over the fair value of identifiable net assets acquired. Acquired intangible assets are separately recognized if the benefit of the intangible asset is obtained through contractual or other legal rights, or if the intangible asset can be sold, transferred, licensed, rented, or exchanged, regardless of the Company's intent to do so.

The Company assesses the impairment of its goodwill and indefinite-lived intangible assets at least annually on November 1 and whenever events or changes in circumstances indicate that the carrying value may not be recoverable.

Important factors that may trigger an impairment review include but are not limited to:

- significant underperformance relative to expected historical or projected future operating results;
- significant changes in the manner of use of the acquired assets or the strategy for the overall business;
- significant negative industry or economic trends; and
- significant decline in the Company's estimated enterprise value relative to carrying value.

The Company is required to write down its goodwill and indefinite-lived intangible assets if they are determined to be impaired. The Company tests its goodwill for impairment on a reporting unit basis. A reporting unit is the operating segment unless, at businesses one level below the operating segment (the component level), discrete financial information is prepared and regularly reviewed by management and the businesses are not otherwise aggregated due to having certain common characteristics, in which case such component is the reporting unit.

We have the option to assess goodwill for impairment by initially performing a qualitative assessment to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If we determine that it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, then the quantitative goodwill impairment test is not required to be performed. If we determine that it is more likely than not that the fair value of a reporting unit is less than its carrying amount, or if we do not elect the option to perform an initial qualitative assessment, we perform a quantitative goodwill impairment test. In the quantitative impairment test, we calculate the estimated fair value of the reporting unit using a (i) discounted cash flow analysis, (ii) comparable public company analysis and (iii) comparable acquisitions analysis, giving equal weight to the three approaches. If the carrying amount of the reporting unit after all of the reporting unit's other assets (excluding goodwill) have been adjusted for impairment exceeds the estimated fair value, an impairment charge is recorded for the amount that its carrying amount, including goodwill, exceeds its fair value, limited to the total amount of goodwill allocated to that reporting unit.

Indefinite-lived intangible assets, such as certain trademarks with indefinite lives, are subject to an impairment review annually and whenever indicators of impairment exist. We have the option to assess indefinite-lived intangible assets for impairment by first performing qualitative assessments to determine whether it is more-likely-than-not that the fair values of the indefinite-lived intangible assets are less than the carrying amounts. If we determine that it is more-likely-than-not that an indefinite-lived intangible asset is impaired, or if we elect not to perform an initial qualitative assessment, we then perform the quantitative impairment test by comparing the fair value of the indefinite-lived intangible asset with its carrying amount. If the carrying amount exceeds the fair value of the indefinite-lived intangible asset, we write the carrying amount down to the fair value.

We performed our 2021 qualitative impairment assessment of goodwill and indefinite-lived intangible assets and determined that no impairment existed as of November 1, 2021. No goodwill or indefinite-lived intangible asset impairment was identified in any of the periods presented. The Company's management is not aware of any triggering events subsequent to the impairment review, and management concludes no impairment exists as of December 31, 2021.

The value of definite-lived intangible assets is recorded at their acquisition date fair value and amortized on a straight-line basis over their estimated lives. The Company tests definite-lived intangible assets for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. We measure recoverability of these assets by comparing the carrying amounts to the future undiscounted cash flows that the assets or the asset group are expected to generate. If the assets are considered to be impaired, the impairment to be recognized equals the amount by which the carrying value of the asset exceeds its fair market value. No definite-lived intangible asset impairment was identified in any of the periods presented.

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Following is a summary of the range of estimated useful life of other intangible assets:

Asset Classification	Range of Estimated Useful Life
Client relationships	10 to 16 years
Provider Network	15 years
Technology	4 to 5 years
Trade Names	1 year to indefinite

See Note 8 Goodwill and Other Intangible Assets for additional information.

Revenue Recognition

All revenue recognized in the consolidated statements of income (loss) and comprehensive income (loss) is considered to be revenue from contracts with customers.

Revenue is generated from the compensation received from healthcare cost payors in exchange for various cost management services and solutions. Our service offerings include the following: (i) Network-Based Solutions that process claims at a discount compared to billed fee-for-service rates while using an extensive network, (ii) Analytics-Based Solutions that use its leading and proprietary information technology platform to offer clients Analytics-Based Solutions to reduce medical costs and (iii) Payment and Revenue Integrity Solutions that use data, technology and clinical expertise to identify improper, unnecessary and excessive charges. Compensation from payors includes (1) commissions received for each claim based on the PSAV achieved compared to the providers' billed fee-for service rates and (2) fees for standing ready to provide cost management solutions for each covered member, which are based on a PEPM.

Our performance obligation to the customer for a PSAV arrangement is the cost management services provided for each submitted claim regardless of the service offering used to achieve savings, as they are not distinct in the context of the contract. Our performance obligation for PEPM arrangements is to stand ready to process and achieve savings for all covered members each month.

For services performed under a PSAV arrangement, the Company enters into a contract with the customer once the claim is submitted. Revenue under a PSAV arrangement is entirely variable and estimated using the expected value method obtained by applying the contractual rates to the materialized savings that can be reliably estimated leveraging extensive historical data of results obtained for claims of similar nature. Revenue is recognized at a point in time where the customer obtains control over the service promised by the Company, which generally occurs when the Company successfully transfers the savings for the claim to the customer. Judgment is not typically required when assessing whether the savings have materialized.

Fees from customers for standing ready to provide cost management solutions for each customer's members each month vary depending on the number of employees covered each month. PEPM contracts represent a series of performance obligations to stand ready to provide cost management solutions to our customers' covered employees on a monthly basis with each time increment representing a distinct service. We recognize revenue over time using the time elapsed output method. In accordance with the series guidance, we allocate variable consideration to the period to which the fees relate.

Variable consideration is estimated using the expected value method based on our historical experience and best judgment at the time. Due to the nature of our arrangements, certain estimates may be constrained if it is probable that a significant reversal of revenue will occur when the uncertainty is resolved. For our PSAV contracts, portions of revenue that is recognized and collected in a reporting period may be returned or credited in subsequent periods. These credits are the result of payors not utilizing the discounts that were initially calculated, or differences between the Company's estimates of savings achieved for a customer and the amounts self-reported in the following month by that same customer. Significant judgment is used when assessing whether estimates of variable consideration are constrained and these estimates are calculated based upon both client-specific and aggregated factors that include historical billing and adjustment data, client contract terms, and performance guarantees. When assessing the estimate of variable consideration, the period of historical experience considered as part of the expected value method requires significant management judgment. We update our estimates at the end of each reporting period as additional information becomes available.

The timing of payments from customers from time to time generates contract assets or contract liabilities; however these amounts are immaterial in all periods presented.

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Payment terms vary on a contract-by-contract basis, although terms generally include a requirement of payment within 15 to 30 days. We do not have any significant financing components in our contracts with customers.

The Company expenses sales commissions and other costs to obtain a contract when incurred, because our commissions are deemed contingent on factors broader than the simple intention of the contracts and cannot be considered directly incremental. These costs are recorded within cost of services.

Practical Expedients and Accounting Policy Elections

The Company excludes sales taxes and other similar taxes from the measurement of the transaction price.

The Company does not disclose the value of unsatisfied performance obligations, nor do we disclose the timing of revenue recognition for contracts with an original expected length of one year or less.

The Company uses a portfolio approach when estimating the amount of consideration it expects to receive from certain classes of customer contracts with similar characteristics, and expects that the difference from applying the new revenue standard to a portfolio of contracts as compared to an individual contract would not result in a material effect on the financial statements.

Disaggregation of Revenue

The following table presents revenues disaggregated by services and contract types:

	For the Year Ended December 31,		
(in thousands)	**2021**	**2020**	**2019**
Revenues			
Network Services	**$ 278,457**	**$ 271,262**	**$ 314,510**
PSAV	*215,449*	*208,276*	*249,095*
PEPM	*55,684*	*55,301*	*56,841*
Other	*7,324*	*7,685*	*8,574*
Analytic-Based Services	**709,272**	**564,661**	**561,525**
PSAV	*692,880*	*560,981*	*560,675*
PEPM	*16,392*	*3,680*	*850*
Payment Integrity Services	**129,873**	**101,840**	**106,866**
PSAV	*129,477*	*101,753*	*106,782*
PEPM	*396*	*87*	*84*
Total Revenues	**$ 1,117,602**	**$ 937,763**	**$ 982,901**

Costs of Services

Costs of services consist of all costs specifically associated with claims processing activities for customers, sales and marketing and the development and maintenance of the Company's networks and analytics-based solutions.

Insurance

The Company employs various risk transfer methodologies in dealing with the various insurance policies it purchases, including, for certain risks, a wholly-owned captive insurance subsidiary. These methodologies include the use of large deductible programs and self-insured retentions with stop loss limits. Errors and omissions liability, directors and officers liability, fiduciary liability, cybersecurity, employment practices liability and crime insurance are all claims made coverages and utilize self-insured retentions subject to an annual aggregate limit. These self-insured retentions range from $10,000 to $20,000,000 per claim. The Company retains the services of an insurance broker to assess current risk and exposure levels as a standalone entity. The appropriate types and levels of coverage were determined by the Company, and the Company had active policies providing the desired level of coverage deemed necessary by the Company.

Health insurance and employee benefits are subject to the participant's deductible amounts with amounts exceeding the deductibles self-insured by the Company. The Company uses historical claim data and loss trends to project incurred losses and record loss reserves. Other factors utilized in determining loss reserves include, but are not limited to, the amount and timing of

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historical payments, severity of individual claims, jurisdictional considerations, the anticipated future volume of claims, the life span of various types of claims and input from the Company's legal representatives responsible for the defense of these claims. The ultimate value of casualty claims (primarily general liability) and professional liability (primarily errors and omissions) claims may take several years before becoming known. Liabilities associated with the risks that are retained by the Company are not discounted.

The Company’s wholly-owned captive insurance subsidiary receives direct premiums, which are netted against the Company’s insurance company costs in general and administrative expenses, in the consolidated statements of income (loss) and comprehensive income (loss).

Stock-Based Compensation

Prior to the Transactions

The Company's awards were granted in the form of Units via the Polaris Agreement.

Stock-based compensation was measured at the grant date based on the fair value of the award and was recognized as compensation expense, net of forfeitures, over the applicable requisite service period of the stock award using the straight-line method for awards with only service conditions and using the graded-vesting method for awards with performance conditions. The fair value of the awards was remeasured at each reporting period. The Units were classified as liabilities and their fair value was remeasured at each reporting period.

We determined the fair value of our awards based on (i) the customized payout structure of the subject Units, (ii) liquidity timing, and (iii) vesting hurdles, as applicable, based on the output of Monte Carlo simulations. The simulation was based on a risk neutral framework which is a common technique for valuing financial derivatives that possess optionality.

Changes in the assumptions made on (i) liquidity dates, (ii) volatility, (iii) discount rates and (iv) the risk-free rate can materially affect the estimate of fair value and ultimately how much stock-based compensation expense was recognized. The Company has historically been a private company and lacked company-specific historical and implied volatility information. Therefore, it estimated its expected stock volatility based on the historical volatility of a publicly traded set of peer companies. The risk-free interest rate is based on US Treasury constant maturity yields commensurate with the remaining term for each liquidity date assumption. These inputs are subjective and generally require significant analysis and judgment to develop.

After the consummation of the Transactions

The Company's awards are granted via the 2020 Omnibus Incentive Plan in the form of Employee RS, Employee RSUs, Fixed Value RSUs, Employee NQSOs (together "employee awards"), and Director RSUs.

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as compensation expense for employee awards, net of forfeitures, over the applicable requisite service period of the stock award using the straight-line method for awards with only service conditions. The compensation expense for Director RSUs is recognized in the same period(s) and in the same manner as if the Company had paid cash in exchange for the goods or services instead of a share-based award. The Company recognizes forfeitures as they occur.

We determine the fair value of the Employee RS, Employee RSUs and Director RSUs with time based vesting using the value on our common stock on the date of the grant.

We determine the fair value of Employee NQSOs with an exercise price equal to the price of the Company's Class A common stock on the grant date ("at-the-money") using a Black-Scholes option pricing model while taking into consideration the price of the Company's Class A common stock, vesting conditions, and the expected term obtained using the simplified method of averaging the vesting term and the original contractual term of the options. The fair value of Employee NQSOs with an exercise price higher than the Company's Class A common stock on the grant date ("out-of-the-money") is estimated on the date of grant using a binomial-lattice option pricing model while taking into consideration the price of the Company's Class A common stock, vesting conditions, and a sub optimal exercise factor calibrated to the valuation obtained from the Black-Scholes options model used for a hypothetical at-the-money option with the same vesting schedules.

We determine the fair value of the Fixed Value RSUs using the fixed dollar amount of the award. The Fixed Value RSUs are classified as liabilities.

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Certain assumptions used in the model are subjective and require significant management judgment, and include the (i) risk-free rate, (ii) volatility, (iii) expected term, and (iv) suboptimal exercise factor. The Company has historically been a private company and lacked sufficient company-specific historical and implied volatility information. Therefore, it estimated its expected stock volatility based on the implied volatility of our publicly traded financial instruments and the historical volatility of a publicly traded set of peer companies. The risk-free interest rate is based on the interpolated 5 and 7 year U.S. Treasury constant maturity yields. Changes in these assumptions can materially affect the estimate of the grant date fair value of the Employee NQSOs and ultimately compensation expenses.

See Note 15 Stock-Based Compensation for further information.

Private Placement Warrants and Unvested Founder Shares

The Company classifies the Private Placement Warrants and unvested founder shares as a liability on its consolidated balance sheets as these instruments are precluded from being indexed to our own stock given the terms allow for a settlement adjustment that does not meet the scope of the fixed-for-fixed exception in ASC 815.

The Private Placement Warrants and unvested founder shares were initially recorded at fair value on the date of consummation of the Transactions and are subsequently adjusted to fair value at each subsequent reporting date. Changes in the fair value of these instruments are recognized within change in fair value of Private Placement Warrants and unvested founder shares in the consolidated statements of income (loss) and comprehensive income (loss). The fair value of the unvested founder shares and unvested Private Placement Warrants is obtained using a Monte Carlo model and the fair value of the remaining Private Placement Warrants using a Black Scholes model, together referenced as the "option pricing" model. The Company will continue to adjust the liability for changes in fair value for the founder shares until the earlier of the re-vesting or forfeiture of these instruments. The Company will continue to adjust the liability for changes in fair value for the Private Placement Warrants until the warrant is equity classified.

We determine the fair value of the Private Placement Warrants and unvested founder shares using an option pricing model while taking into consideration (i) the price of the Company's Class A common stock, (ii) transfer restrictions, and (iii) vesting hurdles, as applicable. The simulation was based on a risk neutral framework which is a common technique for valuing financial derivatives that possess optionality.

Certain assumptions used in the model are subjective and require significant management judgment, and include the (i) the risk-free rate, (ii) volatility, and (iii) the discount for lack of marketability. Changes in these assumptions can materially affect the estimate of the fair value of these instruments and ultimately other income and expenses. The Company has historically been a private company and lacked sufficient company-specific historical and implied volatility information. Therefore, it estimated its expected stock volatility based on the implied volatility of our publicly traded financial instruments and the historical volatility of a publicly traded set of peer companies. The risk-free interest rate is based on the 5 year U.S. Treasury constant maturity yields. The discount for lack of marketability for privately held securities is based on the average rate protective put method that estimates the discount based on the average price over the restriction period rather than based on the final price.

Customer Concentration

Three customers individually accounted for 34%, 19% and 10% of revenues for the year ended December 31, 2021 and 35%, 20% and 9% of revenues for each of the years ended December 31, 2020 and December 31, 2019. The loss of the business of one or more of our larger customers could have a material adverse effect on our results of operations.

Fair Value of Financial Instruments

The carrying amounts of the Company's financial instruments, which include cash and accounts receivable, approximate their fair values due to their short maturities.

The fair value of long-term debt is based on interest rates currently available for instruments with similar terms. The fair value of the Private Placement Warrants and unvested founder shares described in Note 10 Private Placement Warrants and Unvested Founder Shares is based on the price of the Company's Class A common stock while taking in consideration restrictions and vesting conditions, as applicable.

See Note 11 Fair Value Measurements for additional details.

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Income Taxes

The Company accounts for income taxes using the asset and liability method. Under the asset and liability method, deferred income tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred income tax assets and liabilities are measured using the enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. Deferred income tax assets are recognized for deductible temporary differences, net operating loss carry forwards and tax credit carry forwards if it is more likely than not that the tax benefits will be realized. The ultimate realization of deferred income tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible.

The Company evaluates all factors on a regular basis to determine the amount of deferred income tax assets to recognize in the financial statements, including its recent earnings history, current and projected future taxable income, the number of years its net operating loss and tax credits can be carried forward, the existence of taxable temporary differences and available tax planning strategies.

Earnings and Loss per Common Share

The Company calculates basic EPS based on the weighted average number of common shares outstanding for the period.

The Company determines diluted EPS using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with warrants, shares which may be issued upon conversion of the Senior Convertible PIK Notes, unvested founder shares and awards within the 2020 Omnibus Incentive Plan (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares. Out-of-the-money common stock equivalents are considered anti-dilutive and are excluded in the computation of diluted EPS.

In periods when the Company records net loss, common stock equivalents are excluded in the computation of diluted EPS because their inclusion would be anti-dilutive.

See Note 17 Basic and Diluted Earnings and Loss Per Share for additional information.

3. New Accounting Pronouncements

We consider the applicability and impact of all ASUs and applicable authoritative guidance. The ASUs not listed below were assessed and determined to be either not applicable or are expected to have an immaterial impact on our consolidated financial position.

New Accounting Pronouncements Recently Adopted

ASU 2016-13, Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses. In 2016, the FASB issued Accounting Standards Update ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses* on Financial Instruments including subsequent amendments to the initial guidance: ASU 2019-04, Codification Improvements to Topic 326, Financial Instruments-Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments, ASU 2019-05, Financial Instruments - Credit Losses (Topic 326): Targeted Transition Relief and ASU 2019-11, Codification Improvements to Topic 326, Financial Instruments - Credit Losses. ASU 326 and related amendments require credit losses on financial instruments measured at amortized cost basis to be presented at the net amount expected to be collected, replacing the current incurred loss approach with an expected loss methodology that is referred to as CECL. The new standard is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. We adopted this standard on January 1, 2020, using a modified retrospective approach. Our financial instruments in the scope of the new standard consist primarily of trade receivables and loans. The adoption of ASC 326 had no material impact on our consolidated financial statements.

ASU 2018-15, Intangibles-Goodwill and Other - Internal-Use Software (Subtopic 350-40) - Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract. In August 2018, the FASB issued ASU 2018-15, *Intangibles-Goodwill and Other - Internal-Use Software (Subtopic 350-40) - Customer's Accounting for*

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Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract. This ASU addresses a customer's accounting for implementation costs incurred in a cloud computing arrangement that is a service contract. The amendment aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal-use software license). We adopted this new accounting standard as of January 1, 2020 on a prospective basis. The adoption of this ASU did not have a material impact on our consolidated financial statements.

ASU 2018-13, Fair Value Measurement (Topic 820): Disclosure Framework - Change to the Disclosure Requirements for Fair Value Measurement. In June 2016, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework - Change to the Disclosure Requirements for Fair Value Measurement*, which modifies the disclosure requirements for fair value measurements by removing, modifying and adding certain disclosures. This ASU is effective for annual reporting periods beginning after December 15, 2019, including interim periods within those fiscal years, with early adoption permitted. We adopted this guidance on January 1, 2020 and it had no material impact on our consolidated financial statements.

ASU 2019-12, Simplifying the Accounting for Income Taxes (Topic 740). In December 2019, the FASB issued ASU 2019-12, *Simplifying the Accounting for Income Taxes (Topic 740)*. This standard simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in ASC 740 related to the approach for intra-period tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The standard also simplifies aspects of the accounting for franchise taxes and enacted changes in tax laws or rates and clarifies the accounting for transactions that result in a step-up in the tax basis of goodwill. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2020. Early adoption is permitted. We adopted this guidance on January 1, 2021 and it had no material impact on our consolidated financial statements."

ASU 2020-06, Debt — Debt With Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging — Contracts in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity. On August 5, 2020, the FASB issued ASU 2020-06, *Debt — Debt With Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging — Contracts in Entity's Own Equity (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity*. The amendments simplify the accounting for certain financial instruments with characteristics of liabilities and equity, including convertible instruments and contracts on an entity's own equity. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2021. Early adoption is permitted. The Company adopted this new accounting standard on January 1, 2021 on a modified retrospective basis. As a result, comparative financial information has not been restated and continues to be reported under the accounting standards in effect for those periods. The adoption of the standard resulted in a reclassification to long-term debt of $297.9 million, corresponding to the equity component of $233.9 million previously recorded in additional paid-in capital, the deferred taxes related to the equity component as of January 1, 2021 of $70.0 million, and a cumulative-effect adjustment to increase retained earnings as of January 1, 2021 by $6.0 million, which reflects the elimination of the discount amortization related to the equity component in prior periods, net of deferred taxes. See Note 9 Long-Term Debt below for additional information on the impact of this adoption.

New Accounting Pronouncements Issued but Not Yet Adopted

ASU 2020-04 and 2021-01, Reference Rate Reform (Topic 848) and Reference Rate Reform (Topic 848): Scope. In March 2020, the FASB issued ASU No. 2020-04, *Reference Rate Reform (Topic 848)*, which provides optional expedients and exceptions for applying GAAP to contracts, hedging relationships, and other transactions affected by reference rate reform if certain criteria are met. The amendments apply only to contracts, hedging relationships, and other transactions that reference LIBOR or another reference rate expected to be discontinued because of reference rate reform. In January 2021, the FASB issued ASU No. 2021-01, *Reference Rate Reform (Topic 848): Scope*, which expanded the scope of Topic 848 to include derivative instruments impacted by discounting transition. ASU 2020-04 and ASU 2021-01 are effective for all entities through December 31, 2022. The expedients and exceptions provided by the amendments do not apply to contract modifications and hedging relationships entered into or evaluated after December 31, 2022, except for hedging transactions as of December 31, 2022, that an entity has elected certain optional expedients for and that are retained through the end of the hedging relationship. The Company has senior secured credit facilities for which the interest rates are indexed on the LIBOR. The guidance did not have an impact on our financial position, results of operations or disclosures at transition, but we will continue to evaluate its impact on contracts and hedging relationships modified on or before December 31, 2022.

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4. The Transactions

As discussed in Note 1 General Information and Business, on October 8, 2020, the Company consummated the Transactions. Upon the consummation of the Transactions: (i) First Merger Sub was merged with and into Polaris with Polaris being the surviving company in the merger and (ii) immediately following the First Merger and as part of the same overall transaction as the First Merger, Polaris was merged with and into Second Merger Sub, with Second Merger Sub surviving the merger as a wholly owned subsidiary of the Company. In connection with the consummation of the Transactions:

- $1,521.0 million in cash was paid to Holdings on behalf of Holdings' equity holders as the closing cash consideration;
- the Company issued 415,700,000 shares of its Class A common stock as closing share consideration;
- holders of 8,693,855 shares of the Company's Class A common stock sold in its Initial Public Offering properly exercised their right to have such shares redeemed for a full pro rata portion of the Trust Account holding the proceeds from the Company's Initial Public Offering, calculated as of two business days prior to the consummation of the Transactions, or approximately $10.03 per share and $87.2 million in the aggregate;
- the Company issued and sold to investors in a private placement, (x) 130,000,000 shares of the Company's Class A common stock at a purchase price of $10.00 per share for aggregate proceeds of $1,300.0 million, (y) warrants to purchase 6,500,000 shares of the Company's Class A common stock and (z) an additional 2,050,000 shares of the Company's Class A common stock in lieu of an original issue discount;
- the Company issued and sold to investors in a private placement $1,300.0 million in aggregate principal amount of Senior Convertible PIK Notes, with an original issue discount of $32.5 million, for aggregate proceeds of $1,267.5 million;
- the Senior PIK Notes were redeemed in full for a total redemption price of $1,237.6 million (which includes accrued interest through October 7, 2020);
- all of the Company's 27,500,000 outstanding shares of Class B common stock were converted into shares of the Company's Class A common stock on a one-for-one basis;
- the Company paid KG a transaction fee of $15.0 million and a placement fee of $15.5 million, all of which was paid in cash; and
- The Sponsor elected to convert the full balance of the unsecured promissory note issued by the Company, in the principal amount of $1.5 million, into 1,500,000 Working Capital Warrants.

The consummation of the Transactions constituted a definitive Liquidity Event under the agreements governing the Unit awards and as a result all unvested Units vested on October 7, 2020, as more fully described in Note 15 Stock-Based Compensation. Polaris recorded these awards within shareholders' equity as an equity contribution from Holdings based on the fair value of the outstanding Units at each reporting period. The settlement of these awards was made in a combination of cash and shares of the Company's Class A common stock and was included in the aggregate consideration paid to Polaris Owners.

After giving effect to the Transactions and the redemption of public shares as described above, there were 664,152,068 shares of the Company's Class A common stock issued and 655,057,192 shares of the Company's Class A common stock outstanding, excluding (i) the 9,094,876 shares purchased by a subsidiary of MultiPlan in August 2020, which shares are held by the Company as treasury shares and (ii) the 12,404,080 founder shares that unvested in connection with the Transactions as more fully described in Note 10 Private Placement Warrants and Unvested Founder Shares. The shares, options and net loss per share available to holders of the Company's common stock, prior to the Transactions, have been retroactively restated as shares reflecting the exchange ratio established in the Transactions.

In connection with the Transactions, the Company has incurred transaction costs. The transaction costs directly attributable to the Transactions represent $113.1 million and have been recorded as a reduction to additional paid in capital in the accompanying consolidated balance sheets. The transaction costs considered incremental have been expensed as incurred and these amounts, $28.7 million for the year ended December 31, 2020, are included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

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Remaining funds held on the Closing Date in the Trust Account of $792.7 million were released to be used for working capital and general corporate purposes.

5. Business Combinations

DHP Acquisition

On February 26, 2021, the Company completed the acquisition of DHP, an analytics and technology company offering healthcare revenue and payment integrity services. The Company acquired 100 percent of the voting equity interest of DHP. The acquisition strengthens MultiPlan's service offering in the payment integrity market with new and complementary services to help its payor customers manage the overall cost of care and improve their competitiveness. It also adds revenue integrity services for plans that receive premiums from the Centers for Medicare and Medicaid Services.

The DHP acquisition was accounted for as a business combination using the acquisition method of accounting. As a result of the DHP acquisition and the application of purchase accounting, DHP's identifiable assets and liabilities were adjusted to their fair market values as of the acquisition date. The amount of DHP goodwill that is deductible for income tax purposes is $48.0 million.

The following table summarizes the consideration transferred to acquire DHP and the amounts of identified assets acquired and liabilities assumed at the acquisition date:

(in thousands)	
Total consideration transferred in cash	$ 151,776
Cash and cash equivalents	2,100
Trade accounts receivable, net	2,993
Prepaid expenses	369
Other current assets, net	119
Property and equipment, net[(1)]	9,056
Other assets	276
Other intangibles, net[(2)]	41,060
Accounts payable	(458)
Other accrued expenses	(5,209)
Deferred income taxes	(6,215)
Long-Term Liabilities	(553)
Total identifiable net assets	43,538
Goodwill	$ 108,238

(1) Includes capitalized software of $8.9 million and other tangible assets of $0.2 million.

(2) Includes client relationships of $39.8 million with a remaining useful life of 16 years, and trade names of $1.2 million with a remaining useful life of 10 years. The weighted average remaining useful life of the acquired intangibles subject to amortization is 15 years, 9 months.

The preliminary purchase price allocation for the business combination is subject to adjustment as valuation analyses, primarily related to property and equipment and intangible assets, are finalized.

The results of operations and financial condition of DHP have been included in the Company's consolidated results from the date of acquisition. Through December 31, 2021, DHP's impact on revenues and net earnings was not material and as a result no pro forma disclosures were required.

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In connection with the DHP acquisition, the Company incurred transaction costs that have been expensed as incurred and these amounts totaling $4.9 million for the year ended December 31, 2021, are included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

HST Acquisition

On November 9, 2020, the Company completed the acquisition of HST, a reference-based pricing company that uses data analytics and tools to engage members and providers on the front and back end of healthcare. The Company acquired 100 percent of the voting equity interest of HST. The acquisition increases the value that MultiPlan offers to healthcare payors by adding complementary services to help them better manage cost, enhances MultiPlan's analytics products and services and further extends the company into adjacent customer segments such as TPAs and Regional Health Plans.

The HST acquisition was accounted as a business combination using the acquisition method of accounting. As a result of the HST acquisition and the application of purchase accounting, HST's identifiable assets and liabilities were adjusted to their fair market values as of the acquisition date. The HST goodwill is not deductible for income tax purposes.

The following table summarizes the consideration transferred to acquire HST and the amounts of identified assets acquired and liabilities assumed at the acquisition date:

(in thousands)	December 31, 2020	Measurement period adjustments	December 31, 2021
Total consideration transferred in cash	**$ 145,416**	**$ (182)**	**$ 145,234**
Cash and cash equivalents	5,384	64	5,448
Trade accounts receivable, net	885	(112)	773
Prepaid expenses	138	—	138
Operating lease right-of-use assets	1,306	—	1,306
Property and equipment, net	78	—	78
Other current assets, net	60	1,635	1,695
Trademark, net	1,430	—	1,430
Technology, net	6,350	—	6,350
Client relationships intangible, net	24,460	—	24,460
Accounts payable	(419)	(139)	(558)
Other accrued expenses	(310)	(140)	(450)
Deferred income taxes	(7,854)	1,016	(6,838)
Operating lease obligation	(1,415)	—	(1,415)
Total identifiable net assets	**30,093**	**2,324**	**32,417**
Goodwill	**$ 115,323**	**$ (2,506)**	**$ 112,817**

The results of operations and financial condition of HST have been included in the Company's consolidated results from the date of acquisition. Through December 31, 2021, HST's impact on revenues and net earnings was not material and as a result no pro forma disclosures were required.

In connection with the HST acquisition, the Company incurred transaction costs. The transaction costs have been expensed as incurred and these amounts totaling $0.1 million and $0.9 million for the years ended December 31, 2021 and 2020, respectively, are included in general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

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6. Property and Equipment

Property and equipment, net consisted of the following as of December 31, 2021 and 2020:

	As of December 31,					
	2021			2020		
(in thousands)	Property and Equipment	Accumulated Depreciation	Property and Equipment, Net	Property and Equipment	Accumulated Depreciation	Property and Equipment, Net
Leasehold improvements	$ 4,279	$ (3,074)	$ 1,205	$ 3,583	$ (2,507)	$ 1,0
Furniture & equipment	5,569	(4,137)	1,432	5,719	(3,810)	1,9
Computer hardware	46,733	(26,776)	19,957	45,865	(29,115)	16,7
Computer software	35,991	(28,477)	7,514	33,903	(27,796)	6,1
Capitalized software development	405,203	(222,073)	183,130	341,844	(180,055)	161,7
Total Property and Equipment	$ 497,775	$ (284,537)	$ 213,238	$ 430,914	$ (243,283)	$ 187,6

Furniture and equipment includes assets under finance leases of $0.5 million and $0.4 million with accumulated depreciation of $0.3 million and $0.2 million as of December 31, 2021 and 2020, respectively.

During the years ended December 31, 2021 and 2020, the Company conducted a review of its property and equipment records and wrote-off assets with a net value of $3.2 million and $0.7 million, respectively.

7. Leases

The Company determines if an arrangement is a lease at inception. Operating leases are included in operating lease ROU assets and current and non-current operating lease obligation on the consolidated balance sheets. Finance lease ROU assets are included in property and equipment, net, and the current and non-current portion of finance lease liabilities are included in other accrued expenses and long-term debt, respectively, on the consolidated balance sheets.

The Company has operating and finance leases for corporate offices and certain equipment. Leases have remaining lease terms ranging from one to six years. Certain leases include options to renew in increments of five years; the options to renew are not considered reasonably certain to be exercised at commencement and are not included in the lease term. Some leases have variable payments, however, because they are not based on an index or rate, they are not included in the measurement of ROU assets and operating lease liabilities. Variable payments for real estate leases relate primarily to common area maintenance, insurance and property taxes associated with the properties. These variable payments are expensed as incurred. The Company elected to not separate lease and non-lease components for building and equipment leases. The Company will account for the lease and non-lease components, such as those described above, as a single lease component.

The Company's lease costs are recorded in cost of services and general and administrative expenses. Short-term and finance lease expense was determined to not be material. For the years ended December 31, 2021, 2020 and 2019 lease costs are as follows:

	For the Year Ended December 31,		
(in thousands)	2021	2020	2019
Operating lease cost	$ 9,851	$ 10,884	$ 11,0
Variable lease cost	1,629	1,886	1,8
Total operating lease cost	$ 11,480	$ 12,770	$ 12,8
Operating cash flow from operating leases	$ 7,709	$ 10,527	$ 10,9

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Future lease payments under operating leases as of December 31, 2021 were as follows:

(in thousands)	
2022	$ 8,5
2023	8,4
2024	5,0
2025	4,9
2026	4,6
Thereafter	7,4
Total lease payments	39,2
Less: Interest	(5,6
Present value of lease liabilities	$ 33,6

Additional information related to the Company's leases as of December 31, 2021 and 2020, respectively, is as follows:

	For the Year Ended December 31,	
	2021	2020
Weighted-average remaining lease term	5 years, 8 months	5 years, 4 mo
Weighted-average discount rate	5.7 %	6.5

As of December 31, 2021 and 2020, there were no material lease transactions that we have entered into but have not yet commenced.

8. Goodwill and Other Intangible Assets

As of each balance sheet date, other intangible assets consisted of the following:

		As of December 31,					
		2021			2020		
(in thousands)	Weighted-average amortization period	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value	Gross Carrying Amount	Accumulated Amortization	Net Carrying Value
Client relationships	15 years	$ 4,178,280	$ (1,531,679)	$ 2,646,601	$ 4,138,460	$ (1,252,892)	$ 2,885,5
Provider network	15 years	896,800	(332,812)	563,988	896,800	(273,026)	623,7
Technology	5 years	6,350	(1,482)	4,868	6,350	(211)	6,1
Trade names	9 years	2,670	(390)	2,280	1,430	(24)	1,4
Trade names	Indefinite	67,300	—	67,300	67,300	—	67,3
Total		$ 5,151,400	$ (1,866,363)	$ 3,285,037	$ 5,110,340	$ (1,526,153)	$ 3,584,1

The estimated aggregate amortization expense for each of the five succeeding years is $340.2 million per year.

The goodwill arose from the acquisition of the Company in 2016 by Holdings, the HST acquisition in 2020 and the DHP acquisition in 2021. The carrying value of goodwill was $4,363.1 million and $4,257.3 million as of December 31, 2021 and 2020, respectively, and no impairment has been recognized to date.

Goodwill for the years ended December 31, 2021 and 2020 are as follows:

(in thousands)	2021	2020
Beginning balance, January 1	$ 4,257,336	$ 4,142,0
Acquisitions	108,435	115,3
Measurement period adjustments	(2,701)	
Ending balance, December 31	$ 4,363,070	$ 4,257,3

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9. Long-Term Debt

As of December 31, 2021, and 2020, outstanding long-term debt is summarized below:

	Key Terms				As of December 31,	
(in thousands)	**Character**	**Priority**	**Maturity**	**Coupon**	**2021**	**2020**
Term Loan G	Term Loan	Senior Secured	6/7/2023	Variable	$ —	$ 2,341,(
Term Loan B	Term Loan	Senior Secured	9/1/2028 (1)	Variable (2)	1,321,688	
5.750% Notes	Notes	Senior Unsecured	11/1/2028	5.750%	1,300,000	1,300,(
5.50% Senior Secured Notes	Notes	Senior Secured	9/1/2028	5.50%	1,050,000	
Senior Convertible PIK Notes	Convertible Notes (3)	Senior Unsecured	10/15/2027	Cash Interest 6.00%, PIK Interest 7.00%	1,300,000	1,300,(
Finance lease obligations, non-current	Other	Senior Secured	2022-2024	3.38% - 20.31%	71	
Long-term debt					4,971,759	4,941,(
Less: current portion of long-term debt					(13,250)	
Less: debt discounts, net					(40,579)	(333,3
Less: debt issuance costs, net					(38,786)	(29,2
Long-term debt, net					$ 4,879,144	$ 4,578,4

(1) Beginning December 31, 2021 and quarterly thereafter, we shall repay a principal amount of the Term Loan B equal to 0.25% of the initial aggregate principal of $1,325.0 million. These scheduled principal repayments may be reduced by any voluntary or mandatory prepayments made in accordance with the credit agreement.

(2) Interest on Term Loan B and Revolver B is calculated, at MPH's option, as (a) LIBOR (or, with respect to the term loan facility only, 0.50%, whichever is higher), plus the applicable margin, or (b) the highest rate of (1) prime rate, (2) the federal funds effective rate, plus 0.50%, (3) the LIBOR for an interest period of one month, plus 1.00% and (4) 0.50% for Term Loan B and 1.00% for Revolver B, in each case, plus an applicable margin of 4.25% for Term Loan B and between 3.50% and 4% for Revolver B, depending on MPH's first lien debt to consolidated EBITDA ratio. The interest rate in effect for Term Loan B was 4.75% as of December 31, 2021.

(3) The Senior Convertible PIK Notes are convertible into shares of Class A common stock based on a $13.00 conversion price, subject to customary anti-dilution adjustments.

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As of December 31, 2021, the aggregate future principal payments for long-term debt, including non-current finance lease liabilities, for each of the next five years and thereafter are as follows:

($ in thousands)		
2022	$	13,250
2023		13,307
2024		13,264
2025		13,250
2026		13,250
Thereafter		4,905,438
Total	$	4,971,759

Debt issuance and redemption

During August and September of 2019, the Company repurchased and cancelled $121.3 million of the Senior PIK Notes. As a result, we recognized a gain on debt extinguishment of $18.5 million in the year ended December 31, 2019 included in Loss (gain) on extinguishment of debt in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

On October 8, 2020, the Senior PIK notes were redeemed in full for a total redemption price of $1,237.6 million. As a result, we recognized a loss on debt extinguishment of $35.7 million in the year ended December 31, 2020 included in Loss (gain) on extinguishment of debt in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

On October 29, 2020, the Company (a) consumed the 5.750% Notes offering by MPH and increased the revolving credit facility under the senior secured credit facilities from $100.0 million to $450.0 million and (b) repaid of all outstanding 7.125% Notes and $369.0 million of indebtedness under Term Loan G with the net proceeds of the 5.750% Notes offering, together with $715.0 million of cash on hand. As a result, we recognized a loss on debt extinguishment of $67.2 million in the year ended December 31, 2020 included in Loss (gain) on extinguishment of debt in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

On August 24, 2021, MPH issued new senior secured credit facilities composed of $1,325.0 million of Term Loan B and $450.0 million of a Revolver B, and $1,050.0 million in aggregate principal amount of 5.50% Senior Secured Notes. MPH used the net proceeds from Term Loan B, and the 5.50% Senior Secured Notes to repay all of the outstanding balance of its Term Loan G of $2,341.0 million, and pay fees and expenses in connection therewith. As a result, we recognized a loss on debt extinguishment of $15.8 million in the year ended December 31, 2021 included in Loss (gain) on extinguishment of debt in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

Debt Discounts

Some of our debt instruments have been issued with a discount. These costs were capitalized and are being amortized over the term of the related debt using the effective interest method.

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The following table is a summary of the cost and accumulated amortization of debt discounts as of December 31, 2021 and 2020:

		As of December 31,					
		2021			2020		
($ in thousands)	Original discount %	Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
Term Loan G	0.5%	$ —	$ —	$ —	$ 17,350	$ (13,519)	$ 3,8
Term Loan B	1.0%	13,429	(565)	12,864	—	—	-
Senior Convertible PIK Notes	2.5%	32,500	(4,785)	27,715	337,501	(8,007)	329,4
Total		$ 45,929	$ (5,350)	$ 40,579	$ 354,851	$ (21,526)	$ 333,3

Prior to the adoption of ASU 2020-06 on January 1, 2021, the nature of the Senior Convertible PIK Notes required management to separate them into liability and equity components. ASU 2020-06's elimination of the beneficial conversion guidance resulted in "recombining" the equity and debt components of the Senior Convertible PIK Notes into a single liability. As a result, $297.9 million of the discount on the liability created by recognition of a component of the convertible debt in equity was eliminated. See Note 3 New Accounting Pronouncements above for additional detail.

Debt Issuance Costs

In connection with the issuance of our debt instruments, the Company incurred specific expenses related to raising the debt, including commissions, fees and expenses of investment bankers and underwriters, registration and listing fees, accounting and legal fees pertaining to the financing and other external, incremental expenses paid to advisors that were directly attributable to realizing the proceeds of the debt issues. These costs were capitalized and are being amortized over the term of the related debt using the effective interest method.

The following table is a summary of the cost and accumulated amortization of debt issuances costs as of December 31, 2021 and 2020:

		As of December 31,					
		2021			2020		
($ in thousands)	Amortization Period	Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
Term Loan G	84 months	$ —	$ —	$ —	$ 32,324	$ (22,658)	$ 9,66
Term Loan B	84 months	7,316	(308)	7,008	—	—	-
5.750% Notes	96 months	19,939	(2,349)	17,590	19,939	(326)	19,61
5.50% Senior Secured Notes	84 months	14,695	(507)	14,188	—	—	-
Revolver[1]	84 months	4,955	(290)	4,665	4,722	(1,076)	3,64
Total		$ 46,905	$ (3,454)	$ 43,451	$ 56,985	$ (24,060)	$ 32,92

(1) The debt issuance costs associated with the revolving credit facility are included in other assets in the accompanying consolidated balance sheets.

Interest expense

During the year ended December 31, 2020, a correcting adjustment of $2.3 million was made to increase interest expense to account for acceleration of debt issuance cost due to principal prepayments made on the Term Loan G in the years 2018, 2019 and 2020. The adjustment was not material to the current period or historical period financial statements.

The Company is obligated to pay a commitment fee on the average daily unused amount of Revolver B. The annual commitment fee can range from an annual rate of 0.25% to 0.50% based on the Company's first lien debt to consolidated EBITDA ratio, as defined in the agreement. Interest expense, including commitment fees and amortization of debt issuance costs, were $2.7 million, $1.9 million and $0.2 million for the years ended December 31, 2021, 2020 and 2019, respectively. These amounts are included in interest expense in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

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Interest expense related to long-term debt was $264.8 million, $333.7 million and $376.1 million for the year ended December 31, 2021, 2020 and 2019, respectively. These amounts are included in the accompanying consolidated statements of income (loss) and comprehensive income (loss).

Guarantees

The senior secured credit facilities and their guarantees are secured, subject to permitted liens and other exceptions, by a first priority lien on substantially all of MPH's and the subsidiary guarantors' tangible and intangible property, and a pledge of all of the capital stock of each of their respective subsidiaries. All obligations under the debt agreement governing the senior secured credit facilities are unconditionally guaranteed by MPH Acquisition Corp. 1, the direct holding company parent of MPH, and each existing and subsequently acquired or organized direct or indirect wholly owned U.S. organized restricted subsidiary of MPH (subject to certain exceptions).

The 5.50% Senior Secured Notes are fully and unconditionally guaranteed, jointly and severally, by each of MPH's wholly owned domestic restricted subsidiaries that guarantee its senior secured credit facilities. The 5.50% Senior Secured Notes are not guaranteed by the Company. The 5.50% Senior Secured Notes and their guarantees are secured, subject to permitted liens and other exceptions, by a first priority lien shared with the senior secured credit facilities on substantially all of MPH's and the subsidiary guarantors' tangible and intangible property, and a pledge of all of the capital stock of each of their respective subsidiaries.

The 5.750% Notes and the Senior Convertible PIK Notes are jointly and severally guaranteed on a senior unsecured basis by each of the issuer's wholly owned domestic restricted subsidiaries that guarantee the issuer's existing senior secured credit facilities.

Debt Covenants and Events of Default

The Company is subject to certain affirmative and negative debt covenants under the debt agreements governing our indebtedness that limit our and/or certain of our subsidiaries' ability to engage in specific types of transactions. These covenants limit our and/or certain of our subsidiaries' ability to, among other things:

- incur additional indebtedness or issue disqualified or preferred stock;
- pay certain dividends or make certain distributions on capital stock or repurchase or redeem capital stock;
- make certain loans, investments or other restricted payments;
- transfer or sell certain assets;
- incur certain liens;
- place restrictions on the ability of its subsidiaries to pay dividends or make other payments to us;
- guarantee indebtedness or incur other contingent obligations;
- prepay junior debt and make certain investments;
- consummate any merger, consolidation or amalgamation, or liquidate, wind up or dissolve itself (or suffer any liquidation or dissolution), or dispose of all or substantially all of its business units, assets or other properties; and
- engage in transactions with our affiliates.

Certain covenants related to the 5.50% Senior Secured Notes will cease to apply to the 5.50% Senior Secured Notes for so long as such notes have investment grade ratings from both Moody's Investors Service, Inc. and S&P Global Ratings.

In connection with the Refinancing, the Revolver Ratio was amended such that, if, as of the last day of any fiscal quarter of MPH, the aggregate amount of loans under the revolving credit facility, letters of credit issued under the revolving credit facility (to the extent not cash collateralized or backstopped or, in the aggregate, in excess of $10.0 million) and swingline loans are outstanding and/or issued in an aggregate amount greater than 35% of the total commitments in respect of the revolving credit facility at such time, the revolving credit facility will require MPH to maintain a maximum first lien secured leverage ratio of 6.75 to 1.00. As of December 31, 2021 and 2020 we were in compliance with all of the debt covenants.

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The debt agreements governing the new senior secured credit facilities, Term Loan G, the Revolver G, the 5.750% Notes and the 5.50% Senior Secured Notes contain customary events of default, subject to grace periods and exceptions, which include, among others, payment defaults, cross-defaults to certain material indebtedness, certain events of bankruptcy, material judgments, in the case of the debt agreements governing the new senior secured credit facilities and the 5.50% Senior Secured Notes, failure of a guarantee on the liens on material collateral to remain in effect, in the case of the debt agreements governing the new senior secured credit facilities, Term Loan G and the Revolver G, any change of control. Upon the occurrence of an event of default under such debt agreements, the lenders and holders of such debt will be permitted to accelerate the loans and terminate the commitments, as applicable, thereunder and exercise other specified remedies available to the lenders and holders thereunder.

10. Private Placement Warrants and Unvested Founder Shares

In connection with the execution of the Merger Agreement, Churchill and the Insiders entered into a Sponsor Agreement. Pursuant to the terms of the Sponsor Agreement, 12,404,080 of the founder shares and 4,800,000 Private Placement Warrants were unvested as of October 8, 2020 and will re-vest at such time as, during the period starting on October 8, 2021 and ending on October 8, 2025, the closing price of our Class A common stock exceeds $12.50 per share for any forty (40) trading days in a sixty (60) consecutive day period. Such founder shares and Private Placement Warrants that do not re-vest on or before October 8, 2025 will be forfeited and cancelled.

With certain limited exceptions, the founder shares are not transferable, assignable or salable (except to our officers and directors and other persons or entities affiliated with the Sponsor and other permitted transferees, each of whom will be subject to the same transfer restrictions) until April 8, 2022. The 4,800,000 Private Placement Warrants that vest are not transferable, assignable or salable (except to our officers and directors and other persons or entities affiliated with the Sponsor and other permitted transferees, each of whom will be subject to the same transfer restrictions) until they re-vest, and not before April 8, 2022.

In the event of an "Acquiror Sale" defined by the Sponsor Agreement as (i) a purchase, sale, exchange, business combination or other transaction in which the equity securities of the acquiror, its successor or the surviving entity of such business combination or other transaction are not registered under the Securities Exchange Act of 1934, or listed or quoted for trading on a national securities exchange or (ii) a sale, lease, exchange or other transfer in one transaction or a series of related transactions of all or substantially all of the acquiror's assets to a third party that is not an affiliate of the Sponsor, the founder shares and Private Placement Warrants that re-vest will change based on the acquiror price. If the Acquiror Price is less than $10 per share, no Founder Shares or vesting Private Placement Warrants will vest; if the Acquiror Price exceeds $12.50 per share, all Founder Shares or vesting Private Placement Warrants will vest; and if the Acquiror Price is between $10 per share and $12.50 per share, the number of founder shares or vesting Private Placement warrants that vest will be determined based on linear interpolation between such share price levels. The remaining Founder Shares and vesting Private Placement warrants will be forfeited and cancelled for no consideration.

As of December 31, 2020, the fair values of the Private Placement Warrants and unvested founder shares were $44.5 million and $62.1 million, respectively. As of December 31, 2021, the fair values of the Private Placement Warrants and unvested founder shares were $38.0 million and $36.0 million, respectively. From the year ended December 31, 2021, and primarily as a result of the decrease in the price of the Company's Class A common stock over that period, the fair value of the Private Placement Warrants and the unvested founder shares decreased by $6.5 million and $26.1 million, respectively, and the corresponding gain is recognized within change in fair value of Private Placement Warrants and unvested founder shares in the consolidated statements of income (loss) and comprehensive income (loss).

11. Fair Value Measurements

Fair value measurements are based on the premise that fair value represents an exit price representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions that market participants would use in pricing an asset or liability. As a basis for considering such assumptions, the following three-tier fair value hierarchy has been used in determining the inputs used in measuring fair value:

- Level 1 — Quoted prices in active markets for identical assets or liabilities on the reporting date.
- Level 2 — Inputs, other than quoted prices in active markets (Level 1), that are observable for the asset or liability, either directly or indirectly.

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- Level 3 — Unobservable inputs in which there is little or no market data, which require the entity to develop its own assumptions

Financial instruments

Certain financial instruments which are not measured at fair value on a recurring basis include cash and cash equivalents, accounts receivable and accounts payable, which approximate fair value due to their short-term nature. The financial instrument that potentially subjects the Company to concentrations of credit risk consists primarily of accounts receivable.

We estimate the fair value of long-term debt, including current maturities of finance lease obligations, based on estimates using present value techniques that are significantly affected by the assumptions used concerning the amount and timing of estimated future cash flows and discount rates that reflect varying degrees of risk. Assumptions include interest rates currently available for instruments with similar terms as well as the five, seven, and eight-year Treasury bill rates. As such, this is considered a Level 2 fair value measurement.

As of December 31, 2021 and 2020, the Company's carrying amount and fair value of long-term debt consisted of the following:

	As of December 31,			
	2021		2020	
(in thousands)	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Term Loan G, net of discount	$ —	$ —	$ 2,337,169	$ 2,390,7
Term Loan B, net of discount	1,308,824	1,294,312	—	
5.750% Notes, net of discount	1,300,000	1,245,436	1,300,000	1,300,0
5.50% Senior Secured Notes	1,050,000	1,029,680	—	
Senior Convertible PIK Notes, net of discount	1,272,285	1,245,958	970,506	970,5
Finance lease obligations	71	71	92	
Total Liabilities	$ 4,931,180	$ 4,815,457	$ 4,607,767	$ 4,661,3

Recurring fair value measurements

Prior to the Transactions, we measured our 2016 Class B Unit Incentive Plan at fair market value on a recurring basis. The fair value of the stock-based compensation awards was determined based on significant inputs not observable in the market which would represent a level 3 measurement within the fair value hierarchy. The Company uses a Monte Carlo simulation to estimate the fair value of the stock-based compensation awards. See Note 15 Stock-Based Compensation for further information.

The Private Placement Warrants and unvested founder shares are measured at fair value on a recurring basis. The fair value of these instruments was determined based on significant inputs not observable in the market which would represent a level 3 measurement within the fair value hierarchy. The Company uses an option pricing simulation to estimate the fair value of these instruments.

Non-recurring fair value measurements

We also measure certain non-financial assets at fair value on a nonrecurring basis, primarily goodwill and long-lived tangible and intangible assets, in connection with periodic evaluations for potential impairment. We estimate the fair value of these assets using primarily unobservable inputs and, as such, these are considered Level 3 fair value measurements. There were no material impairment charges for these assets for fiscal years 2021, 2020 and 2019.

For additional information related to goodwill, intangible assets, long-lived assets and impairments, see Note 2 Summary of Significant Accounting Policies.

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12. Income Taxes

The Company does not have operations in foreign jurisdictions. The provision (benefit) for income taxes for the years ended December 31, 2021, 2020 and 2019 are as follows:

	For the Year Ended December 31,		
(in thousands)	**2021**	**2020**	**2019**
Current			
Federal	$ 95,674	$ 14,602	$ 96,148
State and local	19,628	4,096	16,055
	$ 115,302	$ 18,698	$ 112,203
Deferred			
Federal	$ (73,987)	$ (48,168)	$ (97,326)
State and local	(7,942)	3,127	(14,078)
	(81,929)	(45,041)	(111,404)
Total provision (benefit) from continuing operations	$ 33,373	$ (26,343)	$ 799

The Company's provision for income taxes for the years ending December 31, 2021, 2020 and 2019 continues to be impacted by the TCJA, which was enacted into law on December 22, 2017. Income tax effects resulting from changes in tax laws are accounted for by the Company in accordance with the authoritative guidance, which requires that these tax effects be recognized in the period in which the law is enacted. During 2020 the Internal Revenue Service issued final regulations relating to the TCJA that the Company assessed and was accounted for in the period when issued. Additional changes under the CARES act in Q1 2020 increased the allowable interest expense deduction for 2019 and 2020. These changes reduced the Company's deferred tax asset and taxes payable in the amount of $32.5 million. This was recorded in the period of enactment. Other impacts of the CARES act were reviewed and determined not to be material to the Company.

The pre-tax income during the year ended December 31, 2021 of $135.5 million generated an income tax provision of $33.4 million. The pre-tax loss during the year ended December 31, 2020 was $546.9 million which generated income tax benefits of $26.3 million. The pre-tax income during the year ended December 31, 2019 of $10.5 million generated an income tax provision of $0.8 million.

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31, 2021, 2020 and 2019 is as follows:

	For the Year Ended December 31,		
(in thousands)	**2021**	**2020**	**2019**
Tax at Statutory	$ 28,445	$ (114,850)	$ 2,2
Non-Deductible Expenses	279	639	
Equity Compensation Plan	443	85,227	(3,1
Non-Deductible change in fair value of Private Placement Warrants and unvested founder shares Liability	(6,845)	(7,439)	
State Taxes (net)	6,003	(1,741)	1,7
Valuation Allowance	1,127	2,555	
Non-Deductible Compensation	1,561	2,725	
Tax Credits	(1,064)	(915)	
Other	131	40	
State Deferred Rate Changes	3,293	7,416	(1
Total	$ 33,373	$ (26,343)	$ 7

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Our effective tax rate for the years ended December 31, 2021, 2020 and 2019 differed from the statutory rate primarily due to non-deductible stock-based compensation expense, non-deductible mark-to-market liability, limitations on executive compensation, changes in the Company's deferred state tax rate due to the DHP acquisition, tax credits, operations, and state tax expense.

The following are significant deferred income tax assets and liabilities as of December 31, 2021 and 2020:

	As of December 31,	
(in thousands)	**2021**	**2020**
Deferred income tax assets:		
Allowances on trade receivables	$ 82	$
Net operating loss carryforwards	934	
Capital loss carryforwards	1,421	
Accrued expenses and reserves	4,864	4,
Interest limitation carryforward	57,011	47,
Leases – right-of-use liability	7,935	8,
Transaction expenses	7,696	8,
Other	494	
Valuation allowance	(1,421)	(
Deferred income tax assets	$ 79,016	$ 68,
Deferred income tax liabilities:		
Intangible assets	778,209	846,
Depreciable assets	47,168	42,
Leases – right-of-use asset	7,108	7,
Debt costs	—	73,
Other	356	
Deferred income tax liabilities	832,841	969,
Net deferred income tax liabilities	$ 753,825	$ 900,

The Company has NOL carry forwards for federal income tax purposes of $2.9 million, $0.6 million tax effected, that will be available to reduce future taxable income. The utilization of most of these losses is subject to annual limitations under federal income tax law. The Company believes that it will be able to fully utilize these losses under current federal tax law. The net operating losses begin to expire in 2022. The Company has net operating loss carry forwards for state income tax purposes of $0.3 million. The Company believes that it will be able to fully utilize these losses under current state tax laws. Substantially all of the Company's state NOL carryforwards expire by 2025. The Company has disallowed interest carry forwards for federal income tax purposes of $241.5 million, $57.0 million tax effected, that will be available to reduce future taxable income, subject to certain income limitations and which have an indefinite carryforward period. The Company believes it is more likely than not that these interest carryforwards will be fully utilized considering the weight of all positive and negative evidence under current tax laws.

During the third and fourth quarters of 2020, the Company marked-to-market certain investments which would result in a capital loss deferred tax asset for which the Company recorded a corresponding valuation allowance of $2.6 million. Commensurate with the Transactions, one of these investments and the corresponding deferred tax asset related valuation allowance, were written off to additional paid-in capital totaling $2.4 million. As of December 31, 2021, the Company increased the valuation allowance related to the remaining estimated capital losses in excess of capital gain based on the difference between the tax and book balance of these investments. It is more likely than not the Company will not generate capital gain income to offset these losses.

The Company does not have reserves for uncertain tax positions. Any need for a reserve or changes in a reserve would be a component of the Company's tax provision. The Company includes interest and tax penalties as part of the tax provision. The Company does not reasonably expect any other significant changes in the next twelve months.

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Various regulatory tax authorities periodically examine the Company's and its subsidiaries' tax returns. Tax years December 2018 through 2021 are open for Federal examination. The Company's closed its 2017 IRS audit during the year. There were no impacts to the 2021 financial statements. Tax years 2018 through 2021 are still open for examination related to income taxes to various state taxing authorities.

13. Commitments and Contingencies

Commitments

The Company has certain irrevocable letters of credit used to satisfy real estate lease agreements for three of our offices in lieu of security deposits that reduced the capacity of Revolver G by $1.8 million as of December 31, 2020. The $1.8 million letters of credit remain outstanding and reduced the capacity of Revolver B as of December 31, 2021 .

We are a defendant in various lawsuits and other pending and threatened litigation and other adversarial matters which have arisen in the ordinary course of business as well as regulatory investigations, all which have arisen in the ordinary course of business. While the ultimate outcome with respect to such proceedings cannot be predicted with certainty, we believe they will not have a material adverse effect on our financial condition or results of operations.

On March 25, 2021 and April 9, 2021, we were named as a defendant in two putative class action lawsuits relating to the Transactions that have since been consolidated under the caption In Re MultiPlan Corp. Stockholders Litigation, Consolidated C.A. No. 2021-0300-LWW (Del.Ch) ("Delaware Stockholder Litigation"). The Delaware Stockholder Litigation asserts breach of fiduciary duty claims and aiding and abetting breach of fiduciary duty claims against the former directors of the Churchill board, the Sponsor, KG and M. Klein (collectively, the "Churchill Defendants") and the Company. The Delaware Stockholder Litigation complaint alleges that the Transactions were a product of an unfair process by Churchill, which was allegedly impacted by conflicts of interest, resulting in mispricing of the Transactions. The complaint seeks, among other things, damages, certain equitable relief including the reopening of redemptions, and attorneys' fees and costs. The Company and the Churchill Defendants filed motions to dismiss the complaint. On January 3, 2022, the Chancery Court issued a ruling granting in part the Company's motion to dismiss and denying the motion to dismiss filed by the Churchill Defendants. The Company is therefore dismissed from the Delaware Stockholder Litigation, which will proceed against the Churchill Defendants. Certain of the Churchill Defendants have contractual indemnification rights to the Company.

We accrue for costs associated with certain contingencies, including, but not limited to, settlement of legal proceedings, regulatory compliance matters and self-insurance exposures when such costs are probable and reasonably estimable. Such accruals are included in other accrued expenses on the accompanying consolidated balance sheets. In addition, we accrue for legal fees incurred in defense of asserted litigation and regulatory matters as such legal fees are incurred. To the extent it is probable under our existing insurance coverage that we are able to recover losses and legal fees related to contingencies, we record such recoveries concurrently with the accrual of the related loss or legal fees. Significant management judgment is required to estimate the amounts of such contingent liabilities and the related insurance recoveries. In our determination of the probability and ability to estimate contingent liabilities and related insurance recoveries we consider the following: litigation exposure based on currently available information, consultations with external legal counsel, adequacy and applicability of existing insurance coverage and other pertinent facts and circumstances regarding the contingency. Liabilities established to provide for contingencies are adjusted as further information develops, circumstances change, or contingencies are resolved; and such changes are recorded in the accompanying consolidated statements of income (loss) and comprehensive income (loss) during the period of the change and appropriately reflected in other accrued liabilities on the accompanying consolidated balance sheets.

14. Shareholders' Equity

Preferred Stock

The Company is authorized to issue 10,000,000 shares of preferred stock with a par value of $0.0001 per share with such designations, voting and other rights and preferences as may be determined from time to time by the Company's board of directors. At December 31, 2021 and 2020, there were no shares of preferred stock issued or outstanding.

Class A Common Stock

The Company is authorized to issue 1,500,000,000 shares of Class A common stock with a par value of $0.0001 per share. At December 31, 2021, there were 665,456,180 shares of Class A common stock issued, excluding (i) 77,231,072 shares of Class A common stock available for future grants under our MultiPlan Corporation 2020 Omnibus Incentive Plan, (ii) the

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100,000,000 shares of Class A common stock issuable upon conversion of the Senior Convertible PIK Notes, and (iii) the 58,500,000 shares of Class A common stock issuable upon exercise of the warrants described below.

Except as otherwise required by law or as otherwise provided in any certificate of designation for any series of preferred stock, the holders of common stock will possess all voting power for the election of directors and all other matters requiring stockholder action and will be entitled to one vote per share on matters to be voted on by stockholders. The holders of our Class A common stock will at all times vote together as one class on all matters submitted to a vote of the common stock.

Class B Common Stock

Holders of Class B common stock had the right to elect all of the Company's directors prior to a business combination. The shares of Class B common stock automatically converted into shares of Class A common stock at the time of the Transactions on a one-for-one basis.

Warrants

Each whole Public Warrant entitles the registered holder to purchase one share of our Class A common stock at a price of $11.50 per share, subject to adjustment as discussed below, at any time commencing on February 19, 2021. Pursuant to the warrant agreement, a holder may exercise its Public Warrants only for a whole number of shares of our Class A common stock. This means only a whole public warrant may be exercised at a given time by a holder. The Public Warrants will expire at 5:00 p.m., New York City time, on October 8, 2025 or earlier upon redemption or liquidation.

If the Company calls the Public Warrants for redemption, management will have the option to require all holders that wish to exercise the Public Warrants to do so on a "cashless basis," as described in the warrant agreement. The exercise price and number of shares of Class A common stock issuable upon exercise of the warrants may be adjusted in certain circumstances including in the event of a stock dividend, or recapitalization, reorganization, merger or consolidation. However, the warrants will not be adjusted for issuance of Class A common stock at a price below its exercise price. Additionally, in no event will the Company be required to net cash settle the warrants.

The Company may redeem the Public Warrants:

- in whole and not in part;
- at a price of $0.01 per warrant;
- upon a minimum of 30 days' prior written notice of redemption, or the 30-day redemption period, to each warrant holder; and
- if, and only if, the closing price of the Company's Class A common stock equals or exceeds $18.00 per share for any 20 trading days within a 30-trading day period ending on the third trading day prior to the date on which we send the notice of redemption to the warrant holders.

The Public Warrants are classified as equity on the Company’s consolidated balance sheet.

The Private Placement Warrants (including the Class A common stock issuable upon exercise of the Private Placement Warrants) are not transferable, assignable or salable until (i) with respect to 4,800,000 Private Placement Warrants and pursuant to the terms of the Investor Rights Agreement, April 8, 2022 and (ii) with respect to all other Private Placement Warrants February 19, 2021, (except, among other limited exceptions, to our officers and directors and other persons or entities affiliated with the Sponsor) and they will not be redeemable by us so long as they are held by the Sponsor or its permitted transferees. The Sponsor, or its permitted transferees, has the option to exercise the Private Placement Warrants on a cashless basis and will be entitled to certain registration rights. Otherwise, the Private Placement Warrants have terms and provisions that are identical to those of the Public Warrants. If the Private Placement Warrants are held by holders other than the Sponsor or its permitted transferees, the Private Placement Warrants will be redeemable by us and exercisable by the holders on the same basis as the Public Warrants. All Private Placement Warrants held by the Sponsor or its permitted transferees are classified as a liability on the Company’s consolidated balance sheets.

In connection with the Transactions on July 12, 2020, the Sponsor loaned us an unsecured promissory note (the "Note") in the principal amount of $1.5 million. The Note had no interest and was repayable in full upon the closing of the Transactions. The Sponsor also had the option to convert any unpaid balance of the Note into Working Capital Warrants equal to the principal

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amount of the Note. The Sponsor elected to convert the full balance of the Note, in the principal amount of $1.5 million, into 1,500,000 Working Capital Warrants. The Working Capital Warrants have identical terms to the Private Placement Warrants. All Working Capital Warrants held by the Sponsor or its permitted transferees are classified as a liability on its consolidated balance sheets.

In connection with the Transactions, the Company issued PIPE Warrants on terms identical to the terms of the Private Placement Warrants, other than the redemption feature exists for all holders of the PIPE warrants. Each whole PIPE warrant entitles the holder to purchase one share of our Class A common stock at a price of $12.50 per share. The PIPE warrants are classified as equity on the Company's consolidated balance sheets.

As of December 31, 2021, we had warrants to purchase an aggregate of 58,500,000 shares of Class A common stock outstanding, consisting of: (a) the Public Warrants (warrants to purchase an aggregate of 27,500,000 shares of Class A common), (b) the Private Placement Warrants (warrants to purchase an aggregate of 23,000,000 shares of Class A common stock), (c) the Working Capital Warrants (warrants to purchase an aggregate of 1,500,000 shares of Class A common stock) and (d) the PIPE Warrants (warrants to purchase an aggregate of 6,500,000 shares of Class A common stock).

Additional paid-in capital

Additional paid-in capital is reported in the shareholders' equity section of the balance sheet and corresponds to the cash that shareholders have given the Company in exchange for stock.

Treasury stock

During 2020, a subsidiary of the Company purchased 9,094,876 shares to be held in treasury for the purpose of facilitating the Transactions for a total amount of $100.6 million excluding fees and commissions. Prior to the consummation of the Transactions, this investment was accounted for as equity securities with a readily determinable fair value and carried at fair value with changes in fair value recorded in "loss on investments" in the consolidated statements of income (loss) and comprehensive income (loss). Upon the consummation of the Transactions, the fair value of the shares of $89.5 million was recorded as a reduction to shareholder's equity.

On August 27, 2021, the Company announced a share repurchase program approved by its board of directors, authorizing, but not obligating, the repurchase of up to an aggregate amount of $250,000,000 of its Class A common stock from time to time through December 31, 2022. As of December 31, 2021, the Company has repurchased approximately $100.0 million of its Class A common stock as part of this program using cash on hand.

For the years ended December 31, 2021 and 2020, the Company repurchased 345,733 shares and 13,087 shares, respectively, of Class A common stock in payment of withholding taxes upon the vesting of stock based compensation awards for a total amount of $2.6 million and $0.1 million, respectively.

At December 31, 2021 and 2020, there were 27,117,406 and 9,107,963 shares of Class A common stock held in treasury, respectively.

15. Stock-Based Compensation

Prior to the Transactions

Prior to the Transactions, the Company operated under the Polaris Plan. The purpose of the Polaris Plan was to provide a means through which Holdings may attract and retain key personnel and to provide a means whereby Polaris Plan Participants can acquire and maintain an equity interest in Holdings, thereby strengthening their commitment to the welfare of Holdings and its subsidiaries, including MultiPlan, Inc. Under the Polaris Plan, Holdings may grant awards to select Polaris Plan Participants at the sole discretion of the Holdings Board. Polaris Plan awards are granted in the form of Holdings' Class B Units via the Polaris Agreement.

There were 343,114 Units available for issuance under the Polaris Plan. There were 267,768 Units issued and outstanding as of the date of the Liquidity Event, October 7, 2020. The Company's CEO, with the approval of the Holdings Board, determined participation and the allocation of the Units.

Each individual Award is composed of time vesting units and performance vesting units. Time vesting units and performance vesting units vest based on the vesting dates and the achievement of certain performance measures as defined in each agreement. The Company amortizes the time vesting units on a straight line basis, and the performance vesting units on a

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graded vesting basis. In the event of the termination of an employee Participant due to a Qualifying Termination as defined by the Polaris Agreement, the Polaris Plan Participant shall have the right to cause Holdings to purchase all or any portion of the vested Units owned by the employee, subject to the approval of the Company's CEO. Based on this put right available to the employee Participants, stock-based compensation awards related to the Polaris Plan have been accounted for as liability classified awards within Holdings' consolidated financial statements. The Company records these awards within Shareholders' equity as an equity contribution from Holdings based on the fair value of the outstanding Units at each reporting period. Upon the occurrence of a definitive Liquidity Event all unvested units vest immediately prior to such Liquidity Event. All vested shares will be exchanged for new shares and cash as determined at the time of such Liquidity Event. See Note 4 The Transactions for details regarding the Transactions.

The consummation of the Transactions described in Note 4 The Transactions constituted a definitive Liquidity Event under the agreements governing the Unit awards and as a result all unvested Units vested on October 7, 2020. Therefore, the Company recorded an expense of $106.2 million related to the accelerated vesting during the fourth quarter of 2020. The Company recorded these awards within shareholders' equity as an equity contribution from Holdings based on the fair value of the outstanding Units at each reporting period.

The fair value of the outstanding Units was $475.5 million as of October 7, 2020, and represents the cumulative exit value of the Company, which reflects the transaction value plus prior distributions. We also removed the discount for lack of marketability from the calculation of fair value. The Company recorded stock-based compensation expense for Class B Units of $405.8 million during the period ended December 31, 2020, and stock-based compensation profit of $14.9 million during the period ended December 31, 2019. Forfeitures are accounted for as they occur.

The following table lists the principal assumptions used estimating the fair value of the Units during the year ended December 31, 2019:

Risk free rate of return	1.
Expected volatility	24.
Expected dividend yield	0.
Discount for Lack of Marketability	20.

Stock-based compensation expense related to Class B Units has been allocated between costs of services and general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss) for the years ending December 31, 2020, and 2019 as follows:

	For the Year Ended December 31,	
(in thousands)	**2020**	**2019**
Cost of services	$ 163,025	$ (7,9
General and administrative	242,818	(6,9
Total stock-based compensation	$ 405,843	$ (14,8

After the consummation of the Transactions

The Company operates under the 2020 Omnibus Incentive Plan effective October 8, 2020. The purpose of the 2020 Omnibus Incentive Plan is to provide a means through which the Company and the other members of the Company may attract and retain key personnel and to provide a means whereby directors, officers, employees, consultants and advisors of the Company and its subsidiaries can acquire and maintain an equity interest in the Company, or be paid incentive compensation, including incentive compensation measured by reference to the value of Common Stock, thereby strengthening their commitment to the welfare of the Company and aligning their interests with those of the Company's stockholders.

There are 85,850,000 shares of Class A common stock available for the issuance of awards under the 2020 Omnibus Incentive Plan. The Company's CEO, with the approval of the Board, determines participation and the allocation of the Units. Awards under the 2020 Omnibus Incentive Plan typically vest from 6 months to 4 years and are generally subject to either cliff vesting or graded vesting. Awards do not have non-forfeitable rights to dividends or dividend equivalents.

The Company has adopted an Incentive Compensation Clawback Policy in order to help ensure that incentive compensation is paid or awarded based on accurate financial results and the correct calculation of performance against incentive targets.

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Non-qualified stock options

Non-qualified stock option activity for the year ended December 31, 2021 is summarized below:

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contract Term (Years)	Aggregate Intrin Value
Nonvested at beginning of period	—	$ —		
Awarded	4,167,862	8.43		
Nonvested at end of period	4,167,862	$ 8.43	3 years, 5 months	$ -
Exercisable at end of period	—	—	—	-

Restricted Stock and Restricted Stock Units

Restricted Stock and Restricted Stock Units activity for the year ended December 31, 2021 is summarized below:

	Employee RS	Director RSUs	Employee RSUs	Fixed Value RSUs	Weighted Aver grant date fair v per share
Nonvested at beginning of period	1,468,750	42,847	—	—	$ 8
Awarded	133,689	87,275	2,903,845	492,610	6
Vested	(930,564)	(48,061)	(522,539)	—	8
Forfeited	(671,875)	—	(37,325)	—	8
Nonvested at end of period	—	82,061	2,343,981	492,610	$ 6

On August 4, 2021, the Company granted $2.0 million of Fixed Value RSUs to the chief executive officer as part of the side letter agreement entered into on the same date. The required service period of the grant is the time between the grant date and the vesting date of January 31, 2022, and the compensation cost related to the grant was amortized ratably over the service period. This grant is accounted for as liability-classified award because the obligation is based on fixed monetary amount that was known at inception of the obligation, to be settled with a variable number of shares of our common stock based on the volume weighted average trading price of the common stock of the Company over the preceding 30 consecutive trading days prior to the grant's vesting date, which occurred on January 31, 2022.

Other share based compensation data

The following table lists the principal assumptions used in estimating the grant date fair value of NQSOs during the year ended December 31, 2021:

Risk free rate of return	1.10% - 1.52%
Expected volatility	40% - 52%
Expected dividend yield	0.0%
Expected life in years	6 years - 6 years, 3 months
Sub optimal exercise factor	1.9

The Company has allocated stock based compensation expense under the 2020 Omnibus Incentive Plan between costs of services and general and administrative expenses in the accompanying consolidated statements of income (loss) and comprehensive income (loss) for the years ending December 31, 2021, and 2020 as follows:

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	For the Year Ended December 31,	
(in thousands)	**2021**	**2020**
Cost of services	$ 2,618	$
General and administrative	15,392	
Total stock-based compensation	$ 18,010	$

There was $22.8 million of unrecognized compensation cost as of December 31, 2021 related to the outstanding awards which is expected to be recognized over a weighted average period of 3 years, 3 months.

16. Employee Benefit Plan

The Company sponsors a profit-sharing plan under Section 401(k) of the Internal Revenue Code. The plan covers eligible employees and provides for discretionary employer contributions and a matching contribution subject to certain limitations of employee salary deferrals. Profit sharing expense was immaterial during the periods ended December 31, 2021, 2020, and 2019.

17. Basic and Diluted Earnings and Loss Per Share

Basic and diluted earnings and loss per share was calculated as follows for the years ended December 31, 2021, 2020 and 2019:

	Year Ended December 31,		
($ in thousands, except number of shares and per share data)	**2021**	**2020**	**2019**
Numerator for earnings per share calculation			
Net income (loss)	$ 102,080	$ (520,564)	$9
Denominator for earnings per share calculation			
Weighted average number of shares outstanding – basic	651,006,567	470,785,192	415,700
Effect of stock-based compensation	519,224	—	
Weighted average number of shares outstanding – diluted	651,525,791	470,785,192	415,700
Income (Loss) per share – basic and diluted:			
Net income (loss) per share – basic	$ 0.16	$ (1.11)	$ 0
Net income (loss) per share – diluted	$ 0.16	$ (1.11)	$ 0

Earnings per share calculations for all periods prior to the Transactions have been retrospectively restated to the equivalent number of shares reflecting the exchange ratio established in the reverse recapitalization. Subsequent to the Transactions, earnings per share will be calculated based on the weighted average number of shares of common stock then outstanding.

As of the year ended December 31, 2021, we have excluded from the calculation of diluted net income per share the instruments whose effect would have been anti-dilutive, including (i) 58,500,000 warrants outstanding, (ii) 100,000,000 shares which may be issued upon conversion of the Senior Convertible PIK Notes, and (iii) 12,404,080 unvested founder shares. Additionally, we have excluded from the calculation of diluted net income per share awards within the 2020 Omnibus Incentive Plan whose effect would have been anti-dilutive of 4,935,228 for the year ended December 31, 2021. For the year ended December 31, 2020, potentially dilutive securities were excluded from the calculation of diluted net loss per share, as their effect would have been anti-dilutive given the Company's losses incurred in 2020 and because contingencies for vesting have not been met. Therefore, the weighted average number of shares outstanding used to calculate both basic and diluted net loss per share is the same. There were no warrants, options, unvested founder shares, Employee RS or Director RSUs for the years ended December 31, 2019.

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Notes to Consolidated Financial Statements

18. Related Party Transactions

The accompanying consolidated statements of income (loss) and comprehensive income (loss) include expenses and revenues to and from related parties for the years ended December 31, 2021, 2020 and 2019 as follows:

	For the Year Ended December 31,		
(in thousands)	**2021**	**2020**	**2019**
Revenues	$ 2,632	$ 1,973	$ 2,3
Total revenues from related parties	$ 2,632	$ 1,973	$ 2,3
Cost of services	$ (2,737)	$ (2,137)	$ (3,7
General and administrative	(479)	(231)	(2
Total expense from related parties	$ (3,216)	$ (2,368)	$ (4,0

The accompanying consolidated balance sheets include accruals from related parties as of December 31, 2021 and 2020 as follows:

	As of December 31,	
(in thousands)	**2021**	**2020**
Current liabilities:		
Accounts payable	$ 2,297	$ 2,7
Total liabilities from related parties	$ 2,297	$ 2,7

In the years ended December 31, 2021, 2020 and 2019, the related party transactions included the following:

- The Company purchased PPO network services from a company controlled by Hellman & Friedman LLC to supplement our provider network. We also recognize revenues from that same company for the use of our provider network and other claims processing services.
- The Company has obtained insurance brokered through a company controlled by Hellman & Friedman LLC.
- The Company compensates a non-employee member of the Board for his services on the Board. The Company also purchased cyber security risk management services from a company controlled by that same member of the Board.
- The Company reimburses Hellman & Friedman LLC for reasonable out of pocket expenses that include travel, lodging, meals, and any similar expenses.
- Companies controlled or managed by members of the Board have participated in the PIPE Investment, including the Senior Convertible PIK Notes.
- The Company purchased advisory services in connection with the Transactions from companies controlled or managed by members of the Board.

19. Subsequent Events

On January 31, 2022, and in accordance with a succession plan previously approved by the Board of Directors of MultiPlan Corporation and reported by the Company, Mr. Mark Tabak, Chief Executive Officer of the Company and member and Chairman of the Board, delivered his resignation as Chief Executive Officer to the Company, effective immediately, to be succeeded as Chief Executive Officer of the Company by Mr. Dale White. Mr. Tabak will continue to serve on the Board as Chairman and Mr. White joined the Board on such date.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosures

Not applicable.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures pursuant to Rule 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). In designing and evaluating the disclosure controls and procedures, our management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud, if any, within the Company will be detected. In addition, the design of disclosure controls and procedures must reflect the fact that there are resource constraints and that our management is required to apply its judgment in evaluating the benefits of possible controls and procedures relative to their costs.

Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer concluded that, as of December 31, 2021, our disclosure controls and procedures were effective to provide reasonable assurance that the information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and our Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosures.

Management's Report on Internal Control over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15(d)-15(f) under the Exchange Act. Internal control over financial reporting is a process designed by, or under the supervision of, our Chief Executive Officer and Chief Financial Officer, or persons performing similar functions, and effected by the Company's board of directors, management and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles and includes those policies and procedures that (1) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of our assets; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on the financial statements.

Because of inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision and with the participation of our management, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on criteria established in *Internal Control – Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on that evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2021. The effectiveness of the Company's internal control over financial reporting as of December 31, 2021 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Remediation of Previously Disclosed Material Weaknesses

In previous annual and quarterly reports, we disclosed that we had two material weaknesses in our internal control over financial reporting. The Company's management concluded that:

- We did not maintain a sufficient complement of resources with an appropriate level of accounting knowledge and experience commensurate with the financial reporting requirements for a public company, including condensed timelines to close and sufficient oversight of internal controls over financial reporting.

- We did not maintain sufficient formal accounting policies, procedures, and controls for accounting and financial reporting with respect to the requirements and application of public company financial reporting requirements, including accounting for debt and equity arrangements.

In 2020, the Company started the process to remediate the material weaknesses by hiring a Senior Vice President and Chief Accounting Officer, a Vice President of Internal Audit, and an Assistant Vice President and Assistant General Counsel, Securities in September, October, and December, respectively. The Company also engaged a professional services firm to assist in the design and documentation of formal policies, procedures and internal controls. Additionally, the Company started to formalize and implement accounting policies, procedures, and internal controls for financial close and reporting, in line with public company financial reporting requirements.

Throughout fiscal year 2021, management completed the following remediation actions to ensure that the material weaknesses are remediated:

- The Company hired a Senior Vice President of Finance and Investor Relations and strengthened the financial reporting and technical accounting team with individuals who have significant experience in technical accounting matters and internal controls.
- The Company completed a formal risk assessment process which identified areas where new controls needed to be designed and implemented as well as areas where enhancements to existing controls were necessary.
- The Company completed the evaluation of its key internal controls over financial reporting, which included, where needed, the design and implementation of new controls and the enhancement of existing business process and entity-level controls.
- The Company strengthened the internal control environment by conducting training on policies and procedures, standardizing business practices, improving communication, leadership, and process improvement within various financial functional areas.
- The Company designed and implemented a repeatable formal process and timeline for periodic financial close and reporting which supports public company reporting requirements. An SEC Reporting solution was implemented to complement the public company reporting process.

Since identifying the material weaknesses, management has implemented its plan to remediate the control deficiencies, including updating the Company's design, documentation and implementation of internal controls to address the previously identified control deficiencies. During the fiscal year ended December 31, 2021, management completed the design, implementation and testing of the newly designed and enhanced controls and determined that, as of December 31, 2021, these controls were appropriately designed and operating effectively to conclude the material weaknesses have been remediated.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2021, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspection

N/A

Part III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item 10 of Form 10-K will be included in our 2022 Proxy Statement to be filed with the Securities and Exchange Commission in connection with the solicitation of proxies for our 2022 Annual Meeting of Stockholders and is incorporated herein by reference. The 2022 Proxy Statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

Item 11. Executive Compensation

The information required by this Item 11 of Form 10-K will be included in our 2022 Proxy Statement and is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owner and Management and Related Stockholder Matters

The information required by this Item 12 of Form 10-K will be included in our 2022 Proxy Statement and is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by this Item 13 of Form 10-K will be included in our 2022 Proxy Statement and is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services

The information required by this Item 14 of Form 10-K will be included in our 2022 Proxy Statement and is incorporated herein by reference.

Part IV

Item 15. Exhibits, Financial Statement Schedules

		Incorporated by Reference				
Exhibit Number	Description	Form	File No.	Exhibit	Filing Date	Filed Herewith
2.1	Agreement and Plan of Merger, dated as of July 12, 2020, by and among Churchill Capital Corp III, Music Merger Sub I, Inc., Music Merger Sub II, LLC, Polaris Parent Corp. and Polaris Investment Holdings, L.P.	8-K	001-39228	2.1	July 13, 2020	
3.1	Second Amended and Restated Certificate of Incorporation of MultiPlan Corporation	8-K	001-39228	3.1	October 9, 2020	
3.2	Amended and Restated Bylaws of MultiPlan Corporation	8-K	001-39228	3.2	October 9, 2020	
4.1	Specimen Class A common stock Certificate	8-K	001-39228	4.1	October 9, 2020	
4.2	Specimen Warrant Certificate (included in Exhibit 4.3)					
4.3	Warrant Agreement, dated February 13, 2020, between Continental Stock Transfer & Trust Company and Churchill Capital Corp III	8-K	001-39228	4.1	February 19, 2020	
4.4	Specimen Warrant Certificate (included in Exhibit 4.5)					
4.5	Warrant Agreement, dated October 8, 2020, between Continental Stock Transfer & Trust Company and Churchill Capital Corp III	8-K	001-39228	4.5	October 9, 2020	
4.6	Indenture, dated as of October 8, 2020, by and between Churchill Capital Corp III and Wilmington Trust, National Association	8-K	001-39228	4.6	October 9, 2020	
4.7	Form of 6.00% / 7.00% Convertible Senior PIK Toggle Notes due 2027 (included in Exhibit 4.6)					
4.8	Indenture, dated as of November 21, 2017, between Polaris Intermediate Corp. and Wilmington Trust, National Association	8-K	001-39228	4.8	October 9, 2020	
4.9	Form of 8.500% / 9.250% Senior PIK Toggle Notes due 2022 (included in Exhibit 4.8)					
4.10	Indenture, dated as of June 7, 2016 between MPH Acquisition Corp. 1 (as successor to Polaris Merger Sub Corp.) and Wilmington Trust, National Association	8-K	001-39228	4.10	October 9, 2020	
4.11	Form of 7.125% Senior Notes due 2024 (included in Exhibit 4.10)					

		Incorporated by Reference				
Exhibit Number	Description	Form	File No.	Exhibit	Filing Date	Filed Herewith
4.12	First Supplemental Indenture, dated as of June 7, 2016, to that certain Indenture, dated as of June 7, 2016, between MPH Acquisition Holdings LLC (as successor to MPH Acquisition Corp. 1) and Wilmington Trust, National Association	8-K	001-39228	4.12	October 9, 2020	
4.13	Second Supplemental Indenture, dated as of November 18, 2016, to that certain Indenture, dated as of June 7, 2016, between MPH Acquisition Holdings LLC and Wilmington Trust, National Association	8-K	001-39228	4.13	October 9, 2020	
4.14	Indenture, dated as of October 29, 2020, between MPH Acquisition Holdings LLC, the guarantors named therein and Wilmington Trust, National Association	8-K	001-39228	4.1	October 30, 2020	
4.15	Form of 5.750% Senior Notes due 2028 (included in Exhibit 4.14)					
4.16	Indenture, dated as of August 24, 2021, by and among MPH Acquisition Holdings LLC, the guarantors party thereto and Wilmington Trust, National Association	8-K	001-39228	4.1	August 25, 2021	
4.17	Form of 5.50% Senior Secured Note due 2028 (included in Exhibit 4.16)					
4.18	Description of the Registrant's Securities Registered Pursuant to Section 12 of the Securities Exchange Act of 1934	10-K/A	001-39228	4.16	March 25, 2021	
10.1	Investor Rights Agreement, dated as of July 12, 2020, by and among Churchill Capital Corp III, Polaris Investment Holdings, L.P., Churchill Sponsor III LLC, Hellman & Friedman Capital Partners VIII, L.P., The Public Investment Fund of The Kingdom of Saudi Arabia, and the other parties named therein	8-K	001-39228	10.1	July 13, 2020	
10.2	Private Placement Warrants Purchase Agreement between Churchill Capital Corp III and Churchill Sponsor III LLC	S-1	333-236153	10.6	January 29, 2020	
10.3	Common Subscription Agreement dated as of July 12, 2020, by and between Churchill Capital Corp III and The Public Investment Fund of The Kingdom of Saudi Arabia	8-K	001-39228	10.2	July 13, 2020	
10.4	Form of Other Common Subscription Agreement	8-K	001-39228	10.3	July 13, 2020	
10.5	Form of Convertible Subscription Agreement	8-K	001-39228	10.4	July 13, 2020	
10.6	Promissory Note, dated as of July 12, 2020, by and between Churchill Capital Corp III and Churchill Sponsor III LLC	8-K	001-39228	10.6	July 13, 2020	
10.7	Credit Agreement, dated as of June 7, 2016, among MPH Acquisition Holdings LLC (as successor in interest), the Lenders party thereto, the Co-Obligors party thereto, Barclays Bank PLC, as the Administrative Agent, the Collateral Agent, Letter of Credit Issuer and Swingline Lender, and the other parties party thereto	8-K	001-39228	10.8	October 9, 2020	
10.8	Incremental Agreement No. 1, dated as of June 12, 2017, in respect of that certain Credit Agreement, dated as of June 7, 2016, among MPH Acquisition Holdings LLC (as successor in interest), the Lenders party thereto, the Co-Obligors party thereto, Barclays Bank PLC, as the Administrative Agent, the Collateral Agent, Letter of Credit Issuer and Swingline Lender, and the other parties party thereto	8-K	001-39228	10.9	October 9, 2020	
10.9	Amendment Agreement No. 2, dated as of July 2, 2020, in respect of that certain Credit Agreement, dated as of June 7, 2016, among MPH Acquisition Holdings LLC (as successor in interest), the Lenders party thereto, the Co-Obligors party thereto, Barclays Bank PLC, as the Administrative Agent, the Collateral Agent, Letter of Credit Issuer and Swingline Lender, and the other parties party thereto	8-K	001-39228	10.10	October 9, 2020	

Exhibit Number	Description	Incorporated by Reference				Filed Herewith
		Form	File No.	Exhibit	Filing Date	
10.10	Incremental Revolving Credit Commitment Increase Agreement No. 1, dated as of October 29, 2020, among MPH Acquisition Corp 1, MPH Acquisition Holdings LLC, as the Borrower, Barclays Bank PLC, as Administrative Agent, the Incremental Revolving Credit Commitment Increase Lenders party thereto and the other parties party thereto	8-K	001-39228	10.1	October 30, 2020	
10.11#	MultiPlan Corporation 2020 Omnibus Incentive Plan	S-8	333-251250	4.1	December 10, 2020	
10.12#	Form of Director Restricted Stock Unit Award under the 2020 Omnibus Incentive Plan	10-K	001-39228	10.12	March 16, 2021	
10.13#	Form of Employee Restricted Stock Unit Award under the 2020 Omnibus Incentive Plan	10-K	001-39228	10.13	March 16, 2021	
10.14#	Form of Restricted Stock Award under the 2020 Omnibus Incentive Plan	10-K	001-39228	10.14	March 16, 2021	
10.15#	Form of Option Award under the 2020 Omnibus Incentive Plan	10-K	001-39228	10.15	March 16, 2021	
10.16#+	Amended and Restated Employment Agreement, dated May 5, 2016, by and among Mark Tabak, Polaris Investment Holdings, L.P. and MultiPlan, Inc.	8-K	001-39228	10.13	October 9, 2020	
10.17#+	Amended and Restated Employment Agreement, dated May 5, 2016, by and among David Redmond, Polaris Investment Holdings, L.P. and MultiPlan, Inc.	8-K	001-39228	10.14	October 9, 2020	
10.18#+	Amended and Restated Employment Agreement, dated May 5, 2016, by and among Dale White, Polaris Investment Holdings, L.P. and MultiPlan, Inc.	8-K	001-39228	10.2	October 9, 2020	
10.19#	Offer Letter to Jeffrey Doctoroff, dated June 25, 2014	8-K	001-39228	10.16	October 9, 2020	
10.20#	Form of Director and Officer Indemnification Agreement	8-K	001-39228	10.17	October 9, 2020	
10.21#	Side Letter between Mark H. Tabak and MultiPlan, Inc., effective August 4, 2021, amending the Amended and Restated Employment Agreement by and between Mr. Tabak, MultiPlan, Inc. and Polaris Investment Holdings, L.P.	8-K	001-39228	10.1	August 6, 2021	
10.22#	Side Letter between David L. Redmond and MultiPlan, Inc., effective August 4, 2021, amending the Amended and Restated Employment Agreement by and between Mr. Redmond, MultiPlan, Inc. and Polaris Investment Holdings, L.P.	8-K	001-39228	10.2	August 6, 2021	
10.23	Purchase Agreement, dated August 17, 2021, among MPH Acquisition Holdings LLC, the guarantors named therein and Goldman Sachs & Co. LLC., as representative of the several initial purchasers named therein	8-K	001-39228	10.1	August 18, 2021	
10.24	Credit Agreement, dated as of August 24, 2021, by and among MPH Acquisition Corp. 1, MPH Acquisition Holdings LLC, the Co-Obligors from time to time party thereto, the Lenders and Letter of Credit Issuers from time to time party thereto and Goldman Sachs Lending Partners LLC, as the Administrative Agent, Collateral Agent, Swingline Lender and Letter of Credit Issuer	8-K	001-39228	10.1	August 25, 2021	
10.25#	Employment Agreement dated November 15, 2021, by and between Multiplan Corporation and James Head.	8-K	001-39228	10.1	November 16, 2021	
10.26	Amended and Restated Sponsor Agreement, dated as of July 12, 2020, by and among Churchill Capital Corp III, Churchill Sponsor III LLC, and the other parties thereto	8-K	001-39228	10.5	July 13, 2020	
10.27#	Offer Letter to Paul Galant, dated September 18, 2020					X
10.28#	Agreement and General Release, dated June 30, 2021 by and between MultiPlan, Inc. and Paul Galant					X
10.29#	Employment Agreement dated January 31, 2022, by and between Multiplan Corporation and Dale White.	8-K	001-39228	10.1	January 31, 2022	

Exhibit Number	Description	Incorporated by Reference				Filed Herewith
		Form	File No.	Exhibit	Filing Date	
10.30	Amendment No. 1 to Investors Rights Agreement dated as of January 31, 2022, by and between MultiPlan Corporation and the other parties thereto.	8-K	001-39228	10.2	January 31, 2022	
10.31#	Form of Stock Award Agreement under the 2020 Omnibus Incentive Plan.	8-K	001-39228	10.3	January 31, 2022	
14.1	Code of Business Conduct and Ethics of MultiPlan Corporation, effective October 8, 2020	8-K	001-39228	14.1	October 9, 2020	
21.1	List of Subsidiaries					X
23.1	Consent of PricewaterhouseCoopers LLP					X
31.1	Certification of Principal Executive Officer Pursuant to Securities Exchange Act Rules 13-a - 14(a), as adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
31.2	Certification of Principal Financial Officer Pursuant to Securities Exchange Act Rules 13-a - 14(a), as adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
32.1	Certification of Principal Executive Officer Pursuant to 18 U.S.C. of Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
32.2	Certification of Principal Financial Officer Pursuant to 18 U.S.C. of Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
101	The following financial information from MultiPlan Corporation's Annual Report on Form 10-K for the year ended December 31, 2021 formatted in Inline XBRL (Extensible Business Reporting Language) includes: (i) the Consolidated Balance Sheets, (ii) the Consolidated Statements of (Loss) Income and Comprehensive (Loss) Income, (iii) the Statements of Changes in Stockholders' Equity, (iv) the Consolidated Statements of Cash Flows, and (v) Notes to the Consolidated Financial Statements.					X
104	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101)					X

+ The schedules and exhibits to this agreement have been omitted pursuant to Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule and/or exhibit will be furnished to the SEC upon request.

Management contract or compensatory plan or arrangement.

Item 16. Form 10-K Summary

None

Signatures

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 25th day of February, 2022.

MultiPlan Corporation

By: /s/ Dale A. White
Name: Dale A. White
Title: Chief Executive Officer (Principal Executive Officer) and Director

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Dale A. White Dale A. White	Chief Executive Officer (Principal Executive Officer) and Director	February 25, 2022
/s/ James M. Head James M. Head	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 25, 2022
/s/ Gerald J. Kozel Gerald J. Kozel	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 25, 2022
/s/ Mark H. Tabak Mark H. Tabak	Non-Executive Chairperson of the Board of Directors	February 25, 2022
/s/ Allen R. Thorpe Allen R. Thorpe	Lead Independent Director	February 25, 2022
/s/ Glenn R. August Glenn R. August	Director	February 25, 2022
/s/ Richard A. Clarke Richard A. Clarke	Director	February 25, 2022
/s/ Anthony Colaluca, Jr. Anthony Colaluca, Jr.	Director	February 25, 2022
/s/ Paul D. Emery Paul D. Emery	Director	February 25, 2022
/s/ C. Martin Harris C. Martin Harris	Director	February 25, 2022
/s/ Julie D. Klapstein Julie D. Klapstein	Director	February 25, 2022
/s/ Michael S. Klein Michael S. Klein	Director	February 25, 2022
/s/ P. Hunter Philbrick P. Hunter Philbrick	Director	February 25, 2022
/s/ William L. Veghte William L. Veghte	Director	February 25, 2022

EXHIBIT 10.27

September 18, 2020

Mr. Paul Galant
1801 SE 10th Street
Ft. Lauderdale, FL 33316

Dear Paul,

We are pleased to confirm our offer of employment with MultiPlan.

The position offered is President, New Markets, reporting to Mark Tabak, CEO. Your employment with MultiPlan is contingent upon MultiPlan's pending transaction with Churchill Capital Ill Corp. closing, and your start date will be mutually determined after that closing occurs. The starting rate of pay will be $18,292.31 per pay period (annualized at $475,600.00). Starting in 2021, you will also be eligible to participate in the MultiPlan annual incentive compensation plan, with a target bonus of 100% of your base salary upon meeting a set of goals and deliverables. You will also be eligible to receive equity compensation under our stock option plan, when that plan is finalized and approved, in an amount to be determined in accordance with that plan.

Further, you will be eligible for benefits as provided for full-time employees. Benefit information can be found in the attached 2020 Benefits Guide.

Please note that this offer is also contingent upon the successful completion of a pre-employment background check within the guidelines of state and federal law.

As a condition of your employment, you will need to provide MultiPlan with documents that establish both your identity and employment eligibility to work in the United States. A list of acceptable documents required by the Immigration Reform Control Act of 1986 that are proof of a lawful work status will be provided to you. Your employment is considered employment at will. This means employment is not defined for a specific time, rather either you or MultiPlan may terminate the employment relationship at any time with or without notice and with or without cause.

Please indicate your acceptance of this offer by signing below and returning to me.

We look forward to you joining the MultiPlan Team!

Sincerely,

/s/ Diane Hale
Diane Hale
AVP, Human Resources

Accepted: /s/ Paul Galant Date: 9/29/2020
Paul Galant

EXHIBIT 10.28

AGREEMENT AND GENERAL RELEASE

MultiPlan, Inc., on behalf of itself and its subsidiaries, ("Employer") and Paul Galant ("Employee"), Employee's heirs, executors, administrators, successors, and assigns (collectively referred to throughout this Agreement as "Employee"), agree that:

1. **Last Day of Employment.** Employee's last day of employment with Employer was June 30, 2021 (the "Separation Date").

2. **Consideration.** In consideration for Employer and Employee signing this Agreement and General Release and in accordance with the Employer's severance program, and complying with their terms, Employer agrees:

    a. to pay to Employee, $951,200 (the "Severance Amount"), representing (i) twelve months of salary (the "Severance Period") at Employee's base rate of pay and (ii) Employee's target bonus for 2021. Such sum shall be less lawful deductions and withholdings. The Severance Amount is payable on the earliest practical payday which is at least ten (10) business days following: (i) Employer's receipt of an original of this Agreement signed by Employee and Employer, and (ii) Employee's last day of employment, as indicated herein.

    b. if Employee properly and timely elects to continue medical and dental coverage under the benefit programs offered by Employer in accordance with the continuation requirements of COBRA ("Employee's Election"), Employer shall subsidize Employee's COBRA premiums by paying an amount equal to the sum of the Employer and Employee portion of Employee's medical and dental coverage in effect from the last day of employment through September 30, 2021, in accordance with the COBRA subsidy provision under the American Rescue Plan Act of 2021. Both Employer and Employee shall pay their respective portion of the premium for such coverage beginning on October 1, 2021 and ending on September 30, 2022; provided that Employee timely remits Employee's portion of the premium to Benefit Strategies or any successor COBRA administrator. Thereafter, Employee shall be entitled to elect to continue such COBRA coverage for the remainder of the COBRA period, at Employee's own expense and without contribution from Employer.

    c. The 133,689 shares of restricted stock awarded to Employee on June 23, 2021 pursuant to the MultiPlan Corporation 2020 Omnibus Incentive Plan (the "Awarded Shares") shall be fully vested after the revocation period described below has fully run, and all income, employment and/or other applicable taxes payable upon the vesting of the Awarded Shares shall be satisfied by the withholding from the Awarded Shares that would otherwise be retained by Employee such number of Awarded Shares having an aggregate Fair Market Value that is greater than the applicable minimum required statutory withholding liability (but such withholding may in no event be in excess of the maximum statutory withholding amount(s) in the Employee's relevant tax jurisdictions).

3. **No Consideration Absent Execution of this Agreement.** Employee understands and agrees that Employee would not receive the monies and/or benefits specified in paragraph "2" above, except for Employee's execution of this Agreement and General Release and the fulfillment of the promises contained herein.

4. **General Release of All Claims, Claims Not Released and Related Provisions.**

a. **Claims Released.** Employee knowingly and voluntarily releases and forever discharges MultiPlan, Inc. and its subsidiaries, including their respective parent corporations, affiliates, subsidiaries, divisions, predecessors, insurers, successors and assigns, and their current and former employees, attorneys, officers, directors and agents thereof, both individually and in their business capacities, and their employee incentive compensation plans and practices, employee benefit plans and programs and their administrators and fiduciaries (collectively referred to throughout the remainder of this Agreement as "Releasees"), of and from any and all claims, known and unknown, asserted or unasserted, which the Employee has or may have against Releasees as of the date of execution of this Agreement and General Release, including, but not limited to, any alleged violation of:

Federal. Title VII of the Civil Rights Act of 1964; The Civil Rights Act of 1991; Sections 1981 through 1988 of Title 42 of the United States Code, as amended; The Employee Retirement Income Security Act of 1974 ("ERISA") (except for any vested benefits under any tax qualified benefit plan); The Immigration Reform and Control Act; The Americans with Disabilities Act of 1990; The Age Discrimination in Employment Act of 1967 ("ADEA"); The Workers Adjustment and Retraining Notification Act; The Occupational Safety and Health Act; The Fair Credit Reporting Act; The Family and Medical Leave Act of 1993 ("FMLA") 29 U.S.C. 2601, et seq.; The Equal Pay Act of 1963, 29 U.S.C. § 206(d), as amended; The Genetic Information Nondiscrimination Act of 2008; The Families First Coronavirus Response Act, 29 C.F.R § 826, The Emergency Paid Sick Leave Act, The Emergency and Medical Leave Expansion Act, The Coronavirus Aid, Relief, and Economic Security Act, 15 U.S.C.S. § 9001 et seq.. If any claim is not subject to release, to the extent permitted by law, Employee waives any right or ability to be a class or collective action representative or to otherwise participate in any putative or certified class, collective or multi-party action or proceeding based on such a claim in which Employer or any other Release identified in this Agreement is a party;
California. California Family Rights Act – Cal. Gov't Code § 12945.2; California Fair Employment and Housing Act – Cal. Gov't Code § 12900 et seq.; California Unruh Civil Rights Act – Cal. Civ. Code § 51 et seq.; Statutory Provisions Regarding the Confidentiality of AIDS Information – Cal. Health & Safety Code § 120775 et seq.; California Confidentiality of Medical Information Act – Cal. Civ. Code § 56 et seq.; California Parental Leave Law – Cal. Lab. Code § 230.7 et seq.; California Apprenticeship Program Bias Law – Cal. Lab. Code § 3070 et seq.; California Equal Pay Law – Cal. Lab. Code § 1197.5; California Whistleblower Protection Law – Cal. Lab. Code § 1102.5; California Military Personnel Bias Law – Cal. Mil. & Vet. Code § 394; Statutory Provision Regarding California Family and Medical Leave – Cal. Lab. Code § 233; Statutory Provisions Regarding California Electronic Monitoring of Employees – Cal. Lab. Code § 435; The California Occupational Safety and Health Act, as amended, California Labor Code § 6300 et seq., and any applicable regulations thereunder; California Obligations of Investigative Consumer Reporting Agencies Law – Cal. Civ. Code § 1786.10 et seq.; California Political Activities of Employees Law – Cal. Lab. Code § 1101 et seq.; California Domestic Violence Victim Employment Leave Law – Cal. Lab. Code § 230.1; California Court Leave Law – Cal. Lab. Code § 230; Those other provisions of the California Labor Code that lawfully may be released, **Florida.** The Florida Civil Rights Act – Fla. Stat. § 760.01, et seq.; Florida's Private-Sector Whistle- blower's Act – Fla. Stat. § 448.101, et seq.; Florida's Public-Sector Whistle-blower's Act – Fla. Stat. § 112.3187, et seq.; Florida's Statutory Provision Regarding Retaliation/Discrimination for Filing a Workers Compensation Claim – Fla. Stat. § 440.205; Florida's Statutory Provision Regarding Wage Rate Discrimination Based on Sex – Fla. Stat. § 448.07; The Florida Equal Pay Act – Fla. Stat. § 725.07;The Florida Omnibus AIDS Act – Fla. Stat. § 760.50; Florida's Statutory

Provisions Regarding Employment Discrimination on the Basis of and Mandatory Screening or Testing for Sickle-Cell Trait – Fla. Stat. §§ 448.075, 448.076; Florida's Wage Payment Laws, Fla. Stat. §§ 448.01, 448.08; Florida's Domestic Violence Leave Act – FLA. Stat. §741.313; Florida's Preservation & Protection of Right to Keep & Bear Arms in Motor Vehicles Act – Fla. Stat. §790.251; Florida's General Labor Regulations, Fla. Stat. ch. 448;; **In all jurisdictions**. Any other federal, state, local or other law, rule, regulation, constitution, code, guideline or ordinance, any public policy, contract (oral or written, express or implied), tort or common law, or any statute, common law, agreement or other basis for seeking or recovering any costs, fees or other expenses, including but not limited to attorneys' fees and/or costs.

Waiver of California Civil Code section 1542. To effect a full and complete general release as described above, Employee expressly waives and relinquishes all rights and benefits of section 1542 of the Civil Code of the State of California, and does so understanding and acknowledging the significance and consequence of specifically waiving section 1542. Section 1542 of the Civil Code of the State of California states as follows:

> **A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor.**

Thus, notwithstanding the provisions of section 1542, and to implement a full and complete release and discharge of the Released Parties, Employee expressly acknowledges this Separation Agreement is intended to include in its effect, without limitation, all claims Employee does not know or suspect to exist in Employee's favor at the time of signing this Separation Agreement, and that this Separation Agreement contemplates the extinguishment of any such claims. Employee warrants Employee has read this Separation Agreement, including this waiver of California Civil Code section 1542, and that Employee has consulted with or had the opportunity to consult with counsel of Employee's choosing about this Separation Agreement and specifically about the waiver of section 1542, and that Employee understands this Separation Agreement and the section 1542 waiver, and so Employee freely and knowingly enters into this Separation Agreement. Employee further acknowledges that Employee later may discover facts different from or in addition to those Employee now knows or believes to be true regarding the matters released or described in this Separation Agreement, and even so Employee agrees that the releases and agreements contained in this Separation Agreement shall remain effective in all respects notwithstanding any later discovery of any different or additional facts. Employee expressly assumes any and all risk of any mistake in connection with the true facts involved in the matters, disputes or controversies released or described in this Separation Agreement or with regard to any facts now unknown to Employee relating thereto.

b. **Claims Not Released.** Employee is not waiving any rights Employee may have to: (a) Employee's own vested accrued employee benefits under Employer's health, welfare, or retirement benefit plans as of the Separation Date; (b) benefits and/or the right to seek benefits under applicable workers' compensation and/or unemployment compensation statutes; (c) pursue claims which by law cannot be waived by signing this Agreement; (d) enforce this Agreement; and/or (e) challenge the validity of this Agreement.

c. **Governmental Agencies.** Nothing in this Agreement prohibits or prevents Employee from filing a charge with or participating, testifying, or assisting in any investigation, hearing, or other proceeding before the U.S. Equal Employment Opportunity Commission, the National Labor Relations Board or a similar agency enforcing federal, state or local anti-discrimination laws. However, to the maximum extent permitted by law, Employee agrees that if such an administrative claim is made to such an anti-discrimination agency, Employee shall not be entitled to recover any individual monetary relief or other individual remedies. In addition, nothing in this Agreement, including but not limited to the release of claims nor the confidentiality clauses, prohibits Employee from: (1) reporting possible violations of federal law or regulations, including any possible securities laws violations, to any governmental agency or entity, including but not limited to the U.S. Department of Justice, the U.S. Securities and Exchange Commission, the U.S. Congress, or any agency Inspector General; (2) making any other disclosures that are protected under the whistleblower provisions of federal law or regulations; or (3) otherwise fully participating in any federal whistleblower programs, including but not limited to any such programs managed by the U.S. Securities and Exchange Commission and/or the Occupational Safety and Health Administration. Moreover, nothing in this Agreement prohibits or prevents Employee from receiving individual monetary awards or other individual relief by virtue of participating in such federal whistleblower programs.

5. **Acknowledgments and Affirmations.** Employee affirms that Employee has been paid and/or has received all compensation, wages, bonuses, commissions, and/or benefits to which Employee may be entitled. Employee affirms that Employee has been granted any leave to which Employee was entitled under the Family and Medical Leave Act or related state or local leave or disability accommodation laws.

   Employee further affirms that Employee has no known workplace injuries or occupational diseases.

   Employee also affirms that Employee has not divulged any proprietary or confidential information of Employer and will continue to maintain the confidentiality of such information consistent with Employer's policies and Employee's agreement(s) with Employer and/or common law. As noted above, this Agreement does not limit Employee from providing any documents to the U.S. Securities and Exchange Commission as part of a whistleblower action and/or a report of possible violations of any federal securities law. Under the federal Defend Trade Secrets Act of 2016, Employee shall not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that: (a) is made (i) in confidence to a federal, state, or local government official, either directly or indirectly, or to an attorney; and (ii) solely for the purpose of reporting or investigating a suspected violation of law; or (b) is made to Employee's attorney in relation to a lawsuit for retaliation against Employee for reporting a suspected violation of law; or (c) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal.

   Employee further affirms that Employee has not been retaliated against for reporting any allegations of wrongdoing by Employer or its officers, including any allegations of corporate fraud. Both Parties acknowledge that this Agreement does not limit either party's right, where applicable, to file or participate in an investigative proceeding of any federal, state or local governmental agency.

6. **Confidentiality and Return of Property.** Employee agrees not to disclose any information regarding the underlying facts leading up to or the existence or substance of this Agreement and General Release, except to Employee's spouse, tax advisor, and/or an attorney with

whom Employee chooses to consult regarding Employee's consideration of this Agreement and General Release.

Employee affirms that Employee has returned all of Employer's property, documents, and/or any trade secret and/or confidential information, in any form or format, in Employee's possession or control. Employee also affirms that Employee is in possession of all of Employee's property that Employee had at Employer's premises and that Employer is not in possession of any of Employee's property.

7. **Non-Disparagement by Employee.** Employee agrees that Employee will not in any way disparage or defame the good name of MultiPlan, its officers, directors and employees, in any forum, including the media, and that Employee will not induce any other person to do so.

8. **Governing Law and Interpretation.** This Agreement and General Release shall be governed and conformed in accordance with the laws of the state in which Employee worked at the time of Employee's last day of employment without regard to its conflict of laws provision. In the event of a breach of any provision of this Agreement and General Release, either party may institute an action specifically to enforce any term or terms of this Agreement and General Release and/or seek any damages for breach. Should any provision of this Agreement and General Release be declared illegal or unenforceable by any court of competent jurisdiction and cannot be modified to be enforceable, excluding the general release language, such provision shall immediately become null and void, leaving the remainder of this Agreement and General Release in full force and effect.

9. **Nonadmission of Wrongdoing.** The Parties agree that neither this Agreement and General Release nor the furnishing of the consideration for this Agreement and General Release shall be deemed or construed at any time for any purpose as an admission by Releasees of wrongdoing or evidence of any liability or unlawful conduct of any kind.

10. **Amendment.** This Agreement and General Release may not be modified, altered or changed except in writing and signed by both Parties wherein specific reference is made to this Agreement and General Release.

11. **Entire Agreement.** This Agreement and General Release sets forth the entire agreement between the Parties hereto, and fully supersedes any prior agreements or understandings between the Parties, except with respect to Employee's confidentiality obligations referenced herein pursuant to its employment with Employer and any payment obligations of Employee in connection with benefits, loans or advances offered by Employer. Employee acknowledges that Employee has not relied on any representations, promises, or agreements of any kind made to Employee in connection with Employee's decision to accept this Agreement and General Release, except for those set forth in this Agreement and General Release.

EMPLOYEE IS ADVISED THAT EMPLOYEE HAS UP TO FORTY-FIVE (45) CALENDAR DAYS FROM THE SEPARATION DATE TO CONSIDER THIS AGREEMENT AND GENERAL RELEASE. IF EMPLOYEE DOES NOT ACCEPT THIS AGREEMENT WITHIN THAT FORTY-FIVE (45) DAY PERIOD, THE OFFER IN THIS AGREEMENT IS AUTOMATICALLY REVOKED. EMPLOYEE ALSO IS ADVISED TO CONSULT WITH AN ATTORNEY PRIOR TO EMPLOYEE'S SIGNING OF THIS AGREEMENT AND GENERAL RELEASE.

EMPLOYEE MAY REVOKE THIS AGREEMENT AND GENERAL RELEASE FOR A PERIOD OF SEVEN (7) CALENDAR DAYS FOLLOWING THE DAY EMPLOYEE

SIGNS THIS AGREEMENT AND GENERAL RELEASE. ANY REVOCATION WITHIN THIS PERIOD MUST BE SUBMITTED, IN WRITING, TO JEFFREY DOCTOROFF AND STATE, "I HEREBY REVOKE MY ACCEPTANCE OF OUR AGREEMENT AND GENERAL RELEASE." THE REVOCATION MUST BE PERSONALLY DELIVERED TO JEFFREY DOCTOROFF OR MAILED TO JEFFREY DOCTOROFF 16 CROSBY DRIVE, BEDFORD, MA 01730; EMAIL JEFF.DOCTOROFF@MULTIPLAN.COM; PHONE 781-895-6818 AND POSTMARKED WITHIN SEVEN (7) CALENDAR DAYS AFTER EMPLOYEE SIGNS THIS AGREEMENT AND GENERAL RELEASE.

EMPLOYEE AGREES THAT ANY MODIFICATIONS, MATERIAL OR OTHERWISE, MADE TO THIS AGREEMENT AND GENERAL RELEASE, DO NOT RESTART OR AFFECT IN ANY MANNER THE ORIGINAL UP TO FORTY-FIVE (45) DAY CONSIDERATION PERIOD.

EMPLOYEE FREELY AND KNOWINGLY, AND AFTER DUE CONSIDERATION, ENTERS INTO THIS AGREEMENT AND GENERAL RELEASE INTENDING TO WAIVE, SETTLE AND RELEASE ALL CLAIMS EMPLOYEE HAS OR MIGHT HAVE AGAINST RELEASEES.

IN WITNESS WHEREOF, the undersigned have hereto set their hands as of the day and year first above written.

General Partner:

AG Asset Based Credit GP, LLC

By: Angelo, Gordon & Co., L.P.,
its Manager

By: /s/ Gregory Shalette

Name: Gregory Shalette

Title: Deputy General Counsel

Fund General Partner (solely with respect to its rights and obligations hereunder):

AG Asset Based Credit GP, LLC

By: Angelo, Gordon & Co., L.P.,
its Manager

By: /s/ Gregory Shalette

Name: Gregory Shalette

Title: Deputy General Counsel

Organizational Limited Partner:

ANGELO, GORDON & CO., L.P.

By: /s/ Gregory Shalette

Name: Gregory Shalette

Title: Deputy General Counsel

The Parties knowingly and voluntarily sign this Agreement and General Release as of the date(s) set forth below:

By: /s/ Paul Galant
Paul Galant

Date: 6/30/2021

MULTIPLAN, INC.

By: /s/ Mark Tabak
Name: Mark Tabak
Title: CEO

Date: June 30, 2021

EXHIBIT 21.1

Subsidiaries

Entity	Jurisdiction
Polaris Parent LLC	Delaware
Polaris Intermediate Corp.	Delaware
MPH Acquisition Corp [1]	Delaware
DKL Insurance Company, Inc.	Utah
MPH Acquisition Holdings LLC	Delaware
MPH Intermediate Holding Company [1]	Delaware
MultiPlan Holding Corporation	Delaware
MultiPlan, Inc.	New York
HST Acquisition Corp.	Delaware
HSTechnology Solutions, Inc.	Delaware
MARS Acquisition Corp.	Delaware
Medical Audit & Review Solutions, Inc.	Delaware
IHP Acquisition Corp.	Delaware
Integrated Health Plan, Inc.	Florida
HMA Acquisition Corporation	Delaware
Savant Management Concepts, Inc.	Arizona
i/mx Technologies, Inc.	Arizona
HMA, Inc.	Arizona
Medical Management Services, Inc.	Nevada
Rural Arizona Network, Inc.	Arizona
Health Management Network, Inc.	Nevada
NCN Acquisition Corporation	Delaware
National Care Network, LLC	Delaware
MPI Sub, Inc.	Delaware

Associates for Health Care, Inc.	Wisconsin
ForMost, Inc.	Delaware
Admar Corporation	California
ProAmerica Managed Care, Inc.	Texas
Florida Health, L.C.[1]	Florida
Healthnetwork ProAmerica Midwest, Inc.	Illinois
Private Healthcare Systems, Inc. (“PHCS”)	Delaware
Statewide Independent PPO, Inc.	New York
American Lifecare, Inc.	Louisiana
American Lifecare Holdings, Inc.	Louisiana
MultiPlan Services Corporation	Delaware
Viant Holdings, Inc.	Delaware
Viant, Inc. (“Viant”)	Nevada
Beech Street Corporation (“Beech Street”)	California
Viant Payment Systems, Inc.	Delaware
Texas True Choice, Inc.	Delaware
HealthNetwork Systems, LLC	Delaware
Viant Management Services, Inc.	Nevada
HealthEOS by MultiPlan, Inc.	Wisconsin
DHP Acquisition Corp.	Delaware
LaunchPoint Ventures, LLC (“d/b/a Discovery Health Partners”)	Delaware

[1] MPI Sub, Inc. owns a one percent interest in Florida Health, L.C. and ProAmerica Managed Care, Inc. owns the remaining 99% interest in Florida Health, L.C.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (No.333-251250) and Form S-3 (Nos. 333-260783 and 333-249779) of MultiPlan Corporation of our report dated February 25, 2022 relating to the financial statements and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Chicago, Illinois
February 25, 2022

EXHIBIT 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO RULE 13A-14(A) UNDER THE SECURITIES EXCHANGE ACT OF 1934,
AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Dale A. White, certify that:

1. I have reviewed this annual report on Form 10-K of MultiPlan Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a–15(f) and 15d–15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation;

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2022

/s/ Dale A. White
Dale A. White
Chief Executive Officer
(Principal Executive Officer)

EXHIBIT 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO RULE 13A-14(A) UNDER THE SECURITIES EXCHANGE ACT OF 1934,
AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, James M. Head, certify that:

1. I have reviewed this annual report on Form 10-K of MultiPlan Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a–15(f) and 15d–15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation;

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2022

/s/ James M. Head
James M. Head
Chief Financial Officer
(Principal Financial Officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of MultiPlan Corporation (the "Company") on Form 10-K for the year ended December 31, 2021, as filed with the Securities and Exchange Commission (the "Report"), I, Dale A White, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. §1350, as added by §906 of the Sarbanes-Oxley Act of 2002, that:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. To my knowledge, the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 25, 2022

/s/ Dale A. White
Dale A. White
Chief Executive Officer
(Principal Executive Officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of MultiPlan Corporation (the "Company") on Form 10-K for the year ended December 31, 2021, as filed with the Securities and Exchange Commission (the "Report"), I, James M. Head, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. §1350, as added by §906 of the Sarbanes-Oxley Act of 2002, that:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. To my knowledge, the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 25, 2022

/s/ James M. Head
James M. Head
Chief Financial Officer
(Principal Financial Officer)

EXHIBIT 8

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Investor Relations (https://www.multiplan.us/category/investor-relations/), Press Releases (https://www.multiplan.us/category/press-releases/)

MultiPlan Corporation Releases Stockholder Update

November 15, 2021 – MultiPlan Corporation (NYSE:MPLN) ("MultiPlan" or the "Company"), a leading value-added provider of data analytics and technology-enabled end-to-end cost management solutions to the U.S. healthcare industry, today releases a letter to its Stockholders on

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To Our Stockholders:

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As you know, MultiPlan's fundamentals have never been stronger. Since going public, we have reported five consecutive quarters of strong earnings. We continue to integrate our recent strategic acquisitions, and we recently refinanced our debt to significantly extend maturities. In October, we raised both the midpoint of our full-year 2021 revenue guidance and raised our full year 2021 EBITDA guidance.

Unfortunately, our strong fundamental performance has been overshadowed by the unsubstantiated allegations by short sellers – motivated by their own economic self-interest – that our largest customer, UnitedHealthcare (UHC), is planning to terminate its relationship with MultiPlan.

Recent sworn testimony makes clear UHC's position with respect to its relationship with MultiPlan, and further supports our previous comments that these short-seller assertions are false.

Along with many others, we have been closely following the ongoing litigation between UHC and an emergency physician staffing business. Last week, a document that called MultiPlan's and UHC's relationship into question surfaced in that trial and became a subject of interest in the securities markets. Later in the week, however, a recently retired UHC senior executive testified under oath that, as recently as August 2021, when he left UHC, UHC had no plan in place to terminate its contract with MultiPlan and had not created a product or service to replace MultiPlan. This senior executive, who oversaw the MultiPlan relationship, also attested to the strength and the interconnectedness of the commercial relationship between UHC and MultiPlan.

The false UHC "termination" narrative has been deployed tactically by opportunistic short sellers seeking to profit at the expense of MultiPlan's shareholders and bondholders. Last week's trial testimony by this executive directly contradicts this narrative.

MultiPlan has been closely following the trial testimony and wishes to share the following key takeaways directly from what we heard from the broadcast of the trial. This testimony is consistent with what we have continuously communicated to you:

1. **<u>UHC is not planning to terminate its relationship with MultiPlan, notwithstanding market rumors to the contrary.</u>**

The senior UHC executive responsible for out-of-network programs and the MultiPlan relationship and who created the document referenced earlier, testified that it wasn't plausible for UHC to replace MultiPlan.

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- UHC's Naviguard product was not created to replace MultiPlan. Naviguard does not provide to UHC and its clients the same breadth of services provided by MultiPlan.
- It was not plausible for UHC to terminate its relationship and contract with MultiPlan, because UHC clients wanted to use MultiPlan's suite of products and UHC would not require its clients to change from MultiPlan's services.

2. **The UHC "termination" rumor has been used by opportunistic short sellers to profit by driving down MultiPlan's stock and other securities.**

The false claim that UHC was terminating its relationship with MultiPlan was perpetuated by short sellers, motivated by their own economic self-interest. Although UHC does not publicly comment on its outside partners and contracts, the former UHC senior executive has now testified under oath that there is no such plan.

3. **MultiPlan's relationship with UHC remains strong.**

Over the past three years, MultiPlan's revenues from UHC have grown more than 30% to an all-time high. MultiPlan and UHC have partnered on a series of strategic initiatives that we expect will further grow this business in 2022 and beyond.

UHC is an extraordinary customer and partner of MultiPlan. For nearly 30 years, MultiPlan and UHC have worked together to reduce healthcare costs for millions of Americans and their employers, utilizing MultiPlan's unique set of technologies, independent industry-wide

information and proprietary network. We are excited to continue that partnership in the years to come as we continue to find ways to make healthcare more affordable, efficient, and fair.

* * *

The bottom line is that MultiPlan's relationship with UHC remains strong and recent sworn testimony contradicts the false suggestion that UHC intends to terminate that relationship.

MultiPlan has built a business over decades by working with payors, providers and patients to expand care while reducing costs. In 2020, we processed approximately $105B in billed charges and identified approximately $19B in potential savings opportunities for payors, healthplans and plan members. UHC is one of our many partners with whom we work closely to deliver significant savings to consumers and their employers. We plan to continue to grow our platform to benefit and drive value for our customers, employees and stockholders, and we remain fully committed to acting in the best interests of our stockholders and other stakeholders in the years to come.

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We appreciate your continued support.

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Sincerely,

Mark Tabak, Chief Executive Officer, MultiPlan Corporation

Forward-Looking Statements

This letter contains forward-looking statements within the meaning of Section 27A of the Securities Act, and Section 21E of the Securities Exchange Act of 1934, as amended. These statements often include words such as "anticipate," "expect," "suggest," "plan," "believe," "intend," "project," "forecast," "estimates," "targets," "projections," "should," "could," "would," "may," "might," "will," and other similar expressions relating to 2021 guidance and the Company's relationship with its clients. Although the Company believes that these forward-looking statements are based on reasonable assumptions at the time they are made, you should be aware that many factors could affect such forward-looking statements. Such forward-looking statements, including those related to the resale registration statement being declared effective, are based on current expectations that are subject to known and unknown risks and uncertainties.

Factors that may impact such forward-looking statements include the factors discussed under "Risk Factors" in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020 and the Company's Quarterly Reports on Form 10-Q for the quarterly periods ended March 31, 2021, June 30, 2021 and September 30, 2021, as such risk factors may be updated from time to time in the Company's periodic and other filings with the SEC.

The Company's periodic and other filings are accessible on the SEC's website at www.sec.gov. You should not rely upon forward-looking statements as predictions of future events. Although the Company believes that the expectations reflected in the forward-looking statements are reasonable, the Company cannot guarantee that the future results, levels of activity, performance and events and circumstances reflected in the forward-looking statements will be achieved or occur. Except as required by applicable law, the Company undertakes no obligation to update publicly any forward-looking statements for any reason after the date of this news release to conform these statements to actual results or to changes in our expectations.

About MultiPlan

MultiPlan is committed to helping healthcare payors manage the cost of care, improve their competitiveness [illegible] gy, data analytics and a team rich with industry experience, MultiPlan interprets clients' needs and

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customizes innovative solutions that combine its payment and revenue integrity, network-based and analytics-based services. MultiPlan is a trusted partner to over 700 healthcare payors in the commercial health, government and property and casualty markets. For more information, visit **www.multiplan.com.** (http://www.multiplan.com/)

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Merging Artificial and Human Intelligence to Pursue Payment Integrity–MultiPlan's Ben Perryman and Evan Pollack to speak at the NHCAA Annual Training Conference (https://www.multiplan.us/merging-artificial-and-human-intelligence-to-pursue-payment-integrity-multiplans-ben-perryman-and-evan-pollack-to-speak-at-the-nhcaa-annual-training-conference/)

READ MORE > (HTTPS://WWW.MULTIPLAN.US/MERGING-ARTIFICIAL-AND-HUMAN-INTELLIGENCE-TO-PURSUE-PAYMENT-INTEGRITY-MULTIPLANS-BEN-PERRYMAN-AND-EVAN-POLLACK-TO-SPEAK-AT-THE-NHCAA-ANNUAL-TRAINING-CONFERENCE/)

November 10, 2022

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MultiPlan Reports Third Quarter 2022 Results and Updates

2022 Guidance (https://www.multiplan.us/multiplan-reports-third-quarter-2022-results-and-updates-2022-guidance/)

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READ MORE > (HTTPS://WWW.MULTIPLAN.US/MULTIPLAN-REPORTS-THIRD-QUARTER-2022-RESULTS-AND-UPDATES-2022-GUIDANCE/)

November 8, 2022

Navigating the No Surprises Act – MultiPlan's Susan Mohler to Speak at the Texas Covered Health Care Conference Nov. 8 (https://www.multiplan.us/navigating-the-no-surprises-act-multiplans-susan-mohler-to-speak-at-the-texas-covered-health-care-conference-nov-8/)

READ MORE > (HTTPS://WWW.MULTIPLAN.US/NAVIGATING-THE-NO-SURPRISES-ACT-MULTIPLANS-SUSAN-MOHLER-TO-SPEAK-AT-THE-TEXAS-COVERED-HEALTH-CARE-CONFERENCE-NOV-8/)

November 2, 2022

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For Health Plan Members (https://www.multiplan.us/members/)

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Nominate a Provider (https://www.multiplan.com/nominate/nominate.cfm?type=patient)
Health Plan Member FAQs (https://www.multiplan.us/members/)

For Payors

Payor Portal Log In (https://client.multiplan.com/webcenter/portal/client)
Self-Service Tools(https://www.multiplan.us/payers/)

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EXHIBIT 9

CHURCHILL CAPITAL | MultiPlan

Virtual Analyst Day

August 18, 2020

Participants

Mark Tabak - Chief Executive Officer of MultiPlan
Michael Kim - Chief Information Officer of MultiPlan
Dale White - Chief Revenue Officer of MultiPlan
Paul Galant - Operating Partner of Churchill Capital Corp III
David Redmond - Chief Financial Officer of MultiPlan
Michael Klein - Chairman & Chief Executive Officer of Churchill Capital Corp III

Presentation

Operator
Good morning. At this time, I would like to welcome everyone to the MultiPlan Sell-Side Analyst Day Presentation. As a reminder, participants will be able to submit their questions throughout the presentation and during the Q&A session, by typing the question in the text box below the video presentation.

The company will hold the Q&A at the end of the scheduled presentation. Thank you.

Mark Tabak - Chief Executive Officer
Welcome, everyone, to MultiPlan's first-ever Analyst Day Presentation. We're really excited to share the MultiPlan story today and present our strategy for the future as a public company.

MultiPlan is a leading value-added provider of data analytics and technology enabled end-to-end cost management solutions to U.S. healthcare industry. Our primary mission is to make healthcare in the U.S. affordable, accessible, efficient and fair to the 3 constituencies we serve: patients, providers and payers.

Our services and business processes are aligned with this goal. We provide a mission-critical service and are recognized as a truly independent source of trusted information to the U.S. healthcare industry. We are the leader in out-of-network cost containment for our customers and have multi-year contracts with the leading payers.

We have a proven track record with historical revenue growth of 6% to 7% annually since 2007, producing robust margins and a high conversion to free cash flow. Our growth is driven by consistent increase in the number of customers we serve, the growth in the number of claims that we receive, medical inflation and the ever-increasing algorithms we develop to identify clinical and financial aberrations that drive overall savings.

MultiPlan has additional growth opportunities in front of us. And as a result of this merger with Churchill into a public company, we will share these with you throughout the session today.

We will enhance our existing business, extend our business into adjacent markets and to new customers, and expand the platform beyond payers, to providers and consumers, enlarging our TAM. We will increase our growth trajectory organically and through a more aggressive focus on identifying accretive opportunistic M&A opportunities.

All said, we will redeploy/invest capital to drive MultiPlan's growth rate beyond the 6% to 7% CAGR and build upon the proven track-record of generating robust margins and conversion to free cash flow. I'd like to start with a brief video, and then we'll move directly on to the presentation.

Could we roll the video, please?

The U.S. healthcare system is vast, complex and growing. Insurers, healthcare providers and consumers all play a critical role. MultiPlan is on the right side of healthcare, bringing order, efficiency, affordability and fairness to the system, providing savings to insurers and patients alike; using technology, data, algorithms and IP to create cost management solutions across the board.

Today, MultiPlan is mission-critical to the healthcare system, providing essential and patented tech solutions, with a robust IT infrastructure; 3.5 petabytes of data; a database of 1 billion claims; proprietary IP and algorithms; with a modern high-scale platform and operating a network of 1.2 million healthcare providers; with more than 60 million consumers, who also benefit from the savings that MultiPlan generates; by processing 370,000 medical claims per day to save the industry over $19 billion annually; working with a customer base of over 700 commercial insurers today, as well as consumers who are shouldering more of the burden.

We stand behind the promises and commitments we make to our customers, collaborating with them, helping them improve their performance, grow revenue and advance their competitiveness.

By any measure, as I look at MultiPlan, it really is a world-class technology and value-add transaction processing company. I look at it from this lens, importantly because the strong foundation in technology is going to be critically important to support MultiPlan's strategy. And that strategy is to extend its platform to adjacent payer customer segments, including: Government, and Property & Casualty insurers, as well as expanding into new customer segments with value-added services targeting millions of healthcare providers and consumers.

And they've laid the groundwork for a high growth opportunity, using AI and machine learning to continue to innovate.

MultiPlan stands uniquely: unique in its data, unique in its technology, unique in the relationships and partnerships its accrued for decades, unique as a result to expand its value and partnerships across the entire ecosystem, from insurers, providers, to patient service.

The time is right for investors to accelerate growth. Together, we'll help more payers, help more healthcare providers, help more consumers and help shape the healthcare industry for the future. MultiPlan, the country's leading transaction processing and analytics company serving the critical and growing healthcare ecosystem.

Operator
You're live, Mark.

Mark Tabak - Chief Executive Officer
Good morning, again, everyone. Next slide, please. Next.

Joining me today is the leadership team at MultiPlan. David Redmond, our CFO, who brings 30 years of experience in financial management, fiscal control and budgeting. He has outstanding experience with our investors and bondholders. Also with me is Dale White, our Chief Revenue Officer. Dale is responsible for sales and account management. Under his leadership, we have built an extraordinary partnership with our customers. And Michael Kim, our Chief Information Officer. Michael has great experience in managing large IT platforms and staff. He continues to keep MultiPlan at the forefront.

Also here today are Allen Thorpe, Partner at Hellman & Friedman, our lead investor, who will continue on the Board of Directors following our listing. Michael Klein, Chairman, CEO of Churchill Capital, who'll be joining the Board as well and will be speaking later on this morning.

We're also fortunate to have 2 of the Operating Partners of Churchill, Paul Galant and Bill Veghte. We've been working closely with these gentlemen for many months and they will continue to be deeply involved in the company going forward.

We will continue to benefit from their expertise and experience in operations, financial services and technology, having served in executive positions at Citigroup, Microsoft and Hewlett Packard. Next slide, please.

MultiPlan is the leading platform in providing affordability to the U.S. healthcare system. Next, please.

As many of you know, the U.S. healthcare industry is characterized by volatility, very uncertain times, complexity and full of ambiguity. These manifest themselves in ever-increasing cost, and opaque pricing that are often hamstrung by legacy technologies which prevent efficiency and real-time changes. For more than 40 years, MultiPlan has worked to address these challenges for the benefit of the 3 constituency we serve: payers, providers and patients. Next slide, please.

Our mission has been to deliver affordability, efficiency and fairness to these 3 constituencies. We have 700-plus payer customers, commercial insurers, Blue Cross and Blue Shield plans, third-party administrators, regional health plans, and TPAs, both in the public sector and the private sector. We have direct contracts with 1.2 million directly contracted providers, hospitals, practitioners, ancillary service providers, and more than 60 million consumer patients have access to our solution set.

This is accomplished with a single product. That product being affordability which is supported by 3 distinct offerings. Network-Based Services are contracts with 1.2 million providers through discounted rates in exchange for access to patients. This was the legacy

PPO business that also enabled us to build an incomparable database of charge, claim and provider credentialing data.

The Analytics-Based Services use our data and technology to determine fair reimbursement for claims, not re-priced, under our network contract. And the Payment Integrity Services, our newest product identifies improper charges, like: clinical errors, waste and abuse, and at times fraud. It's the power of these 3 offerings integrated together that provide healthcare affordability, and fair reimbursement. Next slide, please.

MultiPlan is mission critical, driving fair reimbursement and healthcare affordability. Since our inception 40 years ago, we've been a customer-centric company. We identified a major area of concern for our customers many years ago, a pain point if you will, and that was out-of-network expense.

We built the set of solutions to address this financial concern and become the industry-leader in out-of-network cost management for the more than 700-plus customers we serve today. Many of our customers have been with MultiPlan for more than two decades, and all of the top 10 payers are customers, many under multiyear contracts. Our strength is our culture as evidenced by the long stable tenure of a leadership team and the longevity of these client relationships for decade upon decade and, of course, operational excellence by doing the right thing at the right time the very first time.

Next slide, please. MultiPlan's unique end-to-end cost management platform is in perfect alignment with our three key constituencies, patients, providers and payers. The system works as follows.

Next slide, please. MultiPlan's unique end-to-end cost management platform is in perfect alignment with our three key constituencies, patients, providers and payers. The claim flow works as such, the patient goes to the provider, the provider provides services and sends those claims to MultiPlan. Last year, we received 135 million claims and $106 billion in charges. We captured those claims and we direct that to the proper solution set.

Last year, we generated over $19.1 billion of savings opportunities for our customers. The application of these services at the bottom of this slide are customized to maximize the value we provide to the people that we serve. Our recurring revenue business model generates revenues on a modest percentage of savings formula based upon the savings realized by MultiPlan's customers, the payers, the payers' customers, the employer, and ultimately the end user, the consumer, since the consumer often pays 20% of the healthcare bill. MultiPlan is on the right side of healthcare providing affordability and fairness to the three key constituencies: patients, providers and payers.

Next slide, please. Since our founding, we have brought cost management innovation, driving affordability, efficiency and fairness. Agility and adaptability have been the hallmark of MultiPlan since our founding in 1980. MultiPlan 1.0, we built the largest independent contracting network focusing on managing out-of-network expense. We've also aggregated an incomparable database of claims, charge and provider credentials. MultiPlan 2.0 began to leverage the data by expanding our offering into Analytic-Based and Payment Integrity Services.

We saw then that healthcare was moving from a system that reimbursed solely on volume and frequency to one that was reimbursed on volume, frequency, and also quality, outcome and patient experience. This movement was accelerated by two small acquisitions in 2011, we acquired a small company for $50 million that became the foundation of our analytics business, NCN Data iSight product. And in 2014, we acquired a small company for $15 million, Medical Audit & Review Solutions, which became the foundation for our payment integrity program.

And now we're at MultiPlan 3.0. Our future transition to a public company implementing a three component strategy of Enhance, Extend and Expand. And now we have the financial and strategic flexibility to achieve these successes over time.

Next slide, please. This platform is the model for our future growth. I can recall when we were in one market, one service and had less than $10 million of EBITDA. 1.0 started as a network-only company, a PPO, and as an aggregator of claims charges and provider credentials. For MultiPlan 2.0, we moved aggressively to analytics and payment integrity, to supplement the Network-Based solutions to your greater savings. All the while we continue to bring affordability, efficiency and fairness to the U.S. healthcare industry.

And now we're at MultiPlan 3.0 the triad of growth, Enhance, Extend and Expand. This is the evolution from a network's business to an analytics business to a broader growth platform serving the entire healthcare marketplace of payers, providers, and patients and consumers. As we embark upon Multiplan 3.0, we will do even more to make the U.S. healthcare system more affordable, efficient and fair. The evolution has been 40 years in the making, and its execution would not be possible without the foundation of a provider network, data, analytics, algorithms and the longstanding relationships we have with our payer customers.

At the heart of 3.0 is the move to a platform enabling MultiPlan to better leverage cloud computing, employee dynamic algorithms, artificial intelligence and machine learning, and enhance our distribution and connectivity with payers, providers and consumers, both directly and through partnerships with the best companies that provide a broad range of important services to the U.S. healthcare industry. You'll hear more about this from our team later on in the presentation as we move forward. MultiPlan continues to be a nimble and innovative company and 3.0 is the beginning of the next chapter of MultiPlan.

Next slide, please. This has been quite the journey. We took our first outside capital in 2003 with a minority investment from General Atlantic Partners. We sold the company in 2006 to Carlyle for $1 billion, then $3.1 billion in 2010 to BC Partners in Silver Lake, then to Hank Greenberg and C.V. Starr and Partners Group for $4.4 billion in 2014. And then in 2016 to Hellman & Friedman for $7.5 billion, and now we are on the cusp of being a publicly traded company.

We grew revenues and earnings with each and every transaction for each and every financial sponsor. The growth here was about operational excellence, not multiple expansion, growing revenues and growing bottom line EBITDA.

Next slide, please. The question now is why now? We want to direct our free cash flow to fuel growth. We're going to accelerate the execution of our growth strategy by driving top-line revenue growth, earnings as well as expand the addressable market. The added value of having public currency will enhance our ability to be more aggressive in the M&A market. We can also maximize the inherent tailwinds in healthcare today; the ageing of the population increases new complexities, new therapies and treatments.

And finally, the merger with Churchill not only gives us financial flexibility, but also, adds a significant amount of intellectual capital to pursue these goals and objectives over time.

With that, I'd like to turn things over to my colleague Dale White to do a business overview. Dale?

Dale White - Chief Revenue Officer
Good morning, everyone. Next slide. Thanks, Mark. Good morning, everyone. We appreciate you taking the time to be with us this morning and let's get started.

Next slide. MultiPlan occupies the space between the providers claim submission to the payer and the payers' payment of that claim to the provider. In between, there are a number of adjudication steps the payer takes that determine the amount to be reimbursed to the provider. MultiPlan's current services are accessed during these steps, and our role is twofold. First, we determine an appropriate payment amount for the payers out of network claims. And secondly, we remove inappropriately billed charges from the claim that the payers program doesn't address. And as Mark said earlier, our focus historically has been on out of network claims.

We are generally engaged by the payer at the point in their adjudication process where they determined the claim is not in their network. But our Payment Integrity Services are applicable to payers' in-network and out of network claims. And one of the goals of our extend strategy is to deepen that penetration in network segments of the payers business. Other potential extend or expand strategy opportunities address other aspects of claim processing shown here, such as facilitating the claim payment itself, and improving claims accuracy post payment.

Next slide. We divide the market into three payer segments: Commercial Health, Government Health and Property & Casualty. We've been in the Commercial Health business for all of our 40 years. Customers include large national carriers, Blue Cross Blue Shield plans, regionally provider sponsored and independent health plans, third-Party administrators, Taft-Hartley funds, and other entities that pay healthcare claims.

Most of our commercial business is in group health, both large and small. But some of our clients offer benefit plans to individual consumers. The commercial business is a mix of fully-insured and self-funded ASO employer groups.

For Government, we entered the government market in 2010, with the acquisition of Viant and its Medicaid network in Texas. Today, our Government business is largely Medicare Advantage focused, due to the tremendous growth of that business for our payers. As many

of you probably know, about 10,000 baby-boomers turn 65 every day, and we're responding to the resulting demand for both Network and Payment Integrity Services.

We have also developed network access in the past for other government payers and still believe our services are applicable to other government programs.

The Property & Casualty market segment consists of workers' compensation and auto-medical payers. MultiPlan also entered this market with the Viant acquisition in 2010. We have historically worked through bill review companies in this market segment versus going directly to the carriers. So this is an area of consideration as well for our Extend strategy.

We also believe there is an opportunity within other areas of the Payment & Casualty market beyond these 2 segments. In terms of services, the 3 service categories listed at the right are applicable to all 3 market segments. I'll go into more detail on the services on the next slide.

But for now, let me talk about the exceptions to that rule. The Government segment and in particular Medicare Advantage plans use custom networks and network access versus our networks off the shelf. They need access, but generally not the pricing or steerage. The Property & Casualty market has state-mandated fee schedules in a number of states. It doesn't eliminate the applicability of our pricing services programs like Data iSight, but Payment Integrity Services are more broadly applicable.

Payment Integrity Services are applicable across all markets, particularly when applied to a payer's in-network claims. Notably, as Mark said, MultiPlan is on the right side of healthcare. We are all about affordability. Our job is to take cost out of the system, which we do to the tune of about $19 billion annually in medical cost savings that we identify for payers, and in a way that benefits not only payers, but also providers and consumers.

Next slide. Let's spend a little more time on our services. MultiPlan is a customer-centric organization. Our services play a mission-critical function in the day-to-day operations of our healthcare payer customers. They are modular in design. They work alone or in virtually any combination as appropriate for the customer-specific objectives. These objectives can vary significantly between fully insured and ASO business and from employer to employer. So our flexibility and our seamlessness are key attributes.

The Network-Based Services category consists of different configurations of our network contracts, and largely fall into 2 types, primary and complementary. The complementary network is typically used to wrap around a primary network in order to give plan members greater choice of providers.

It is used by large national payers that have extensive primary networks as well as by regional health plans, third-party administrators, Taft-Hartley and Property & Casualty payers.

Primary network access is used most commonly by regional health plans to extend their own networks outside their local service areas. We also offer primary network access as the payers' full-time primary network. And this is how government plans, as well as the number of TPAs, third-party administrators, use our network.

The Analytics-Based Services category is the largest in terms of revenue. It consists of negotiation services and pricing services. Negotiation services feature provider sign-off prior to reimbursement. Pricing services give a fair and reasonable reimbursement recommendation to the payer, based on our pricing methodologies.

Both services are used to reduce the cost of claims that don't have a network contract available, either because the provider doesn't participate in networks that the payer accesses, or because the payer doesn't use networks. These services are used broadly within our commercial market segment by all types of payers, and are also used by some Property & Casualty payers.

The Payment Integrity Services category consists of 2 types of services: clinical negotiation, which targets out-of-network medical claims, and claim negotiation, which is a complex claims editing service applicable for in- and out-of-network medical and dental claims.

Unlike most in the industry, our services were designed from the very beginning to be prepayment services. That is prior to when the provider gets paid.

Next slide please. MultiPlan stands apart from competitors in a number of ways, but most impactful is our payer relationships. We work with more than 700 payers. And as a payer-centered company, we are absolutely invested in their success. For many, including our largest clients, these relationships span decades. In fact, we've been partners with some of our major customers since the mid-1990s.

Our customers don't view us as a technology or a services vendor, but as an important partner. Our mission is not only to reduce medical cost and generate savings, but also, perhaps more importantly, to help them improve their competitive position in the market.

We have an ongoing cadence of collaboration, where we perform a deep-dive on their claims mix and savings performance, present opportunities to enhance their cost management programs, and then work with them on selection and implementation of those opportunities.

We are also often invited to learn more about their own strategic initiatives, so that we can align our service roadmaps accordingly. From an operational standpoint, as a mission-critical component of our payers' day-to-day business, we are electronically connected and deeply embedded in their processes and their claims' processing platforms.

Our network grants are displayed on their members' ID cards, and over the years, we have developed customized business logic for a number of our larger clients. Most customers use multiple services often across all 3 of our service categories, and most of our revenue growth comes from selling into these existing customers.

Next slide please. We have 5 simple business drivers, number of claims processed, value per claim, percentage of overbuild claims, average size of savings per claim, and our share of the savings. The first 2 taken together reflect the total charges that we process. This figure has grown steadily as the population has grown, as costs have risen, and as healthcare services have expanded.

Costs rise at 4% to 5% per year and we expect that to continue going forward. We will accelerate growth of charges received as we extend further into adjacent market segments, and in particular, into the in-network segment of our commercial clients business.

Percentage of claims received that have savings opportunity today is about 45%. It depends on each segment, but it should increase as clinical complexity and network arrangement complexity grows.

Average size of savings on charges processed will increase as we further refine our algorithms to get even better, with more granular data and by further leveraging artificial intelligence and machine learning. And finally, MultiPlan's share of savings really depends on a host of variables, including the volume of claims that a client sends and the number of services that clients buy. Next slide, please.

Our deep payer relationships and understanding of how we grow our customers' business, aided by industry tailwinds have helped us generate substantial growth in our core drivers. We have taken claim charges received from our customers from about $70 billion to $106 billion in seven years. Over the same period, we've increased savings process by our programs from about $12 billion to about $19 billion. What's more is our business is highly scalable.

As you see on the right, with just a small change, another $1 billion in claims' charges or a half percentage point in savings opportunity enables us to generate about $10 million in adjusted EBITDA at effectively no additional cost to the business. We're very well positioned to deliver continued growth in our core revenue drivers as our Enhance, Extend and Expand strategies take hold.

Next slide, please. One of the tools we've used selectively to help drive growth is acquisitions. Earlier you heard Mark describe our evolution from a network company to a diversified cost management and Payment Integrity Services company. Much of this evolution to MultiPlan 2.0 was accelerated by acquiring businesses that could expand our service offerings. MultiPlan has been very deterministic in our use of M&A, and we're really good at it.

Our highly disciplined management team has a proven track record of successfully integrating acquired businesses both operationally and culturally. We have started to build our analytics-based business organically. But Mark recognized the shift could be accelerated and the execution risk better managed through strategic use of acquisitions. One of the key factors that make us successful with acquisitions is the ability to leverage the power of our payer distribution. This is really showcased here in these two examples.

On the left, we acquired NCN, National Care Network in 2011 to help fuel our analytics growth. We took it from a small company with revenues of about $23 million to a $324 million product line in only seven years. That's about a 46% annual growth rate. We acquired Medical Audit & Review Solutions in 2014 to enter the payment integrity market. We grew it from a small $2 million business to an over $100 million product line in only five years, a CAGR of about 135%. We intend to step up our use of this growth strategy, but continue with our highly disciplined approach, which I'll review a little later in the slides.

Next slide, please. Every company has competitors, and MultiPlan is no different. MultiPlan has different competitors in each of our three service categories with some overlap. It's ingrained in MultiPlan's culture to have a healthy respect for our competitors. Mark likes to say we need to have a healthy paranoia when it comes to the competitors and the competition. If we aren't working every day to be better, to deliver greater value to our customers every day than we can assume that the companies out there knocking on our customers' doors will finally have those doors start to open for them. So we take our competitors very seriously.

Most of our competitors do a great job. And while they each have their strengths, no one competitor has a holistic approach to medical cost reduction and payment accuracy like MultiPlan. For payers an end-to-end suite of services usually trumps use of a single point solution, because of the added cost and the administrative complexities of managing multiple vendors and connections. For the most part, our competitors are focused on certain products or certain market segments.

In the network area, we compete with regional PPOs targeting primary network business, and network aggregators offering complimentary network access. Only one company can effectively deliver both, but they have no analytics based or Payment Integrity Services.

And the analytics space service area, we have a number of competitors offering reference-based pricing services aimed primarily at the TPA market segment. With payment integrity, MultiPlan competes with a number of companies that have a much longer tenure than MultiPlan does in this particular segment. We go toe-to-toe with these competitors in the prepayment arena. But most of the companies you see here largely occupy the post-payment space and are newer to prepayment. We believe we have a distinct advantage having entered the market segment with an approach that is deeply rooted in our prepayment claims processing programs.

Next slide, please. There are four factors of note that impact our targeted healthcare payer market continuing tailwinds in the healthcare spend, ongoing consolidation, payer provider litigation, and the potential for federal surprise billing legislation. I'll cover each of these trends in the next few slides.

Next slide, please. With regard to healthcare spend the overall U.S. healthcare market is massive at $3.8 trillion in 2019, growing at a 9% compounded annual rate since 1960. It is 18% to 20% of the U.S. GDP, and it expands every year because of aging, growth and technology. About one-third of the market can be attributed to some form of waste and abuse.

And as you've heard, we're on the frontlines in working to reduce these costs by addressing excessive prices, simple billing errors and complex billing schemes. And because healthcare billing waste, abuse and potential fraud takes on a number of different forms, as you can see here, we are well positioned with our expansive data, our algorithms and our IP across a variety of services. It is also important to note that MultiPlan again, is on the right side of healthcare.

As I said earlier, we don't bear insurance risk, we don't underwrite risk, we don't make claims payments, we don't deliver care, therefore, we have no malpractice risk, and we don't pay claims.

Next slide, please. For the trending continuing consolidation MultiPlan has been well positioned with the past big payer combination. The industry today has consolidated to four major commercial insurers, and we have long-going, longstanding relationships with all four. In fact, we have 25-plus year relationships with three of the four, and are deeply embedded through both connectivity and service value to all four. We work with these large payers as a partner.

And as I mentioned before, we're invited to the strategic table to help deepen their competitive advantage. This level of engagement isn't limited to the top four payers, but the top relationships do most of us in terms of opening doors, which will be very helpful as we execute our Extend and Expand strategies. Our own customer concentration aligns approximately with that of the market and that of the industry. And our top 10 clients have accounted for about 80% of our revenues over the past four years.

Next slide. The third industry trend that I want to touch on is litigation. It's not a trend per se, but it is a constant in the industry. Litigation typically involves disputes by providers over amounts reimbursed by the payer. In the grand scheme of total claims paid, litigation targets a very low percentage, and has to date not materially impacted the industry or MultiPlan. Because the disputes typically are about the amount reimbursed to the provider, they become an issue when the payer reimburses the provider using a methodology other than a network contract or a negotiated agreement.

Today, over 60% of the charges MultiPlan reduces on behalf of its customers are through a network contract or a negotiated agreement, and therefore, are not typically subject to these types of disputes. Next slide, please.

And finally, there's a lot of discussion on the surprise billing front. So this is a trend we continue to watch closely. In addition, Churchill has conducted diligence to understand the regulatory landscape, and has hired a number of independent healthcare consulting firms to help analyze the potential financial risks to MultiPlan from existing and possible future surprise billing laws.

There's a great deal of uncertainty around the likely timing and approach a final bill may take and just makes it impossible to measure the implications of a federal bill on MultiPlan. But here's what we know, surprise billing regulation is not new. It's already in place in 30 states and has had a limited impact on our business.

In these states with our focus on affordability, MultiPlan has been part of the solution helping payers to reduce out-of-network costs, while protecting members and avoiding costly arbitration. The state regulations and the federal proposals are designed to protect consumers from unexpected out-of-network medical bills resulting when care is sought at an in-network facility, but the physician is not contracted.

This largely impacts ER and select ancillary services only. MultiPlan's business model is broad in nature and this helps to mitigate the impact of any surprise billing legislation. The revenues associated with out-of-network ER and the ancillary hospital services that are the targets of surprise billing legislation are about $90 million to 100 million or about 16% to 18% of our analytics-based revenues, and 9% to 10% of our total 2019 revenue.

Until a law is passed and rulemaking is completed, we don't have the precise information we need to determine the exact impact to MultiPlan. We also know that federal legislation faces a number of hurdles such as significant opposing views from providers and payers, the upcoming election and, of course, COVID-19 and the impact it is having on healthcare providers and ER physicians in particular.

If a bill does pass in 2021, we believe, given the rulemaking process that the timing for payers to comply will likely be at the earliest sometime in 2023. Notably, any risk to our revenues depend on many factors, including the degree of reference pricing employed in any potential legislation, the probability of a federal law being passed, the potential timing of passage and implementation, and the resulting changes, if any, to customer behavior.

As I said, we continue to monitor the subject very closely. And Churchill has engaged a number of leading experts to help analyze our potential exposure. And if you're really interested in learning more, we know that Avalere Health is about to publish a whitepaper on the topic. Avalere is spelled A-V-A-L-E-R-E, Avalere Health.

I just told you about MultiPlan as we operate today. Now, I'd like to introduce my partner, Paul Galant, who will talk to you about MultiPlan 3.0 and our strategy to drive growth and create new value. Paul?

Paul Galant - Operating Partner of Churchill Capital Corp III
Thank you, Dale. Welcome, everybody. Next slide – oh, no, can you go to Slide 27, please? Next slide. Next slide, please.

Great. Well, look, you've now heard Mark and Dale talk about MultiPlan's business and the mission-critical role that the company plays in the U.S. healthcare system. But I'd like to now pivot to our discussion as to MultiPlan's future, as a public Platform-as-a-Services company, which we enthusiastically call MultiPlan 3.0.

Put simply, we believe that MultiPlan's healthcare affordability products are among the very best in the industry, and its strategy is to work with payers to deploy MultiPlan's products well beyond the $6 billion to $8 billion out-of-network market TAM that it participates in today and which you see on the left-hand side of this page.

The time to do that is now. And the merger with Churchill provides MultiPlan with the resources and the flexibility to aggressively pursue business in a $50 billion TAM market, representing virtually all payers as well as their providers and consumers. This push into a higher TAM is very much at the heart of Mark Tabak's MultiPlan 3.0 vision. And to get there, we put in place what I think is a very powerful 3-part growth strategy to execute against it.

Let's move to the next page, please. Consistent with how MultiPlan has always operated its business, its growth strategy is focused entirely on its customers' priorities. And to get it done, management is executing the 3-part plan that you see on this page. The first part of the strategy leverages advances in data and analytics to Enhance MultiPlan's cost containment product and generate more savings for payer customers.

The second part Extends MultiPlan's distribution to its customers in network space, and grows its direct presence and payer customer adjacencies, such as Government and Property & Casualty as just 2 examples.

The third part of our growth strategy really Expands MultiPlan's distribution to deliver services to healthcare providers and consumers in the payers' ecosystems. And we do this by leveraging a partnership-driven Platform-as-a-Service business model, which we hope to monetize through licensing fees.

Over the coming 5 years, MultiPlan's Enhance, Extend and Expand growth strategy should add anywhere from $600 million to $1.15 billion of revenues and $380 million to $720 million EBITDA, and importantly, I think this is the key, significantly broaden our customer base and further diversify our business model. Let's move to the next page, please.

So let me now provide some more detail on each element of the growth strategy. So the Enhance strategy is going to increase the savings that MultiPlan is able to deliver to its customers. And we're going to do that by improving product capabilities in 2 very important ways. First, by leveraging dynamic algorithms with artificial intelligence and machine learning, and as Dale mentioned that in his presentation, we're going to do that to power MultiPlan's analytics engine. That is an important step in getting to MultiPlan 3.0, the use of dynamic algorithms.

Second, by contracting with additional third-party providers of both structured and unstructured healthcare data, to take full advantage of a more powerful analytics architecture. You'll soon hear from Michael Kim, as he talks about our platform's ability to enable that to happen.

So these 2 work streams, in my view, should further improve the savings MultiPlan is able to negotiate in its network. And it should generate additional savings for its customers by identifying a higher percentage of plans operations, and then of course, delivering a higher savings yield on each of those claims.

If you think back to Page 15 of Dale's section that he just presented, it illustrates MultiPlan's revenue drivers, okay. And so, the Enhance strategy directly benefits revenue driver number 3, and number 4 in our business model.

Lastly, given the improvement to MultiPlan's products, MultiPlan will grow the volume of claims that it processes. That's revenue driver number 1 in Dale's model. And we're going to do that by adding salespeople to more actively cross-sell our products into multiple buying centers of our existing payer customers. You'll hear a lot more from Dale about that shortly.

So, we believe, all in all, the Enhance strategy will conservatively help MultiPlan grow revenues, anywhere from $100 million to about $150 million in the coming five years.

Next slide, please. The Extend strategy can increase the volume of claims that MultiPlan processes by growing its distribution into new buying centers, both within existing customers, such as Medicare Advantage plans, and further into adjacent payer customers, like Property & Casualty, regional health plans, and TPAs.

You're going to hear from Dale shortly on how he is building out MultiPlan Salesforce and operationalizing a bigger and more advanced go-to-market approach to ensure that MultiPlan gets more successful at bats with a broader set of customers on a go-forward basis. All of this being done to accelerate the capture of new in-network claims processing, where volumes are roughly 10 times what they are in the out of network space that we have focused on throughout our history.

To that end, MultiPlan is moving aggressively to directly service government, auto, workers comp, regional health, and TPA insurance customers. To enable this growth and distribution, MultiPlan's product and engineering teams are developing new product interfaces, and supplementing our claims editing and specialty investigations products with new features and those features are there to better fit the needs of the in-network customers and the adjacent customer segments. We believe in all the Extend strategy will help multiply and grow revenues by $300 million to $500 million in the coming five years.

Next page, please. Shifting to the third part of our strategy, MultiPlan's 3.5 petabytes of structured claims data, our IP and our algorithms really are the crown jewels of the company. As incurred, MultiPlan monetizes these assets today by delivering savings to our customers using a business model, which generates revenues for us based almost entirely on a percentage of savings that we help our customers achieve.

In many respects, the Expand strategy is fundamentally different from the Enhance and Extend strategies. And I say that because it's going to enable MultiPlan to generate licensing revenues through partnerships that help improved products and services, targeting healthcare providers and consumers. Interestingly, and I think very much in keeping with the culture of MultiPlan. This strategy dovetails very well with payer customers' priorities, which are increasingly focused on their medical providers as well as their member consumers, and those constituents quality of experiences and outcomes. Something that we believe MultiPlan's data and services can help improve.

And so to operationalize this plan, we plan to license our anonymized data and micro services to provide detailed therapy and pricing benchmarks that we believe can be a real game changer to solving some of the biggest pain points felt by medical providers and consumers today. And so by re-architecting, the top portion of MultiPlan's tech stack, which you're going to hear at length about from Michael Kim shortly, MultiPlan will be able to deliver discrete data and micro services through modern API's and will be able to leverage a newly built business development team to help us partner with third-party software and financial services companies to improve existing commercial products, providing services such as patient insights, patient billing and, of course, consumer finance offerings for medical procedures.

Let's move on to the next page, please. Next Page, please. Thank you. So let me peel the onion a little bit for you. For healthcare providers, MultiPlan can partner with software and financial services companies to – for example, three things come to the top of our mind. One, we can help medical providers improve patient satisfaction, something that's very critical to them. And we can do that by taking friction out of administratively burdensome activities. Think about things like obtaining insurance pre-authorizations, which today is highly manual. And if you've tried it recently, it's an entirely painful endeavor.

Secondly, MultiPlan can help medical providers reduce bad debt and slow collections. And this is something that's been plaguing the industry forever. And we can help with that bad debt and slow collections by enabling the software companies that provide services to medical providers to leverage MultiPlan's benchmark therapy and local pricing data to improve the bills that they generate on behalf of providers. The improved patient bills will help consumers to better understand what they're being charged for, and why those charges are fair. We can do that with the reference data that we keep in our data set.

And finally, MultiPlan can help healthcare providers to better fill their vacant capacity. And we can do that by dynamically changing the order in which providers with high vacancies appear on MultiPlan's website directory, which today is used by millions of consumers to find local doctors in their area. Look, it's clearly early days on this, but we believe the Extend strategy targeting providers can help MultiPlan grow revenues by at least an additional $50 million to $100 million in the coming years.

Next page, please. For consumers, MultiPlan's data and micro-services can help software and financial services companies to address three things that are at the top of the list. Number one, reduce complexity and friction of all interactions between consumers, providers and payers. And we can do that by enabling again far greater transparency, therapy, quality, pricing and outcomes. Secondly, MultiPlan can help improve the quality of consumer targeted disclosures, something that is important to everybody. And we can do that by leveraging MultiPlan's data on the relative frequency, the cost and outcome of prescribed therapies.

And finally, MultiPlan's data and algorithms can help consumers get qualified and have far broader access to competitive medical financing alternatives. We're able to do all this by simply enabling our data and algorithms to provide services to consumers through those software company and financial service company intermediaries. Again early days, but we believe the Expand strategy for consumers can help MultiPlan grow revenues anywhere from $300 million to $500 million in the next five years.

Next page, please – sorry, can you go to Page 35? All right. Thank you. So look to turn PowerPoint into action. 2020 is MultiPlan's year of execution. The team is focused 100% as it is their culture on the operational elements to make this strategy, the growth come alive. MultiPlan has begun to execute the 15 initiatives on this page that drive every element of our three-part growth strategy. Our initiatives are organized into four main work streams. Each of those work streams is headed by senior executive whose annual performance scorecard is determined in great part by the KPIs tied to the successful execution of each initiative. Again, very much in concert with the culture of an operating company.

You're going to hear from Dale White, who's going to discuss our four main sales, product strategy and marketing initiatives, as well as our three M&A work streams. You'll also hear from Michael Kim, on our six technology product development initiatives, as well as our two tech-driven efficiency initiatives.

So with that, let me turn it over to my partner Dale White, to give you a bit more color on how we're going to get this done. Dale?

Dale White - Chief Revenue Officer
Thanks, Paul. Next slide, please. As we plan the execution of the MultiPlan 3.0 strategy, we are advantaged by our customer-first culture. We have the foundation of a well-established and highly successful relationship management organization to build on. There are 3 aspects to that building process that we are focused on that will ensure continued operational excellence for our customers.

First, to support the new service development, we will build out the product strategy team. This function within MultiPlan facilitates product roadmap development, working closely with each of our solutions or each of our service-line leaders, and also introduces new opportunities such as channel partnerships. Product strategy will also work to align organic strategies with our acquisition targets.

Second, we will bring in significant new sales talent, focused on new business opportunities. Our plans are to add dedicated sales for the in-network business, Government, Property & Casualty and broker-oriented sales for the third-party administrator and regional health plan markets. We will also formalize the product marketing function to improve our go-to-market strategy and demand generation across all 3 core service lines.

And finally, we will invest in improving our sales operations functions in the areas such as implementation tools, processes, and performance reporting. Turn the page, please. I think as most of you know, MultiPlan has been historically focused on the U.S. healthcare delivery system.

Our algorithms and experience have the potential though to help combat waste, fraud and abuse well beyond the U.S. healthcare system. As part of our effort to extend our platform and diversify our business model, MultiPlan will undertake a strategic business review to determine the feasibility and potential upside of adding international markets. Based on the outcome of this study, we hope to pilot and launch MultiPlan's platform services across several international markets in the coming years. Next slide.

As I mentioned earlier, when discussing the NCN and MARS solution acquisitions, we've had a great track record of executing highly accretive strategic tuck-in M&A. It has been an important tool for us, and we intend to use it to help accelerate and de-risk the execution of our MultiPlan 3.0 vision, just like we did with MultiPlan 2.0.

In fact, we are already building a robust pipeline of potential targets that fit within our highly disciplined and proven strategic and financial framework. For enhancement of our core

services, we are looking for targets that improved network economics expand our access to data and provide technology such as artificial intelligence.

For our Extend strategies, we're focused on deepening our penetration into adjacent markets such as Property & Casualty, and Government as well as in-network claims, including potentially through post-payment integrity, and network analytics.

And finally, for our Expand strategy, as you just heard from Paul, we will cast a wider net as we pursue opportunities to stall provider and consumer pain points on behalf of our payer customers, such as in the area of healthcare payments. Next slide, please.

Paul and I have talked about our growth strategy. And as a technology-driven company, a critical element of our transition to MultiPlan 3.0 is our technology platform.

With that said, I'm very pleased to hand the floor and the microphone to Michael Kim. Michael is our Chief Information Officer. And he'll walk us through his vision and his plans for that platform. Michael?

Michael Kim - Chief Information Officer

Thank you, Dale. Good morning, everyone. Earlier today, you've heard Mark, Dale and Paul reference some of the technology capabilities and initiatives at MultiPlan. I have the pleasure of doing a deeper dive into our technology platform. So over the next few minutes, I'll provide you an overview of the technologies supporting MultiPlan today, as well as discuss some of the plans to evolve the platform to support the vision represented by MultiPlan 3.0.

As we contemplate this broad vision, it's important to note that we're starting with a really solid technology foundation today. Next slide, please.

I'm sure you all have seen a variety of platforms that have a really good perspective on scalability, performance and throughput of the technology platforms at many companies. In relative comparison, I believe that our current platform has a solid foundation reflected in a number of different ways.

It's a highly scalable architecture, with 3-plus petabytes of structured data, processing roughly 370,000 claims a day, with the ability to process 5 times the current volume without any material investment. We also have the best-in-class cybersecurity controls as a result of a robust information security program executed over the past 6 years.

In fact, we are in the top rating by BitSight among healthcare companies for cybersecurity control. Additionally, our customer feedback on implementation projects range predominantly from excellent to very good. This has been consistent over the past 5-plus years. Finally, business disruption due to employee attrition in the technology department has been minimal, because our workforce is engaged and deeply committed to MultiPlan.

Last year, as you can see, our attrition rate was 6.7%, which is significantly lower than any industry average. And attrition rates have ranged from 4% to 7% over the past 5 years. Next page, please.

I want to start with the chart that Mark shared with you earlier about our platforms. He talked about our capability to deliver affordability, fairness and efficiency to our customers through this platform. When you decompose the platform, these outcomes are enabled by 4 basic set of capabilities. The first is the ability to ingest data from our customers. Today, this data is in the form of a claim.

The second is the ability to store and move this claim across our platform to our various products, algorithms and intelligence engine. The third is the ability to analyze this claim to provide meaningful actionable insights. In this case, it's the ability to reduce the cost of a claim for our customer.

And finally, it's the ability to deliver this value back to the customer in exactly the way they want it, which can at times be challenging, which we'll discuss a little bit more on the following page. Next Page, please.

As Dale mentioned earlier, MultiPlan is a very customer-centric organization. So I'll discuss the technology capabilities from a customer's perspective, represented by the middle row of boxes. When it comes to ingestion, customers want to integrate our systems quickly and easily. It also has to handle whatever volume they want to send, and whatever format they want to send it.

Remember, we're often connecting with the customer's archaic legacy system. As I mentioned already, the good news is that the feedback we've consistently received over the 5-plus years is the proof-point that we have a very proven mature methodology to make the ingestion of claims from a customer quick and easy.

Once we have this claim, which has personal health information, what customers worry about is that MultiPlan secures our PHI. Our proof-point on this capability is the industry certifications like HITRUST, NIST, SOC 2 Type 2, as well as the highest BitSight rating in the healthcare industry.

BitSight in cybersecurity is a little like FICO in the credit industry. It's a measure of overall cyber hygiene. The other element of store and move is that we've completely transitioned from batch transfers of data to real-time movement of the data across our network. Once the claim hits our front door, all the pipes and infrastructure exist for the eligible claims to be processed within 5 seconds and delivered back to the customer.

Moving across to analyze. Customers want value-added actionable insights represented by savings, which are accurate and acceptable. The proof point on accuracy and acceptance is our industry leading low appeals rates from providers, which is a reflection of the quality of our algorithms and intelligence engines in a plug-and-play architecture. Customers can determine how and what algorithms and products they want in the order they are applied in our flexible architecture.

As we move further right to deliver, as I mentioned before, this can at times be challenging. Customers want to be able to customize business rules. As a result, there are literally hundreds of thousands of business rules to support the complexity of this business. The good news is that MultiPlan's flexible business rules driven platform supports this complexity. The

interesting thing about these sets of capabilities is the insight it provides into customer retention in the competitive landscape.

Let's start with analyze, though IP represented by the algorithms and intelligence engines were developed over years, sometimes decades, fueled by data, it would be extraordinarily difficult to replicate this intellectual capital without the data and years of experience. Think about the cost to rent or build the infrastructure needed to store all these petabytes of structured and unstructured data and the applications to analyze and deliver this value pack to clients. It's quite a substantial investment.

But more importantly, even if they built out the infrastructure to manage and analyze this data, wherever they get, MultiPlan built deep integration into 700-plus payers and their archaic legacy systems over the course of decades, replicating these integrations would be a herculean task. Finally, uncertain enough for all the top customers which have complex custom deliver business rules. No one would be able to replicate these complex business rules coded into our platforms easily. We coded these business rules over decades and hold this documentation very closely. Given these factors, it's not surprising to see such higher cut – to see such high customer retention figures.

Next page. Part of the success delivering, as Mark indicated, affordability, fairness and efficiency to our customers is a relentless focus we have on leveraging technology to drive efficiency improvements across all of our products and processes. I've included a few examples on this page. The first chart on the bottom is the negotiation business that Dale referred to. In 2010, there was no automation, all claims were manually negotiated. And as you can see today, 80% of the negotiations are completely automated and do not require human touch as a result of technology.

The second chart and third chart track the pricing analytics business, the MRA business, as you can see in 2017, as the volume of claims has increased in the second chart, the percent of claims that require manual handling has decreased by more than 60% using technology. Finally, another initiative that we're excited about is the industry partnerships known as the Synaptic Blockchain Alliance, the founding members are United Optum, Humana, Aetna plus MultiPlan. We believe leveraging blockchain technology, we have the opportunity to significantly reduce our provider data management costs, as well as improve the quality of our data. The invitation to join this group of companies as a founding member reflects MultiPlan's proven track record and execution, the business expertise we have and the fact that we have one of the largest provider data sets in the industry.

Next page, please. As we pivot to thinking about the technology capabilities, the requirements to support the growth vision represented by MultiPlan 3.0, some enhancements to our technology platform are necessary. This page has a number of enhancements that are already being launched shortly that will support this growth vision, when we think about the connect and adjust capability today. Our integration with customers focused on the ability to receive a claim and send a claim back to them.

In the future, the growth strategy and visions are more granular set of products and services that Paul had discussed that we might want to let customers and potentially other third parties use or consume directly with us, or through the cloud. This requires an acceleration of our in-

flight architecture transformation. We're in the midst of decomposing our large applications to a more granular set of microservices. We can then expose these microservices externally through a set of application programming interfaces, known as API's, which Paul referred to. A good example of this microservice API integration is one customer who has already accessed provider database with an ability to search that database.

In the analyze capability, we believe machine learning has a broad range of applications that will materially improve results. There are basically two flavors of machine learning. The first is machine learning that replaces deterministic rules with dynamic algorithms. An example of this is a use case of payment integrity. Payment integrity's deterministic rules, known as factors were identified by a bunch of clinicians who review claims over many years. We could leverage machine learning to accelerate the identification of new factors, which would mean more savings for the customer and more revenue for MultiPlan. This is augmenting deterministic rules-based system with dynamic machine learning algorithms.

The second flavor of machine learning is using it to replace manual human decision making to improve for closure outcome. The example of this, which went live last month is in the negotiation business. The machine recommends a work queue prioritization for a negotiator based on predictions on the probability of success and magnitude of savings for every given claim. In the past, negotiators typically spend the first 15 to 30 minutes of each day prioritizing claims assigned that day.

As a result, there's instant productivity gain of 15 to 30 minutes for all the negotiators, as well as expected improvements and savings as a result of machine learning by working on the right claim, and understanding what the magnitude of the savings ought to be.

Finally, to support the delivery capabilities discussed earlier in the day. We need to upgrade the interface with more use cases that reflect the products and services that we could potentially offer to third parties. Our current interface customer portal supports the entry of a claim and delivery of savings back to the customer. As we start offering microservices we'll need to enhance our user interface and API management platform to facilitate this capability.

Next page. On the slide is the future-state architecture envisioned to support MultiPlan 3.0. The dark blue boxes are components that are mature today. For instance, tight integration with payers already exists. The green on this page represent initiatives in-flight that are building out components. As you can see, in-flight components include machine learning, cloud architecture and the API layer. The light blue represents new component that needs to be built out in the future. These could include integration with providers or consumers directly or third-party developers as an example.

All this to say the technology platform today is a solid foundation with some mature components as well as work underway that are significant enabling the growth vision and even though build out of some components hasn't started yet. I feel confident in our ability to support the growth and efficiency initiatives with our technology platform.

Thank you for let me share my perspective on MultiPlan's technology platform. With that said, let me turn it over to our CFO, David Redmond.

David Redmond - Chief Financial Officer
Thank you, Michael, very much. Next slide.

We believe that all great companies really have 3 things in common: an excellent business model; a CEO with great vision, as you've heard from Mark earlier today; and a leadership capable of executing on that great vision. MultiPlan has an excellent business model, driven by U.S. healthcare spending without the typical risk of delivering and managing care.

As you've heard many times today, our business model is customer-centric, 2 words that will be repeated often and frequently by Dale, Mark, Michael Kim, and the rest of us – a fee-based model with revenues directly aligned with our customers' incentives.

We also have a very attractive free cash flow model. We've generated and paid down over $1.1 billion of debt since 2016. But what is equally important is what you'll see on the MultiPlan basic business model today. This great business model is the foundation for providing for the Enhance, Extend and Expand strategy as several of our speakers including Mark, and Dale, and Paul have talked about earlier today.

It's important to understand this is not about just MultiPlan 2.0 as it exists today, but for you to understand and focus on MultiPlan 3.0, and the great benefit that this transaction will have in terms of executing on 3.0. Next slide.

We released our Q2 results yesterday on Churchill's 8-K publicly, and filed our Q2 compliance packages on Friday, August 14. Our Q2 results reflect revenues of $207 million, down $38.8 million from Q2 2019 and approximately $49 million below our original Q2 2020 estimate, principally because of the impact of COVID, which I will discuss in a later slide.

The quarterly budgets on this slide reflect the budgets that we prepared in the fourth quarter of 2019, based on the information that we had at that time and reflected the growth initiatives that we felt very comfortable with. As you can see, in Q1 2020, we actually exceeded slightly our revenue budget, exceeded our EBITDA budget and exceeded last year's Q1 result. We were on our way to executing against all of these quarterly budgets in 2020, when obviously we were impacted by COVID. Next slide.

As you look at our annual performance over the years, MultiPlan has had a long history of organic revenue growth and steady margin improvement for over a decade. When Mark and I first joined forces in 2010, we frequently got the question, "Your margins are 50%. Do you think you can sustain that?" As you can see, over the last 4 years, our margins have been in excess of 70% and in many cases in the high 70%s.

We've grown this business from about $300 million of pro-forma EBITDA in 2010 when we merged MultiPlan and Viant, to close to $800 million in EBITDA today. 2018 and 2019 growth were impacted by an idiosyncratic customer behavior that began in late Q3 of 2018, with the full impact of this behavior felt in Q4 2018 and throughout 2020.

In spite of this and with this behind us in 2019, we participated in annual revenue growth of 5.8% in 2020, and an EBITDA growth of 6.4% to just short of $800 million in 2020. Next slide please.

To better understand 2018 and 2019, as I said before, we saw a change in claims practice by certain customers that negatively impacted our performance. It was unique to a specific customer group. As I've been often asked, it could never happen with any other customers and we do not expect it to ever happen again.

Our year-over-year impact in 2019 was $50 million to $60 million. It was resolved by the end of 2019. And we are moving forward from the end of 2019. And as you saw in our budgets, we reflect this as something behind us, not something to deal with us today.

As you can see on this chart, if you look at our pre- and post-customer-change, from 2016 to 2018, we grew revenue by about 5%. And from Q4 2018 to Q1 2020, we continue to grow revenue by mid-single-digits. Also EBITDA growth has been typically in the high-single-digits and low-double-digits during this period of time. Next slide, please.

Obviously, we could not talk about 2020 results without talking about the impact of COVID. COVID, as we've publicly stated, did not really have an impact on our Q1 2020. And we exceeded Q1 2020 budget for both revenues and EBITDA.

We estimated in March 2020, that COVID impact on revenues could be as much as $135 million to $150 million in revenue, primarily concentrated in Q2 and Q3, with an expectation of our business returning to normal budgeted revenues, and EBITDA by Q4 and into 2021. The actual results in Q2 were about $50 million below our budget, about $40 million below last year, which is significantly better than we anticipated.

When we made our initial comments about $135 million to $150 million, we expected an impact of $65 million to $70 million in Q2, which would have delivered about $195 million of revenues, and our actual Q2 was $207 million. We believe that we're still – as we read today in papers, not totally out of the woods, our original estimate was that we would be impacted in Q3 by about $70 million to $80 million. We think that will be appreciably better than that. And in a minute, I will give you our overall guidance for the remainder of 2020.

In March 2020, the stay-at-home orders resulted in only about 5% to 10% of healthcare providers being able to offer services. By June, almost all healthcare providers were seeing patients and elective procedures had returned to normal level. We believe that this pent-up demand from delayed care should help us meet our financial goals in Q4 and into 2021, as hopefully the COVID crisis subsides and patients fully resumed access to care.

As a result we now expect full year 2020 total – next slide please. As a result, we now expect full year 2020 total revenue to be in the range of $910 million to $930 million and adjusted EBITDA guidance in the range of $685 million to $705 million.

The preliminary proxy statement for Churchill stockholders' meeting that was filed with the SEC by Churchill on July 31, 2020 included selected forecasted financial information for the calendar-year ended December 31, including total revenues in the range of $1085 million to

$1125 million, adjusted EBITDA in the range of $845 million to $875 million, and leveraged free cash flow of $425 million to $450 million.

We will be reviewing by year-end our forecast, as we do every year with the facts and circumstances then occurring. However, subject to the assumptions and qualifications stated in the preliminary proxy statement, we are comfortable as of today regarding the ranges represented for such forecasted financial information.

Please note that such forecasted financial information should not be relied on as guidance as further events and actual result may differ materially from such forecasts. Next slide please.

As we look at the Churchill transaction in the summary and timing, and again, I want to re-emphasize, the impact of the Churchill transaction provides significant financial capital and flexibility, and significant intellectual capital and flexibility, as you've heard from Paul, you will hear from Michael, and as we've received from all of the Churchill team.

The Churchill shareholders and the common PIPE investors will have about 40% of MultiPlan, when this transaction is completed. And the H&F and sponsor group are expected to roll about 73% of their stake in MultiPlan, and have an ownership of about 62%. As I stated earlier, we filed a preliminary proxy on July 31, 2020. We hope to receive comments from the SEC in late August, have those comments cleared in September and send a mailing out for an annual meeting to be held either in late September or early October, with a closing shortly thereafter.

Next slide. In addition to the $1.1 billion of cash in the Churchill III stack, Michael and his team have raised an impressive additional $2.6 billion, $1.3 billion in PIPE common stock commitments, and $1.3 billion of convertible debt. The existing sponsor group will roll about $4.2 billion of their equity in MultiPlan and have about a 60% ownership going forward.

Management shares are locked up for 12 months and management is rolling almost $250 million into this transaction. All of this is important to achieve, as we've heard earlier today MultiPlan 3.0, a transformational event for MultiPlan and transformational execution, which would be accomplished by the leadership team you heard today and the people that worked so diligently with us.

Next slide. Our capital structure today consists of three components of debt, our term debt, which will stay in place and matures in 2023. Our OpCo debentures which are 7% and 8% mature in June 24, and basically will stay in place, and our PIK/Toggle notes of 8.5% will be paid in full at the closing of the transaction. As you've heard, we will have a $1.3 billion PIPE convertible debt, which is a significant improvement over the existing PIK/Toggle note that has a seven-year maturity from the closing of this transaction and an interest rate of 6%.

It is now my distinct honor to turn the program over to Michael Klein to give you his thoughts and conclude this presentation. Thank you.

Michael Klein - Chairman & Chief Executive Officer of Churchill Capital Corp III
Thank you very much. If we can go ahead and push forward the slides into the conclusion section. Thank you very much. If you skip ahead to the next slide, please.

Let me say thank you to the whole team for their very thorough, very detailed presentation. I hope as you all have heard this story you have begun to understand why we at Churchill have been so enthusiastic about an investment in MultiPlan, that we have been reviewing this opportunity since 2013, first on behalf of Warren Buffett and Berkshire Hathaway, and then on behalf of our own vehicles that we created starting in 2018.

MultiPlan has been the number one company that we have sought to partner with during the entire time period that we have had a public equity vehicle. The reasons I think are quite clear, first and foremost, as we've done with Clarivate, and some of you may be aware of Clarivate, which is a life science, data and information company that we merged with in mid-2019. And since then, has provided investors about 4 times return on their investments.

As we did in that situation, we look for a market-leading company. We look for companies that have a sustainable advantage. We look for companies in particular that are in a position that as a private company, they may be constrained either by virtue of being private or by virtue of leverage, where if we were to bring them into the public market, deleverage the balance sheet and invest behind growth, the growth phase of the company can be enhanced materially.

We also look specifically for companies where our operating executives can add a degree of value. And we look for companies that we can put significant capital to work ourselves. MultiPlan meets all of those characteristics, as I think you've heard MultiPlan has a very, very unique differentiated business model. It's unquestionably critical to its clients. I had the good fortune of speaking to the senior executives, at customers that represent about 65% of the revenue base of MultiPlan. And what they came back with in terms of their responses, both of MultiPlan, its services and its team were extraordinarily powerful. They indicated that MultiPlan was critical to their operation, and that MultiPlan's business was the gold standard in terms of pricing, transparency and information in the U.S. healthcare space. They indicated that the U.S. healthcare space was large and growing, but by virtue of $1.2 trillion of spending, that was perceived as either overcharges or waste, or in some form of administrative abuse, that put them in a position that they required the tools of MultiPlan to make healthcare more affordable, so that they could provide more healthcare to more of their particular clients and consumers that work for employers that are part of their systems as payers.

So we were quite taken by the customers' view that MultiPlan was critical to them, was valuable to them, and was a company that they would be providing more of their internal and external business to MultiPlan over the coming years now. You've heard from the team, so I won't be repetitive but what we found compelling is that: A, the market is growing significantly and continues to grow on a basis that has consistency that we can actually really forecast based upon the cost structure of U.S. healthcare. We can do so because the company has 100% contracted revenues. We can do so because the customers have long-term relationships, 75% of which are more than three years in terms of contract length, but all of them have long and deep historical relationships.

We also can be comfortable underwriting our forecasts, because the growth opportunity ahead is based principally upon achieving more revenues from the same clients using the

same services. That's very rare as I think you will understand that a company can grow and double their top-line by applying the same services to the same customers by taking more wallet share. We've also felt it's critical in our prior situations and certainly in this situation, to set the balance sheet up to win. So as you heard from Dave, we have raised substantial capital, we have reduced substantially the leverage on this company.

The company has been comfortable, because of its strong cash flow operating at levels of 7 times to 8 times debt to cash flow. We did not feel that that was the front footing to win in terms of investing in growth and investing with acquisitions. So we've raised capital to bring down the operating company debt to cash flow and the cash required debt to cash flow to 4 times. Now, the company generates almost one times EBITDA in excess cash flow for debt paid down each year. So that's paid down quite quickly. We would hope and we will plan to make significant acquisitions. But we will over the long-term drive a company with a balance sheet that is in the 3 times to 4 times leverage and not beyond that.

We're quite pleased to be joined by Hellman & Friedman, who's rolling their capital and management that are rolling their capital. This is a partnership for growth, as we showed with Clarivate the ability for private equity investors to migrate their company into the public market to enter the next phase of growth is a better long-term value creator for them paying down $1 of debt to raise $1 of equity value is very different than the ability to generate an increased dollar free cash flow that can improve the value of the enterprise by $25 per share to $30 per share. That's the element that we're particularly focused on – is the focus on growth.

We've had the ability to learn about Mark and his great management team, and MultiPlan and their great business when they were in fact MultiPlan 1.0. We have watched as they migrated into MultiPlan 2.0 to build this data and analytical machine that they have, and we're enthusiastic to be part of MultiPlan 3.0. That enthusiasm also continues as we look at this as a public investment. And one thing you will know as you have heard today's presentation and you'll know as we look at the business and its investment terms, we view this company as what it truly is, which is a data and analytics business, a payments processor, that has a leading, and some might say, dominant position, in the U.S. healthcare space.

We're very comfortable in the data and analytics and payments processing space. We've been on the boards of and leaders of businesses in this space for over 3 decades, and bringing in Paul Galant, who's probably one of the best payments processing executives in the world, to be part of the operating management, and Bill Veghte, who has the most extensive enterprise technology experience, having run Microsoft Windows for 20 years and HP for its entire turnaround phase. He'll be joining the Board as you've heard.

Those areas of value-add in the continued expansion of the data and analytic expertise will be quite critical. And it's critical as well as we look at our investment. Our Board and our investment committee have put $1.35 billion into this investment. We've done so with a very long-term focus and we've done so with enthusiasm. We've done so on the basis that we have underwritten next year's performance at the projected $850 million EBITDA level through deep analysis to give us comfort, as you can see on this page, to being able to set this business into the public market, at a very attractive valuation for our investors.

You'll see that we negotiated this transaction with Hellman & Friedman in the midst of COVID, with a requirement for us to set the business up at a discounted multiple to both the healthcare IT companies, and the data and analytics companies, both in the language that private equity understands, which is EBITDA multiples; but more importantly, in the language that public equity investors understand, which include free cash flow multiples, and also earnings and earnings per share multiples.

And what you can see is we have set this business into the public market at what is a 6 or 7 multiple discounts on an EBITDA basis and more than a 50% discount on a free cash flow basis. We think it's a very attractive business with a very attractive growth strategy and a very attractive next several years. And in fact, we intend to be holders well beyond that. Go ahead, skip the page.

You all know, as analysts, the comparable universe very well. You'll see that we have laid in front of you both the healthcare IT comparables as well as the data and analytics and payments processing comparables. I think you've seen from the presentation, the P&L of this company looks most like payments processors.

The only companies that have these kinds of EBITDA margins are Visa and Mastercard. And quite frankly, their margins are often lower, because they have significant consumer advertising expenses. The other companies that look similarly with 100% recurring revenues, high margins, high free cash flow characteristics are the data and analytics companies.

Clarivate as an example we know well, because we helped create Clarivate. It's in the life sciences space, as our other companies, including Verisk on this space. They all generate significant recurring cash flow. And as a result, trade at between 30 to 35 times free cash flow.

What we've also looked to the healthcare IT companies, and of course, you'll know these companies. But we've dug very deeply to understand the references that many of these companies make in terms of the business they're in relative to the actual business that they're in. So we look deeply, for instance, at Inovalon, and we see a company that is a very high-quality company, of course.

But in the business of recurring revenues and in the business of data and analytics, we have 100% recurring revenues and they are now 88% subscribers. They have 319 million customer datasets. We have well in excess of 1 billion claims, that is multiples, upon multiples of that in terms of medical events.

They have a business model that touches a couple of hundred payers, which is still the principal side of their business. 85% is payers and providers. We touch all of the payers and all of the relevant providers. They have one thing that is a critical element to what you're hearing about for our MultiPlan 3.0.

They've taken their sales-force from 15 people in 2015, to almost 300 people today and over 250 people at their last reporting period. That increase in front-end sales force is the only thing that is part of our 3.0 plan that is in front of us rather than behind us relative to

Inovalon. We also happen to have twice the margins that they have, far better retention, and of course, as I've said, far better data sets.

Yet, as you can see, we've set our business up at a 15 times free cash flow multiple, which is less than half of their multiple at a 12.9 times EBITDA multiple, which is again 6, 7, 8 multiples less expensive. So we feel that this has been positioned with the help of Hellman & Friedman, and of course, with the leadership of Mark Tabak and an excellent management team, very attractively for our investors. Go ahead, skip the page.

Because we're in the business of setting up attractive public equity vehicles, one, that we're proud to be associated with, and given that MultiPlan is in the business of making healthcare more affordable, because it is on the right side of healthcare, because we've watched them for 8 years navigate every potential rumored or enacted, legislative framework, because they are the gold standard in terms of data, because they provide $19 billion of savings, because they create a model that makes healthcare more affordable.

Both our own diligence as well as our outside consultants and our lawyers have come back with the exact same report to us consistently. This is a company that contractually will be able to grow with the growth in U.S. healthcare expenses at a minimum. That's the 6% minimum case you see in front of us. That would have driven business from $1 billion to about $1.4 billion in revenues.

Given the structure of a data and analytics business, where you make something once and you can sell it millions of times, and that is the framework of this P&L. What you see is every incremental dollar drops $0.91 to $0.94 cents to the bottom-line in terms of EBITDA. So the $1.4 billion of revenues would generate comfortably a $1 billion of EBITDA.

But that isn't our business plan. We are not focused on running an LBO case. We're not focused on $1 of debt pay-down generates $1 of equity. We're focused on driving the advantages this company has, to deliver significantly enhanced top-line growth by selling principally the same services to the same customers, but by taking advantage of the network, the in-network revenues that they have asked us specifically to serve.

And now, we will serve more constructively and more aggressively. I'll note that what we learned from the customers, they felt in 2018 or 2019 that our data and analytics business was both network agnostic, and was providing greater savings for them than any other tools. So they asked MultiPlan to provide the data and analytics and payment integrity services into their in-network business.

That wasn't up to Dale to sell in the past and it is up to Dale to sell now. So as the same path that Inovalon followed from 15 to 250 salespeople, we'll take our 42 salespeople and we'll quickly grow them, double them, enhance them. We'll have the ability to more constructively win in a build basis. And we feel that underwriting the case that drives a $1.7 billion to $1.9 billion of revenues and $1.4 billion of EBITDA is our core base case, before acquisitions, before increased investments, all of which we think will enhance significantly the value.

When we take the projections that we see, underwritten by our view at Churchill, of the confidence in the 2021 EBITDA, our view at Churchill, in the confidence of this growth plan,

and our view of the setup value being a meaningful discount, we view this as very attractive. We were also pleased to see that bondholders, who have been the only audience outside of private equity players to have been exposed directly to MultiPlan for the past decade, they also felt that this was extremely attractive.

And the $1.3 billion of convertible, which is at our option, cash-pay or non-cash-pay, has no covenants. It will allow us to layer on top of that for acquisitions. That converts at a value of almost $15 billion, despite our setup value of $11 billion. So we're quite pleased with the simplicity of a model that takes a contractual base case, invests in a proven frontend to drive revenue growth, will drive significant EBITDA and free cash flow growth, and that we've set up on an attractive basis.

Let me conclude with the final slide if you can move ahead.

As I've indicated, we at Churchill decided that MultiPlan was our principal partner for our public equity vehicles at the beginning. We did so because we want to be associated with companies that we are proud to invest in, proud to be part of. We want to be on the right side of healthcare, which MultiPlan is. We want to be in a company that has proven itself on a private levered basis, but can grow much more aggressively on a public delevered basis, and where our leading executives can partner with a strong management team to grow.

We are very enthusiastic from our customer diligence, that this is a mission-critical company, that this is a more substantial and proven company than others in this space, with the 3.5 petabytes of data, with the 40-year history in the network, with the provider and payer lock that they have, and with the mission-critical technology to reduce the cost structure by $19 billion. They really are a critical force and a force that has the ability to be grown.

We're confident that we've underwritten our analysis on our forecasted year of 2021 and on our strategic plan. And we're extremely comfortable with the valuation that we've set up behind this. We think management is certainly an industry leader. And we think management has proven that it can create value for a very difficult set of investors in the institutional private equity market. And we think that they're going to drive significantly more value in the public markets.

We're proud to be associated with MultiPlan and its team. We're enthusiastic about its position of being on the right side of healthcare. And we're extremely constructive on the ability for it to grow substantially for equity investors. Thank you.

Operator

With that, we open into the Q&A section of the call. Please just flip to Q&A slide. As a reminder to ask a question, please click the "Ask a Question" button under the speaker video panel, type in your question and press "Send."

First question from Daniel Grosslight of Citi. Can you provide more detail on what products are driving revenue growth in your forecast? In particular, as you expand into in-network, is most of that growth due to payment integrity?

Mark Tabak - Chief Executive Officer
Let me respond and I'm going to hand it off to my colleague Dale White. Again, think of MultiPlan as a 1 product company that is affordability. Embedded in that affordability product are 3 offerings: networks, analytics and payment integrity; that are fully integrated to maximize savings and fairness. Dale, why don't you follow up with your comments, please?

Dale White - Chief Revenue Officer
Mark's right. I mean, it is – we do have 1 product – we do have 1 solution set with multiple product offerings. And the product set that largely – as you've noticed, we've migrated from MultiPlan 1.0, where we were largely network companies MultiPlan 2.0, where we incorporated and introduced analytics and started down the path of payment integrity.

That diversification of product offerings has helped fuel our growth and will continue to fuel our growth. As you cross over to your question, as you cross over into the in-network space, it's less driven by networks, particularly with larger payers, because they tend to have their own network except for customization and other things like where they may need assistance in extending their network reach or they may need assistance in accelerating their Medicare Advantage: Blueprint.

The opportunity, as you cross over into the in-network spaces with our prepayment and payment integrity program. And in between 2 of those, those 2, the customization of our networks and the expansion of payment integrity, and you'll recall from my remarks earlier, everything we do is on a prepay basis. And so, from our networks, to our analytics, to our payment integrity, we sit in front of [one of the payer name site] that has made that payment to the provider. And that's the unique position to be in.

David Redmond - Chief Financial Officer
Daniel, this is Dave Redmond. I think as you guys pair out your models, our largest percentage grower, as we look at our 5-year projections, if you will, will be payment integrity, which will probably be in the low-double-digits, 10%, 12%, 13%. So second largest will be analytics, which will be in the mid- to high-single-digits in the network. As we break out that component, we'll be relatively flat.

Obviously, when you when you extrapolate those percentages, the biggest absolute dollar grower will continue to be analytics, followed by payment integrity. But from a percentage standpoint, payment integrity will probably grow in, what I would call, the extremely low double digits, but in double digits with analytics in the mid- to higher-single-digits. Correct, Dale?

Dale White - Chief Revenue Officer
Yeah.

Operator
Our next question is from David Windley of Jefferies. More on growth, the growth strategy leans on product development and enhancement. Have product development capabilities been augmented? What investments have been made? And what impact might those investments have on profitability in the near- to medium-term – near- to medium-term?

Mark Tabak - Chief Executive Officer
Paul, why don't you step in and respond to that, and then I'll punctuate that at the end.

Paul Galant - Operating Partner of Churchill Capital Corp III
Sorry, Mark, did you – who did you call up?

Mark Tabak - Chief Executive Officer
Yeah, Paul, go on. Paul, would you?

Paul Galant - Operating Partner of Churchill Capital Corp III
Yeah, sure, for sure. So, historically, the company has spent approximately 6% of its revenue on its R&D budget. And because you heard from Michael Kim, he runs a tech-stack, but has virtually no legacy software. That percentage and that amount has gone to a greater extent to building out new capabilities.

And it's one of the reasons why you saw the percentage savings generated by those algorithms continue to grow year after year. We have certainly started to implement the 15-part growth set of initiatives that I covered on the page.

You'll notice that many of those have to do with upgrading, if you will, product capabilities and features, as well as enabling our products and solutions to fit the specific needs of adjacent customers. So, auto insurers as an example, their interface, if you will, and the way in which they process the medical element of claims is going to be different than how perhaps some of our traditional commercial insurers that focus entirely on healthcare.

And so, we are focusing on, one, being able to give Dale a product set that is absolutely ready for the customers that he wants to go after. And that enables them to interface more easily to us and for us to be able to deliver higher savings than what those particular customers have seen from other providers. Okay? So that's one.

Two, we are investing significantly in the upgrade of our algorithms. And it's not just adding factors to our rules-based algorithms. More importantly, it's moving from rules-based to dynamic algorithm. And if you move that, if that move occurs, we can better leverage AI/machine-learning.

And that's very important to us, because we believe that will generate more savings for our customers. Lastly, we are moving into micro-services, as we discussed, and being able to take our anonymized data, make it available to software companies, financial services companies, who today support providers and payers in the medical ecosystem.

All of that work is both technology oriented, which is creating an API layer, moving some of our data into the cloud; and then, also on the sales sides, which is creating that product and business development team. And the business development team that we're going to create with Dale's help and that of Michael Kim is a BD team that knows software, that knows how to talk to a software provider, knows how to talk to a financial services provider, all in the context of supporting our payers, who, as we said, have a lot of demands that they want to put forth with regard to improving patient and provider experiences.

So all of those things are going to be funded by increasing the R&D from 6% to 10% of revenues, and adding capital, where we see episodic needs in order to be the best for the customer sets that Dale and team want to go after.

Operator
Moving to the next question from Kevin Fischbeck of Bank of America, 30 states have surprise billing legislation. How do the services that you provide in those states differ from those provided in the other 20 states? Is the $90 million to $100 million of revenue that you cited being at risk entirely in the 20 states that don't have surprise bill legislation? Or is there an ability to provide some of these types of services even when – if legislation is passed?

Mark Tabak - Chief Executive Officer
Dale, why don't you reply, recounting our experience to date in those 30 states and the opportunities for business development expansion, both in other states as well as on a federal level?

Dale White - Chief Revenue Officer
Yeah, there are 30 states that do have some form of surprise billing legislation. And then – and in some cases that they all vary – the surprise billing legislation that was passed in those 30 states, it varies by state in terms of its scope, its reach and the narrowness of the application. The services we provide in those states and the other states are, we provide all of our services in all 50 states, and in terms of network and analytics, and then ultimately payment integrity. The $90 million to $100 million that we cited, that being at risk it wasn't necessarily in just the remaining 20 states that don't have surprise billing legislation. That $90 million to $100 million is really the amount of revenue that we derive associated with emergency room and other hospital related services.

That's across our total base of revenue not just limited to the 20 states that don't have federal – I'm sorry, don't have legislation at the state level. It was really looking at it from the perspective of if the federal government passed a form – a legislation as well and they brought into the self-funded market space that all in we see about from our revenue, we get about $90 million to $100 million of revenue, that that would focus on ER and select ancillary services.

The state regs in the federal proposals, as I said, are really designed to protect consumers from those unexpected out-of-network medical bills, and when carriers saw that it at in-network facility but the position is not contracted. And we've – as I said have also been part of that solution with helping payers to comply with the state regulations and to helping them reduce their out of network cost and by protecting members and part of the work we've done at the state level, is when these individual states have had passed legislation we've worked with select customers on helping them to comply with the respective legislation in the 30 states that have it.

Mark Tabak - Chief Executive Officer
Let me cast it even a broader net. Look, with respect to government regulation in total, most of MultiPlan businesses insulated from regulation given we do not operate insurance plans. We do not deliver care and we do not assume any payment responsibility. And for years – for many years, we've monitored state and federal regulation to address out-of-network care

completely relative to surprise billing in specifically. We along with our regulatory advisors believe that there is low likelihood congress is going to enact any form of surprise billing legislation in 2020. While 30 states have been active in addressing surprise medical bills to date, the approach has generally been limited to specific care settings, categories of care, or network situations, which have had limited impact to us.

Notably, the definitions used in both federal and state legislation typically pertain to a very specific care such as emergency services anesthesiology, radiology services. And they are not written or enforced with the intent of eliminating out-of-network services or disrupting plan and provider negotiations in the process.

And finally, within MultiPlan's $1.2 million provider network, we have contracts with emergency service providers, anesthesiologist, radiology providers that by contract hold the member harmless, with no exposure to surprise billing. In addition, our negotiation offering also secures signed agreements with these providers, thereby eliminating surprise billing as well. Hope that answers your question.

Operator
The next question from Daniel Grosslight of Citi. Can you go into more detail about the claims change that impacted 2019? What exactly happened and why are you confident this cannot occur in the future?

Mark Tabak - Chief Executive Officer
Dave, you want to step in and recount the late 2018, 2019 issue with the customer?

David Redmond - Chief Financial Officer
Yeah, it was from a subset of a unique group of customers. It had to do with really regulatory compliance and legal compliance relative to some of their limited benefit plans. No other customer is in that situation. So we do not believe that that will happen anywhere else. That basically got wrapped up at the end of 2019. As Dale's talked very eloquently, we don't really have just customer-vendor relationships. We have unique partner relationships. And so when you partners have to address certain issues, a good partner stands up and works with the partner.

So we were impacted by that in late 2018, mostly in 2019. By the end of 2019, that has basically been resolved, but by that group of customers and it will methodically come back into our revenue over the next few years. Like a lot of things, sometimes the drops are fast and the recoveries are slower. And there will be steady recovery in those clients now that it has been resolved, but it's not a hockey stick going up and down, it is just a methodical recovery over a period of time. You certainly can add to that.

Mark Tabak - Chief Executive Officer
Dale, why don't you just comment on that once corrected the other opportunities that came to the MultiPlan as a result of that revision of the policy program.

Dale White - Chief Revenue Officer
Yeah, Mark, it's right. I mean, coming out of that issue in late 2018 and into 2019, with a particular set of customers once that was resolved, they resolved that regulatory policy issue.

We were able to move forward and continued to not only do expand implementation and activities within that group of customers, we added more customers. We were able to add more than 3 additional customers to our – to that began accessing our services in 2019.

And we have another set of customers that are in the process of implementing in 2020. And, in addition, I'd say across multiple sets of those customers once the issue was clarified, and resolve those same set of customers began looking at again expanding their use of our services in different ways. And as Dave said that the fall is always quicker than the recovery, but the recovery is exciting to us, because of the new relationships we've been able to capture coming out of that particular issue.

Operator
Next question from Sandy Draper of Truist Securities. When you think about adding to your salesforce, where are you looking for new people? What are the characteristics you are looking for? And since you already have relationships with many customers, are you all adding people to call on more points of contact at the customers, or what do these new hires bring?

Mark Tabak - Chief Executive Officer
Dale, well, he has been our Chief Revenue Officer responsible for sales and account management, and customer growth since 2003. He has a current salesforce of 42 people that we intend to secretly increase. And Dale, why don't you walk through the sectors and discipline and qualifications that we seek to bring into the organization which is already – new recruitment is already underway.

Dale White - Chief Revenue Officer
Mark, right, it is. And we really expect – as Mark said, we have about 40 to 43 individuals that make up the sales and account management, what I'll say customer facing function for MultiPlan. They are both a combination of a small set of individuals who are focused on adding new customers or new logos, and the lion's share of those individuals who focus on up-selling or cross-selling our product offerings to our customers. We actually want to increase the size of both. As we move into the adjacent markets, where we have a much smaller presence in Property and Casualty and Government, there are hundreds of Medicare Advantage plans to consider.

And in that, that way we want to augment our team by bringing in sales talent that that has experienced in Property and Casualty, and remember Property and Casualty is workers' comp in auto medical and in Government, its Medicaid or Medicare Advantage largely. And so we want to expand our reach into those adjacent markets and by bringing in sales talent to in that way. At the same time, we want to augment our existing teams to further enhance our ability to upsell to existing customers.

In many cases, we are connected into each of our payer accounts as I said in my remarks. We have great relationships with them at multiple levels throughout the organization, but particularly with larger payers, they silo their activities and commercial may be that the heads up of their government area may be different than the heads of their commercial space. And so we want to take advantage of bringing in added expertise to help us augment the existing teams that are in place and further our ability to cross sell into those other areas of the payer.

I'd say at the same time, we want to – as Dave said, one of our longer-term growth drivers is in their area of payment integrity, it's our newest product offering. We've done quite well building on the success of MARS. But we clearly want to grow on what I'll call that foundational footprint that we have today into – just like we did with our analytics business continue to grow on that footprint today and will augment our sales team by bringing in additional sales talent that's focused on – or has background in the payment integrity space.

Mark Tabak - Chief Executive Officer
The merger with Churchill really provides the financial flexibility for us to invest in growth. That investment will be in people, people that are experienced in those areas like Government and Property and Casualty. It will allow us to modify our existing products of networks, analytics, and payment integrity to meet the nuances that are inherent in Medicare, Medicaid, and Property and Casualty. What we're excited about is that when we look at those sectors, Government, Medicare, Medicaid and Property & Casualty. It's the very same products. It's the very same operational workflow. It's just a different set of customers if you will, particularly in the Property and Casualty world. It's the Hartford. It's Liberty Mutual. It's Travelers in the workers' comp area. It's State Farm. It's GEICO. It's USAA in the in the auto area.

And the Government business are very same commercial carriers are the market leaders in both Medicare and Medicaid. So we think we're well positioned with the addition of experienced people in sales and servicing will be able to grow significantly in those logical adjacencies.

Operator
Next question from Kevin Fischbeck of Bank of America, when you think about the five-year growth projections you have, how much of that is organic driven versus coming through acquisitions?

Mark Tabak - Chief Executive Officer
If you want to – going to walk through the bifurcation.

David Redmond - Chief Financial Officer
Yeah. I think if you look at – let me pull that page up. If you look at Slide 52, where we talked about 2021, and then out into 2025, essentially that bottom number, the $1,085 million and the $1,375 million, are based on pure organic growth with no additional acquisitions at all. The $1,125 million that goes up to, I think, $1.6 billion is slightly higher than that are based on growth with some small tuck-in acquisitions. In the analysis that we've provided, we do not have any major acquisitions in any of those longer-term projections.

Operator
Next question from Daniel Grosslight of Citi. In previous call you alluded to a large M&A transaction was in the works this year. Can you provide an update on that large acquisition?

Mark Tabak - Chief Executive Officer
We're not on this call going to speak about specific acquisitions. We have a growing pipeline of companies who would like to be part of MultiPlan, because of the value that we bring to

the healthcare industry. We have incredible payer relationships. We have a second to none IT platform. We have operational excellence. And there are a number of companies out there who have approached MultiPlan. And likewise, we have approached them about M&A opportunities. But I'm not prepared at this point on this call to talk about anything specific.

I will show you that we will look – we will provide the same discipline we do operationally to look at these acquisitions. I assure that they are going to be accretive and advance our top-line growth and advance our bottom-line EBITDA performance.

Operator
Next question from Jailendra Singh of Credit Suisse. Oh, go ahead.

Michael Klein - Chairman & Chief Executive Officer of Churchill Capital Corp III
It's Michael Klein. Just to circle back, maybe perhaps to the genesis of the question. It is true and clear that the conversations that Churchill began with MultiPlan in the January, February timeframe. And the rationale and drive that both MultiPlan and Hellman & Friedman had for this partnership was specific acquisition approaches and a specific acquisition approach that came to MultiPlan. That would clearly be a substantial opportunity for MultiPlan and still can be as that transaction was postponed due to the target company's weakness relative to COVID.

We're not – as Mark said speaking about any particular opportunities or focused on only one opportunity. But the reference to that initiating this process was clear, and then opportunity continues to be under consideration. Thank you.

Operator
Next question from Jailendra Singh of Credit Suisse, with respect to the impact of COVID, can you elaborate a little more about the underlying utilization trends you saw on your books relative to pre-COVID in Q2? Where are you now? And what are your expectations there with respect to the pace of recovery for the rest of second half of 2020?

Mark Tabak - Chief Executive Officer
Dave, why don't you give them some sight line into our Q1 performance, what we forecasted for Q2 and Q3? And then what we look -- what we see looking beyond that in Q4, and then recovery in 2021?

Dale White - Chief Revenue Officer
We initially thought that our Q2 could be impacted by $60 million to $70 million. The reality is we were about $39 million below last year and about slightly less than $50 million below budget, which is better. We expected Q3 will be probably somewhat comparable. We had actually estimated Q3 would be as much as $75 million to $80 million to add up to the $135 million to $150 million.

We brought those numbers down. And now, we are projecting essentially $910 million to $930 million for revenue, and $685 million to $705 million for EBITDA. We hope and we believe, when we made the projections in March, that most of COVID would be behind us and that we would be back to our target budget by Q4. That, we don't know that for sure.

The trends are going in the right direction. We think the bottom was – for us was probably in May and June. And we believe we're trending in the right direction. But it's still difficult to quantify. But at this point, we're saying $910 million to $930 million as our full-year revenue forecast, and $685 million to $705 million as our full-year EBITDA forecast.

The difference between that and our budgeted number is totally driven by the impact of COVID.

Mark Tabak - Chief Executive Officer
As you who are healthcare analysts on the call, I'm sure you recognize that at the end of March the ability of the healthcare industry to deliver non-life-threatening, so called, elective care was less than 5%. As of the June 1, that ability to deliver care was 95%. As the country reopens, we think there will be the continued migration of that unmet need back into the healthcare system, back into the healthcare industry.

We think we're well positioned to benefit from that increase in utilization, claim and charge capture. This assessment has been confirmed a number of times by the CEOs of some of our larger – of some of our larger customers who in their statements have indicated that there is a rebound in utilization taking place through Q3 into Q4 and then – and into 2021.

Operator
Next question is from Daniel Grosslight of Citi. What is driving the large increase in personnel and G&A cost this year? It looks like more clients are choosing to pay for network services on a PEPM basis. What is driving this change?

Mark Tabak - Chief Executive Officer
Dave?

David Redmond - Chief Financial Officer
If you're looking at the GAAP financial statements that we reflected for Q2, almost all of the increase in personnel expenses is the impact of higher stock-based compensation in Q2 than it was in Q1 and higher than Q2 last year. Most of that is driven by the Class B stock-based compensation that we have at MultiPlan, which was the 4-year plan that basically ended in June.

As a result of that, the market discount was reduced in Q2 by our independent valuation firm. And, obviously, the impact potentially of this transaction has some bearing on the overall valuation. But we've not gone up in personnel costs from an EBITDA standpoint. All of the personnel cost increase is related to stock-based compensation.

Mark Tabak - Chief Executive Officer
Relative to our headcount, please recognize that we run this company with about 2,000 employees, which speaks to the incredible automation that we bring to the industry, which allows us to do the right thing at the right time, the very first time. And that investment in automation will continue with the assistance of Bill and Paul working closely with Michael Kim, as we leverage machine learning and artificial intelligence to continue to advance the automated nature of our company.

Again, as I said, in my introduction, MultiPlan is not a traditional healthcare company. It's a tech-enabled data analytics company that receives claims. We re-price and process those claims, and return them to our customers. And last year, on a $106 billion of charges that we received, we generated savings opportunities in excess of $19 billion for our customers, their customers, the employer, and the patient; again, being on the right side of healthcare to make it affordable for the marketplace.

Operator
Next question is from Michael Cherny of Bank of America. How do you think about the competitive landscape of APIs, and the return profile needed to capture as you decide what APIs to focus on?

Mark Tabak - Chief Executive Officer
Paul, why don't you take that one?

Paul Galant - Operating Partner of Churchill Capital Corp III
I'm happy to. So, look, the entire strategy, the 3-part strategy is, as you probably have heard, is really taking what is today a very advanced and highly scalable platform, and enabling more parties to connect to it. And those connections, although to our customers traditionally have been through EDI. Obviously, over time, they're going to evolve to being more and more API connected.

And there are many, many benefits to API connectivity. And so, we look at it as really twofold. One is we develop APIs, in order for both our existing customers and future customers to be able to deliver data to us, API into us to get specific elements of the services, algorithms and solutions we provide as opposed to the entire thing; because I think in the future, what you're going to see is a convergence where our platform, which today is already deeply, deeply integrated with our customers, it's what makes us so unique, that integration should be able to do a lot more than just move claims.

And so, that's the next evolution, if you will, of MultiPlan 3.0. The other element of the API set and micro-services is to be able to talk to software companies, software companies that are not healthcare providers, but software companies that create solutions for the healthcare industry, such as billing system software companies, such as therapy insight, consumer advocacy, all of these folks are very much committed to the same thing we are, making healthcare more affordable, making it more efficient, and making it more effective.

And so, we believe that our crown jewels, which are data and algorithms, can be much – could be better levered, if you will, through these API connections. The prioritization of API development is 100% a function of the 15 initiatives that I took you through. And so, they will follow exactly the order of which we're executing.

And, of course, our execution depends on where we think we can make the biggest impact in the shortest period of time, with the highest returns. And so, I don't look at it as a technology-led prioritization, much more as a business-led prioritization. Hope that helps.

Mark Tabak - Chief Executive Officer
Look, again, just to punctuate Paul's comment, it's the same playbook. It's a different

approach, but it's the very same playbook, identifying pain points, identifying concerns, and the advantage we have is that we have 700-plus payers. And we're deeply embedded in their claims adjudication process.

And we have a unique 1.2 million directly contracted provider network. And every time that provider receives a payment, on the bottom of that remittance, on the bottom of that payment, it says this payment is being made in accordance with your relationship, your agreement with MultiPlan. So there is some brand equity. There is some brand identity there.

And thirdly, with the patient, the consumer, that the MultiPlan logo, if you will, is on over 60 million health insurance cards. No one leaves their house without that health insurance card. So we have that brand relationship there. With the addition of technology and our data, and our operational excellence, we intend to provide a value beyond payers, leveraging the payer relationship and expanding the TAM, with consumers as well as providers.

Operator
Next question is from Daniel Grosslight of Citi. Do you own full rights to 12 petabytes of data you capture? Are the data longitudinally matched?

Mark Tabak - Chief Executive Officer
Paul, you want to step up for that one, please?

Paul Galant - Operating Partner of Churchill Capital Corp III
I'm happy to. So, look, the dataset that comes into us for the purpose of delivering savings is owned by us for the purpose of generating those savings. And we have to own that data in order to develop our algorithms. There's no way to do the things that we do without having a right to manipulate the data.

It's important that everybody understands that the strategy of the company is entirely in support of its payer customers. And so their data, if you will, that we are stewards of, is used to develop solutions that help their end consumers that help the providers that are obviously in the healthcare ecosystem enabling services to be rendered. And so we're not doing something with the data, outside of that core, very important set of objectives that this company has. It's the vision, mission and strategy, this company which is all about making healthcare more affordable, accessible and efficient, for the benefit of everybody.

And so we're very comfortable with our ability to use the data in order to help this industry and more so also, of course, to generate new revenue streams. Hope that covered it.

Operator
Next question from Stephanie Davis with SVB Leerink. What level of annualized R&D investment? Do you need to maintain your most respective payments integrity? How do you mitigate the risk of health plans in housing the lower complexity algorithms each year?

Mark Tabak - Chief Executive Officer
Dale, why don't you start with the latter part of the question, and then we'll hand off to Paul for the R&D investments.

Dale White - Chief Revenue Officer
Dale or Dave?

Mark Tabak - Chief Executive Officer
Dale.

Dale White - Chief Revenue Officer
I'm sorry, Mark.

Mark Tabak - Chief Executive Officer
Yeah, talk about the internal – the risk if you will of our clients internalizing our solution set.

Dale White - Chief Revenue Officer
Yeah, I think the question was specific to payment in integrity, and what's the chances of a client? I think Stephanie's question was, what's the chances of a client internalizing some of the basic algorithms into their system? I mean, the whole payment integrity process is not a static process, right. It's designed to identify instances of waste and abuse, throughout that payment transaction process. And we develop algorithms as treatment change, as complexities change, as you know, to guard against revenue, to guard against creative billing schemes that may be undertaken.

So we've never worried about payers internalizing some of the basic algorithms, as all payers as we know, all payers today have basic edits in the built into their claims platform. They use NCCI edits and they build those basic edits into their platform and augment them as they do. They've always done that. Our job is to go well beyond that, which we have always done historically, and continue to look for other more complex opportunities through our algorithms and going forward with the help of Bill and Michael Kim, using our artificial intelligence and machine learning to continue to fine tune those algorithms to find even more opportunities. So they – again, they have basic edits and but they may internalize some of the basic edits augment what they do today, but it's never it's a dynamic process. We're always see more opportunities and by developing additional algorithms, which we do on a monthly basis to identify some of the new instances of waste and abuse that our system clients.

Mark Tabak - Chief Executive Officer
If you trifurcate the payment integrity algorithms, there are simple claim edits. And many of our payers have those simple claim edits. We were able to enhance that with our incomparable database from 700-plus payers' claims in charge data. A lot of the compelling value comes from the complex claim edits that we uniquely have and identify, and also the aberrant practice patterns that are evident by looking at such a large set of set of data. Paul?

Paul Galant - Operating Partner of Churchill Capital Corp III
Yeah. Look, I think this is an area that we did an enormous amount of diligence on as you could well imagine. The company plays this very mission critical role in the industry. And so we wanted to understand, what are the possible disruptors? Can people internalize, technically, I think that it's very clear. People can internalize and create their own algorithms. The difference here, and this is really important is twofold. Number one, we see data across 700 payers. That data is much, much larger and more diverse than what any single payer has within their system. Okay. And so that is a massively important point of differentiation. We

build our algorithms on a much larger data lake. And because we do that, we believe our products generate bigger savings, whether it's payment integrity or analytics. Okay.

The second thing is just the practical one, which is if a payer decides to do everything on their own. Their ability to go back to providers, and push for savings is fundamentally different than ours. We are the third-party independent source. The gold standard, if you will, of that data that we capture and analyze. And so we can talk to the entire industry, we don't have to talk to anyone specific payer when we do that.

And so just from a political or practical, any way you want to slice it, we are a much better mechanism by which payers can reduce the cost of healthcare versus doing it themselves. In terms of R&D, and how we think about this space. Look, we see the solutions that we bring to market, as Mark said, constantly evolving. And so the R&D dollars that we put in are going to be as you might expect, how do we take the algorithms, how do we take the data and be able to generate more savings from it, and to be able to generate better ways, if you will, for constituents to tap into us through licensing as an example, to improve the product.

And so, we believe that a 10% R&D spend – 10% of revenue R&D spend gets us there. But as Mark and Dale and Dave, all said, we use a build versus buy approach to everything we do. It's highly disciplined. And so that's going to be the decider of whether we use organic spend of R&D or instead we pivot to tuck-in acquisitions, which the company has had enormous success with. Hope that helps.

Mark Tabak - Chief Executive Officer
I'll give you a real-life example, pre-COVID, and we're investing R&D dollars now. With the merger of Churchill, we'll have more flexibility and ability to invest more R&D dollars to identify opportunities to create more value for the constituency we serve. I'll give you a real example. Pre-COVID, virtual care represented less than 1% of physician visits. In the second quarter at the height of the pandemic, virtual care was approaching 10% to 12% of visits.

We immediately saw that trend, began to mine that claims data and developed a set of algorithms to look at financial aberrations and clinical aberrations, which again generated value most in terms of reducing the medical spend, and also identifying waste and abuse through virtual care.

Operator
Next question from Daniel Grosslight of Citi. Most payers will stack payment integrity vendors, how does MultiPlan fit into this technology stack? Is there a particular service or audit most of your PI clients are using you for?

Mark Tabak - Chief Executive Officer
Dale, why don't you speak to the uniqueness of our prospective approach and how that positions us with the payers relative to the retrospective approach?

Dale White - Chief Revenue Officer
Sure. Most of the payment integrity companies in the space today are post-payment and you're absolutely right in your question that they're typically stacked. And in our world, we're prepayment, and so we're largely – we sit in between a payers' decision around

adjudication of the claim, and the ultimate payment of the claim. And there's very little stacking that takes place there. We are in that unique position. So our payment integrity products, in fact, our analytics products and our network products, all sit in that unique space and are deeply embedded into their claims platforms.

Typically, when you're in a postpaid position, you're not linked to a client's or to a payer's claims platform, you simply get a set of data of claims data that can be passed from payment integrity vendor to payment integrity vendor to payment integrity vendor in a stack, harder to do on a prepayment basis, because you're wired into their claims adjudication platforms. Number one, number two, you have issues around timeliness of payment. That and – regulatory and customer SLAs that the payer has to mine.

And so we sit in that unique position deeply embedded into their claims platform. And we've largely focused, again, we listen to our customers and understand where their pain points are in their attempts to save dollars and reduce medical spend and guard against paying claims wrong. And many of the bigger pain points are on what I'll call the physician services side, the HIPAA side. And so again, we started there with our added network and we focused our payment integrity again on out-of-network claims, because that's largely where the payers had the biggest exposure. And now we're crossing over to their in-network side driven largely by focusing on what I'll say are ancillary-related and position-related services.

Mark Tabak - Chief Executive Officer
Yes. Thank you from the conceptual to the reality, if you will, and just talk about how our payment integrity relative to say government business, how we're seeing 100% of those claims, whether they're, in-network and out-of-network and using our algorithms and IP to do that for the customers government business with not just one customers with several of the large government payers.

Dale White - Chief Revenue Officer
Yeah, again, as you heard, all of us say we started out historically as a company that focused on out-of-network claims, because that was the biggest pain point for our customers. We've now continued to expand our reach and work with our customers, particularly around payment integrity. That is, as I said earlier, one of our product offerings that can cross over into the in-network arena. And we're doing that with payment integrity, as Mark said, I think, we're aspirational in that regard. But we've had a lot of success in the area of government and in particular Medicare Advantage, where we've been able to apply our algorithms on the Medicare Advantage senior population.

And so just like there is in commercial health, those same instances of waste and abuse occur on government related claims and on Medicare Advantage related claims specifically, and there's instances to use our algorithms to identify and zero in on the services that seniors tend to utilize and purchase, which may be different than your sort of typical consumer.

And so we've worked in hand with some of the larger Medicare Advantage companies and now apply our algorithms to both the out-of-network claims, but also the in-network claims, as well. So claims that are processed through their own provider network are now routed to us again prepay. Prepay is that critical spot are routed to us on a prepay basis, we're able to

apply our algorithms, identify instances of payment inaccuracy and then work with the MA plans to correct that bill and pay it right the first time.

Operator
We have time for two more questions. Next one from Steven Valiquette, Barclays. How should we think about the potential impact on MultiPlan from a proposed lower age eligibility for Medicare as it would shift medical claims away from commercial towards government and what about MultiPlan's current exposure to ACA exchanges?

Mark Tabak - Chief Executive Officer
Dale, why don't you talk about how we continue to benefit as more and more people receive insurance, whether it's through the commercial market, whether it's through a government program like Medicare, Medicaid, or through a subsidized Obamacare Affordable Act access program.

Dale White - Chief Revenue Officer
Yeah, obviously, look, we are – we have 700 payer customers, right. And as I said in my remarks, they are the larger payers, they are Blue Cross Blue Shield plans, they are provider sponsored delivery plans, they're independent health plans, third-party administrators, and self-funded Taft-Hartley plan. And we continue to work with those payers as they grow, as they look to new market opportunities, both commercially related and government related. Obviously, for many of the plans, one of their fastest growing market segments is Medicare Advantage and we've started to work with payers as they want to expand to respond to the market need with Medicare Advantage networks. We are working with them to help them expand their network footprint and build customized networks that they can use to meet that that market demand.

We also work with our clients and those that are listed currently on the ACA exchanges. Many of the payers are reevaluating those positions coming out of COVID, and are looking to reenter more of the exchanges than they've been on historically in the past and we'll certainly strategize with them on how to take advantage of our services as some do today on using the exchanges that offer products and services on the local state ACA exchanges.

Mark Tabak - Chief Executive Officer
One of the many tailwinds that benefits MultiPlan is the increase in population and the increase in insurance coverage by that ever-growing population.

Michael Klein - Chairman & Chief Executive Officer of Churchill Capital Corp III
If I can just jump in for a moment, because the question on this SPAC versus the IPO, just to give my own perspective, I think the company – and this is not atypical for the kind of companies that we approach – MultiPlan as a company wasn't considering a sale and they weren't considering an IPO. They were progressing with their operations and they were looking at a material acquisition.

They came to the approach of utilizing a SPAC, because we had the ability to bring together the capital to both deleverage the business, invest in growth and potentially fund the acquisition. As you would imagine, a capital raise of $3.7 billion, consistent with what we

raised, is a fairly big exercise. And that is in part achievable, when you have a vehicle and when your own investors are prepared to underwrite $1.3 billion, $1.4 billion out of that.

The second reason, which I think is an important reason that certainly Hellman & Friedman gave to us was their belief that Churchill's operating executive team added value. And it really comes in 3 areas. The first area, of course, is what you've heard with Paul Galant and his payment processing growth skills, working closely with Mark and Dale, to expand the business; Bill Veghte, with his proven enterprise technology skills, to work directly with Michael Kim in terms of expanding AI and machine learning; and of course, having our team who spends full time, as well as Hellman & Friedman, on both merger and acquisitions and capital markets to achieve the growth opportunities.

So the belief was significant value-add. The third piece, which I think relates to just a misnomer around the SPAC marketplace, when constructed appropriately, SPACs do have 2 or 3 advantages when done right. The first advantage is far greater transparency on the company than a pure IPO.

When you file a merger proxy when you have the ability to have these kind of analyst meetings, not just with IPO analysts, and when you don't have the limitation of going to see investors for 30-minute presentations off of a prospectus, you have a better shareholder base. We've seen from Wellington and others who've entered the shares, they're more informed. And we want more informed long-term shareholders.

The second thing you can do, if you do this appropriately, is you can create the right capital structure right out of the box. And that's what we've done here. And the third thing that you can do is you can make it far less dilutive than an IPO and this is something that I think is not always well understood. Given the size of our vehicle, and given the size of the transaction, this transaction is less than 2% dilutive by using a, "SPAC", versus an IPO. It's in fact lower than what would have been the gross spread on an IPO.

So it's actually more advantageous in terms of cost structure, more advantageous in terms of ownership setup, more advantageous in terms of the capital that can be committed, and more advantageous in terms of the ability to pick your shareholders and educate them. So I think those are the reasons. Certainly, we created the vehicle, so we're biased in that regard.

We also created the only opportunity for a, "certain IPO". And when I say certain, I mean, this transaction with the capital we've raised, meets all of the cash conditions of closing. We have cleared Hart-Scott. We are filed with the SEC on a proxy and we'll be done with that in just a matter of weeks. There really is essentially no conditionality.

The team at Hellman & Friedman and at MultiPlan were able to discuss and agree a capital structure, a value, a marketing approach, a balance sheet that can focus on growth and a governance model that were much more effective than what could occur with the vicissitudes of an IPO market.

And for us as well, using this structure, we could put significant capital to work, which is what we wanted. Our investors which include the Jobs family and Michael Dell, include some very significant family offices that are not part of the disclosure as well as very

significant institutional investors sought to put the capital to work for the long-term. So this meets a lot of goals and does so both efficiently, effectively and on a timely basis.

Operator
Turning back to Mark for final remarks.

Mark Tabak - Chief Executive Officer
We appreciate your interest. And this is certainly an important event in the life of MultiPlan, after 40 years, holding our very first Analyst Day presentation, more to follow. So I thank you for your time and interest.

I'd like to leave you with just a few thoughts, if I may. Look, MultiPlan enjoys a market-leading position with real size and scale, and really differentiated advantages as our incomparable database, directly contracted 1.2 million provider network and incredible longevity with our payer customers numbering more than 700.

We're critical and essential to the healthcare industry. And we have a competitive mode. And we have an incredible recurring revenue business model that produces robust EBITDA margins and a strong conversion to cash flow. We're going to redeploy some of that cash flow into fueling our growth and expansion, as you've heard about the enhancing existing products, extending into new markets and new customers, and expanding from payer-centric-only to payer provider and patients.

We have multiple avenues of growth. As I just articulated, that also includes in-network, as well as international, along with government and property/casualty. And there are clear financial and intellectual capital synergies as a result of the merger between MultiPlan and Churchill Capital III.

So, again, I thank you for your time and attention. And we look forward to working with you in the coming months, quarters and years. Thank you again. Have a nice afternoon.

Forward-Looking Statements

This communication includes "forward looking statements" within the meaning of the "safe harbor" provisions of the United States Private Securities Litigation Reform Act of 1995. Terms such as "anticipate," "believe," "will," "continue," "could," "estimate," "expect," "intend," "may," "might," "plan," "possible," "potential," "predict," "should," "would," or similar expressions may identify forward-looking statements, but the absence of these words does not mean the statement is not forward-looking. Such forward looking statements include estimated financial information. Such forward looking statements with respect to revenues, earnings, performance, strategies, prospects and other aspects of the businesses of Churchill Capital Corp III ("Churchill"), MultiPlan (which, for purposes of this communication, refers to Polaris Parent Corp. and its consolidated subsidiaries, unless the context otherwise requires) or the combined company after completion of the proposed business combination between Churchill and MultiPlan ("Business Combination") are based on current expectations that are subject to known and unknown risks and uncertainties, which could cause actual results or outcomes to differ materially from expectations expressed or implied by such forward looking statements.

Actual events or results may differ materially from those discussed in forward-looking statements as a result of various risks and uncertainties, including: the occurrence of any event, change or other circumstances that could give rise to the termination of that Agreement and Plan of Merger, dated July 12, 2020, by and among Churchill, Music Merger Sub I, Inc., Music Merger Sub II LLC, Polaris Parent Corp. and Polaris Investment Holdings, L.P. ("Merger Agreement"); the inability to complete the transactions contemplated by the Merger Agreement

("Transactions") due to the failure to obtain approval of the stockholders of Churchill or other conditions to closing in the Merger Agreement; the ability to meet applicable listing standards following the consummation of the Transactions; the risk that the proposed transaction disrupts current plans and operations of MultiPlan as a result of the announcement and consummation of the Transactions; the ability to recognize the anticipated benefits of the Business Combination, which may be affected by, among other things, competition, the ability of the combined company to grow and manage growth profitably, maintain relationships with customers and suppliers and retain its management and key employees; costs related to the Business Combination; changes in applicable laws or regulations; the possibility that Churchill, MultiPlan or the combined company may be adversely affected by other political, economic, business, and/or competitive factors; the impact of COVID-19 and its related effects on Churchill, MultiPlan or the combined company's projected results of operations, financial performance or other financial metrics; the ability to achieve the goals of MultiPlan's enhance / extend / expand strategy and recognize the anticipated strategic, operational, growth and efficiency benefits when expected; pending or potential litigation associated with the Business Combination; and other risks and uncertainties indicated from time to time in the preliminary proxy statement filed with the Securities and Exchange Commission ("SEC") on July 31, 2020, including those under "Risk Factors" therein, and other documents filed or to be filed with SEC by Churchill. Forward-looking statements speak only as of the date made and, except as required by law, Churchill and MultiPlan undertake no obligation to update or revise these forward-looking statements, whether as a result of new information, future events or otherwise. Anyone using the presentation does so at their own risk and no responsibility is accepted for any losses which may result from such use directly or indirectly. Investors should carry out their own due diligence in connection with the assumptions contained herein. The forward-looking statements in this communication speak as of the date of this communication. Although Churchill may from time to time voluntarily update its prior forward-looking statements, it disclaims any commitment to do so whether as a result of new information, future events, changes in assumptions or otherwise except as required by securities laws. For additional information regarding these and other risks faced by us, refer to our public filings with the SEC, available on the SEC's website at www.sec.gov.

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Additional Information and Where to Find It

In connection with the proposed transactions, Churchill filed a preliminary proxy statement with the SEC on July 31, 2020. Churchill intends to file other relevant material, including a definitive proxy statement with the SEC. Stockholders are urged to read the preliminary proxy statement, as well as the definitive proxy statement when it becomes available, and any other documents filed with the SEC in connection with the Business Combination or incorporated by reference in the preliminary proxy statement or the definitive proxy statement because they will contain important information about the Business Combination.

Investors will be able to obtain free of charge the proxy statement and other documents filed with the SEC at the SEC's website at http://www.sec.gov. Copies of the documents filed with the SEC by Churchill when and if available, can be obtained free of charge by directing a written request to Churchill Capital Corp III, 640 Fifth Avenue, 12th Floor, New York, NY 10019.

The directors, executive officers and certain other members of management and employees of Churchill may be deemed "participants" in the solicitation of proxies from stockholders of Churchill in favor of the Business Combination. Information regarding the persons who may, under the rules of the SEC, be considered participants in the solicitation of the stockholders of Churchill in connection with the Business Combination is set forth in the preliminary proxy statement and will be set forth in the definitive proxy statement and the other

relevant documents to be filed with the SEC. You can find information about Churchill's executive officers and directors in Churchill's filings with the SEC, including Churchill's final prospectus for its initial public offering.

EXHIBIT 10

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MultiPlan (https://www.multiplan.us)

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Data-driven, customized healthcare cost management solutions

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Our reference-based pricing services offer flexible, cost-effective, data-driven solutions for reducing healthcare costs.

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Offer an advantage for surprise bills

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In today's economic market, priorities shift between maximizing healthcare savings and satisfying health plan members. MultiPlan offers a range of data analytics-driven healthcare cost management services that can be arranged and combined to help you strike the right balance not only today, but also when priorities shift tomorrow.

Satisfying health plan members

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$9 Million

claims

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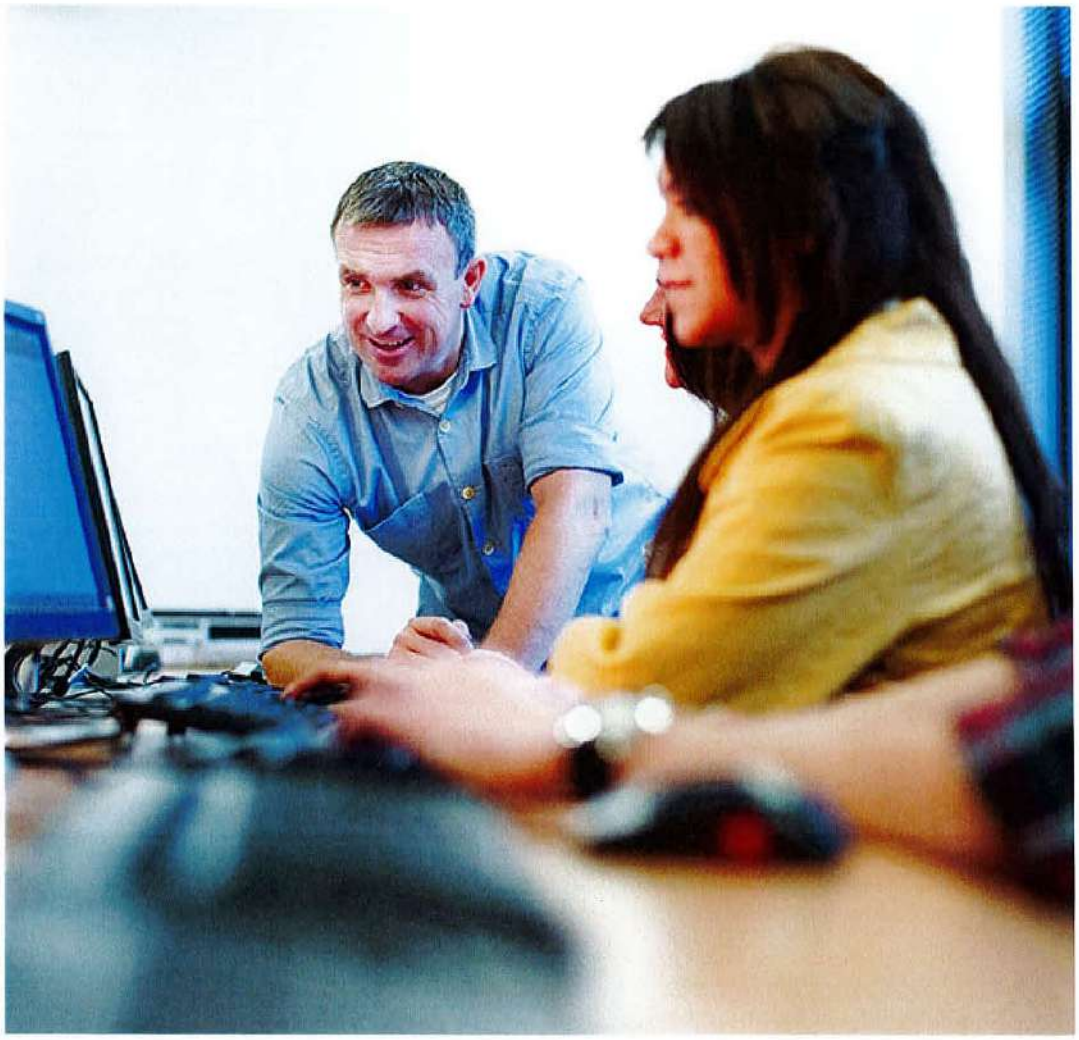

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Unique position, different approach

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EXHIBIT 11

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ELECTRONICALLY
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Superior Court of California, County of San Francisco
09/08/2021
Clerk of the Court
BY: ERNALYN BURA
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

CGC-21-594966

VHS LIQUIDATING TRUST, liquidating trust for Verity Health System of California, Inc., a California corporation,

Plaintiff,

v.

MULTIPLAN CORPORATION; a Delaware corporation; MULTIPLAN, INC., a New York corporation; VIANT, INC., a Nevada corporation; CHURCHILL CAPITAL CORP.; CHURCHILL CAPITAL III; CIGNA CORP.; CENTENE CORP.; HUMANA, INC.; UNITEDHEALTH GROUP, INC.; UNITED HEALTHCARE; WELLS FARGO & COMPANY; ESURANCE HOLDINGS, INC.; ESURANCE INSURANCE SERVICES, INC.; INPHI CORPORATION; and VIANT PAYMENT SYSTEMS, INC., all Delaware corporations; DATA ISIGHT; NATIONAL CARE NETWORK, LP; and NATIONAL CARE NETWORK, LLC, all Delaware companies; BLUE CROSS AND BLUE SHIELD ASSOCIATION, an Illinois corporation; ANTHEM, INC., an Indiana corporation; UNITED HEALTHCARE SERVICES, INC., a Minnesota corporation; AETNA, INC., a Pennsylvania corporation; AETNA HEALTH OF CALIFORNIA, INC.; ANTHEM BLUE CROSS OF CALIFORNIA;

Case No.

COMPLAINT FOR VIOLATIONS OF THE CARTWRIGHT ACT (BUS. & PROF. CODE §§ 16720 *et seq.*) & UNFAIR COMPETITION LAW (BUS. & PROF. CODE §§ 17200 *et seq.*)

JURY TRIAL DEMANDED

BLUE SHIELD OF CALIFORNIA / CALIFORNIA PHYSICIANS' SERVICE; BLUE SHIELD OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANY; CIGNA HEALTHCARE OF CALIFORNIA, INC.; HEALTH NET OF CALIFORNIA; HUMANA HEALTH PLAN OF CALIFORNIA, INC.; and WARNER BROTHERS THEATRE VENTURES, all California corporations,

Defendants.

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Plaintiff VHS Liquidating Trust ("Plaintiff" or "Verity") brings this civil action against Defendants for violations of California's Cartwright Act and Unfair Competition Law and demands a jury trial for all of its claims that can be so tried in accordance with the law. It alleges as follows:

I. INTRODUCTION

1. The most powerful and highly profitable commercial health insurers unlawfully agreed with each other and their corporate hub, MultiPlan, to fix and reduce the amounts of out-of-network reimbursement payments they paid to U.S. health care providers including Verity's non-profit hospitals. The annual nationwide reductions totaled approximately $10 billion per year from 2012 through 2020. Verity and the other providers badly needed that money, which was due to them for services already performed in caring for patients. But the funds never came. Meanwhile, in no small part because of the unlawful conduct at issue in this Complaint, commercial health insurers' profits skyrocketed off the backs of struggling hospitals, like Verity, and other providers. Moreover, Defendants' unlawful conduct dramatically diminished the capacity of Verity and other providers to, among other things: improve their facilities; comply with legally required seismic and building safety standards; upgrade their equipment and technology to keep pace with medical standards of care; and provide the same level of health care to their patients that they would have but for Defendants' unlawful conduct. As a result, Verity went bankrupt as did other hospitals. The major commercial health insurers are among the most wealthy and profitable businesses in the country, and collectively wield massive economic power in the healthcare industry. And MultiPlan recently went public in one of the largest transactions of its type ever, with an $11 billion company valuation. By filing this Complaint, Verity seeks to recover damages for the injuries Defendants caused it to suffer through Defendants' unlawful anticompetitive conduct; those damages are in the hundreds of millions of dollars or more.

2. This is a straightforward case at its core:

a. MultiPlan's primary business is to produce a single, supposedly reasonable, commercial payer reimbursement price for out-of-network services from health care providers;

b. MultiPlan does not produce – nor even claim to produce – different prices for different commercial-insurer reimbursements but instead just "one price";

c. Defendant Insurers secretly agreed among themselves through at least a "hub, spoke, and rim" agreement to follow and adhere to MultiPlan's pricing;

d. They then followed through on their agreement by adhering to MultiPlan's pricing effectively all of the time for a decade or more – most often, as MultiPlan admits, "without any human touch" – leaving health care providers with no option but to take the reduced reimbursements and suffer the consequences;

e. Indeed, the Defendants' stated purpose for the conduct at issue in this Complaint was to reduce commercial-insurer payments to health care providers like Verity, and directly increase their own profits as a result; and

f. As a result of Defendants' conduct, Verity suffered severely, went bankrupt, and lost its valuable enterprise.

3. Defendants broke the law by fixing prices, allocating and stabilizing their markets, and unlawfully exchanging competitively sensitive business information, all with the specific purpose and actual effect of reducing commercial-insurer reimbursements to anticompetitively low levels.

4. For the same purpose and with the same effect, Defendants also agreed to help build and entrench the corporate hub of their unlawful conduct, MultiPlan, as an unlawful monopolist, and to leverage that dominant position unlawfully to the detriment of health care providers.

5. Billions of dollars flowed from health care providers to commercial insurers, including MultiPlan's self-funded-payer customers ("SFPs"), as a result.

6. MultiPlan admits its commercial-insurer customers, which include Defendant Insurers and SFPs, paid Verity and other U.S. health care providers billions of dollars less ***annually*** than they otherwise would have for at least 10 years.

7. Defendants' common purpose was to reduce the amount they paid to Verity and other health care providers for out-of-network general acute care hospital inpatient and outpatient hospital services ("Services").

8. Defendants used methods to achieve this common goal that violate California law.

9. Defendants were effective in their collective goal, and their collective reimbursement reductions substantially increased over the years.

10. Plaintiff Verity includes the non-profit San Francisco, Los Angeles, and San Jose hospitals St. Louise, St. Francis, St. Vincent, Seton, Seton Coastside, and O'Connor, and their non-profit parent, Verity Health Systems of California.

11. Verity served its patients and communities for many years with needed care and diligence to the best of its abilities before going bankrupt in 2018.

12. Although it provided essential services to its patients and these communities, Verity suffered many injuries due in significant part to its inability to secure adequate reimbursement for its Services from commercial health insurers, who are Defendants in this lawsuit.

13. Defendant Insurers – along with MultiPlan, a New York City for-profit reimbursement claim "repricer" of Services, and Defendant Churchill Capital, a New York City for-profit investment banking / special purpose acquisition company ("SPAC") – admit in public investor materials and presentations[1] that their collective goal was to substantially reduce reimbursements to hospitals and other health care providers for the valuable Services they provided.

14. Defendants' unlawful schemes achieved their specific purpose and caused the intended effect of significantly reducing Defendant Insurers' and SFPs' payments on the reimbursements they owed to Verity and other providers in the San Francisco, Los Angeles, and San Jose metropolitans areas, and beyond.

[1] True and correct copies of these materials are attached to this Complaint as Exhibits 1 – 9. The statements of Defendants in these materials are all admissible and binding co-conspirator and party admissions.

15. Defendant Insurer and SFP reimbursements for Services comprise core revenues for California hospitals, including Verity.

16. The large and powerful for-profit commercial health insurer Defendants in this Complaint are Fortune 500 regulars United Health (Fortune #7), Cigna (Fortune #13), Anthem (Fortune #29), Centene (Health Net) (Fortune #42), and Humana (Fortune #52). Aetna, itself a large company, is a member of this group of large for-profit insurers too, and it is a subsidiary of CVS (Fortune #5).

17. Large and powerful California health insurer Defendant Blue Shield of California ("Blue Shield") provides these commercial out-of-network reimbursements too. It participated in the schemes detailed in this Complaint for their entire duration, and enjoyed substantially greater profits as a result.

18. This Complaint refers to the collection of seven large and powerful commercial health insurer "competitors" – United Health, Cigna, Anthem, Centene (Health Net), Humana, Aetna, and Blue Shield – as "Defendant Insurers."

19. For years, beginning at least as early as 2012 and lasting through the present day, and at all times relevant to this Complaint, Defendant Insurers have worked hand-in-hand with each other and MultiPlan in schemes that were admittedly "built to help [insurers and other] payers reduce the cost of" the "out-of-network" segment of reimbursements to Verity and other providers for their Services. (Ex. 5 at 6.)

20. MultiPlan admits its own for-profit goals are only met to the extent it fulfills this collective group purpose because its revenue is based on a percentage of the reductions in insurer and other payer reimbursements generated by the conduct at issue in this Complaint.

21. The core conduct at issue in this Complaint – price (here, "reprice") fixing – is "horizontal" in nature, with the conduct occurring between health insurance competitors, *i.e.*, Defendant Insurers; and this conduct occurred in the markets for commercial out-of-network reimbursements for Services from insurers and SFPs to hospitals and other providers in the San Francisco, Los Angeles, and San Jose metropolitan areas.

22. Hospitals, including Verity, and other providers were and are in direct, rather than indirect, economic relationships with Defendant Insurers and SFPs in these markets.

23. The medical and economic relationships between providers like Verity, on the one hand, and other providers and their patients, on the other hand, occur in different markets than those that are the focus of this Complaint.

24. Further, the economic relationships between commercial health insurers and SFPs, on the one hand, and their enrollees, on the other hand, occur in different markets than those that are the focus of this Complaint.

25. This Complaint focuses on the economic relationships health care providers, including Verity, on the one hand, engage in directly with Defendant Insurers, on the other hand.

26. Defendant Insurers compete with each other in these markets.

27. In many instances, California law prohibits hospitals and other providers from billing their patients for shortfalls in commercial-insurer reimbursements for Services, or "balance billing."

28. And, even where hospitals and other health care providers might be able to bill their patients for shortfalls in commercial-insurer reimbursements for Services, those transactions would occur as part of different economic relationships, and in different markets than those at issue in this Complaint.

29. And, in any event, Verity and other providers were not able to meaningfully bill their patients for shortfalls in commercial-insurer reimbursements for Services during the time period at issue in this Complaint.

30. Defendant Insurers did not compete with each other to offer Verity and other health care providers competitive market prices on reimbursements for the valuable Services they provided.

31. Instead, they followed the anticompetitive schemes detailed in this Complaint.

32. Defendants' horizontal price fixing is especially brazen.

33. MultiPlan does not produce different commercial-insurer prices for claims made, *e.g.*, by a hospital on a single CPT code on the same day.

34. Instead, each MultiPlan commercial-insurer customer with a claim from that hospital for that CPT code on that day would receive exactly the same repricing result from MultiPlan.

35. In a competitive market, those commercial insurers would make their pricing decisions independently, even if they engaged MultiPlan to help them make better decisions.

36. But here, instead, those commercial insurers agreed to follow MultiPlan's pricing effectively all of the time and not make independent pricing decisions.

37. MultiPlan and Churchill (MultiPlan's New York investment banking and SPAC facilitator) admit and publicly trumpet these facts to Defendant Insurers, SFPs, and others. (*See, e.g.*, Exs. 1-8.)

38. They explain that all of the major U.S. insurers have adhered to MultiPlan's fixed prices for Services at least 87% of the time "without any human touch," and often according to "Global agreements." (Ex. 1 at 20 and Ex. 5 at 43.)

39. This 87% number also reflects, as MultiPlan and Churchill admit, provider acceptance "without any human touch." (*Id.*)

40. When human touch is added to the equation to further drive provider acceptance, MultiPlan explains, the percentage of insurer adherence and provider acceptance rises to approximately 95% acceptance of the MultiPlan-set and Defendant-fixed commercial out-of-network reimbursement prices, without any provider appeals. (Ex. 9 at 1.)

41. When provider appeals are added to the equation, MultiPlan and Churchill explain, the number reaches 99% or more. (Ex. 4 at 17.)

42. These facts demonstrate that all of Defendant Insurers and the major U.S. insurers have effectively followed the MultiPlan-set and Defendant-fixed commercial out-of-network reimbursement prices for Services in nearly every instance.

43. Defendant Insurers and other MultiPlan-payer customers may claim they have the "choice" to follow or not follow the fixed prices, but actions speak louder than words.

44. The reality is that Defendants all follow the MultiPlan-set and Defendant-fixed prices regularly, predictably, and almost always automatically.

45. Further, MultiPlan expressly admits, and makes it clear to all, that every major U.S. health insurer participates in the repricing scheme.

46. It does so through its public statements, which serve as assurances to the major U.S. health insurers, Defendant Insurers, and other commercial payers, and assuage what otherwise would be natural concerns about their would-be competitors besting them on price.

47. Verity and other providers have had no option but to accept these artificially low reimbursements because 95% of those who provide them to Verity and other providers in the applicable markets participate in the conduct detailed in this Complaint.

48. Verity and other providers have not benefitted from competition among Defendant Insurers on this aspect of their direct economic relationships with Defendants. Instead, they have been injured by Defendants' anticompetitive conduct.

49. The MultiPlan-set and Defendant-fixed prices to which Defendant Insurers and self-funded payers adhere stem from secret horizontal agreements among Defendant Insurers through hub MultiPlan.

50. Commercial health insurers and SFPs, including Defendants, also submit competitively sensitive reimbursement claims data to MultiPlan and receive granular prices to which they adhere and to which they know all leading commercial health insurers adhere because MultiPlan tells them (and admits doing so publicly), thus effectively monitoring compliance for the group.

51. Commercial health insurers and SFPs, including Defendants, have fed MultiPlan substantial amounts of competitively sensitive claims data for many years. The tremendous volume of data flowing to MultiPlan from insurers and self-funded payers includes 370,000 reimbursement claims a day, 365 days a year, "98%+" of which comes to MultiPlan "through direct technological integration." (Ex. 5 at 47 and Ex. 6 at 21.)

52. No other company like MultiPlan has a comparable collection of data.

53. The granular future pricing output of the unlawful information exchange is detailed even to the level of specific hospital services, *i.e.*, CPT codes like 99284 (an emergency

department examination and moderately complex medical decision), including by geographic regions, according to MultiPlan.

54. The prices MultiPlan sets are specific to the penny, and are followed to the penny by its payer customers, which include Defendant Insurers and SFPs.

55. Defendants' price fixing and unlawful exchange of competitively sensitive business information also stem from independently unlawful vertical agreements MultiPlan has entered into with Defendant Insurers and SFPs, to which MultiPlan readily admits.

56. These vertical agreements have the effect of stabilizing markets, including those at issue in this Complaint, and preserving an oligopsony among the major U.S. commercial health insurers.

57. According to MultiPlan's admissions, it has long-term and "sticky" relationships with all of the top national commercial health insurers, including Defendant Insurers, with contracts ranging from 2 – 5 years in length that automatically renew. (Ex. 5 at 17.)

58. MultiPlan communicates the details of its relationships with each commercial health insurer to all of the significant national commercial health insurers, and others.

59. MultiPlan emphasizes in these communications and publicly that its relationships with its top 10 commercial health insurer customers average 25 years in length and that it is "deeply integrated and embedded" with the largest commercial health insurers.

60. MultiPlan is a large for-profit company in its own right with approximately $1 billion in annual revenues.

61. It dominates the market to provide commercial out-of-network repricing to commercial health insurers and self-funded payers, including Defendants, and has no meaningful horizontal competitors.

62. Verity and other providers were and are in indirect economic relationships with MultiPlan in this market.

63. MultiPlan is an unlawful monopolist in commercial out-of-network repricing. It describes its own products and services as "[m]ission critical," its customers "switching costs [as]

high," and its own margins "best-in-class." (Ex. 4 at 8 & 20; Ex. 5 at 47, 57 & 60; Ex. 6 at 7, 20 & 23; and Ex. 8 at 10, 12, 17 & 17.)

64. Further, MultiPlan admits it "has created a competitive moat around [its] company that drives high recurring revenues." (Ex. 1 at 20.)

65. MultiPlan admits its high recurring revenues produce "best-in-class [profit] margins" that "have been in excess of 70% and in many cases in the high 70%s" over a period of many years. (Ex. 1 at 22.)

66. MultiPlan has long sought to unlawfully monopolize commercial out-of-network repricing, leverage its dominance, and acquire actual and potential competitors.

67. Its plans have succeeded. MultiPlan commenced a series of acquisitions of actual and potential competitors beginning as early as 2010 and 2011 with Viant, Inc. and National Care Network (Data iSight), continued in 2014 with Medical Audit & Review Solutions, and extended through the past year with HST in 2020 and Discovery Health Partners in 2021; indeed, Defendants' plan for MultiPlan to continue extending its dominant repricing market position into other markets in the future.

68. MultiPlan displayed its "moat digging" history, and future "moat digging" and other anticompetitive plans, in recent presentations as part of its explanations for why public investors should pay more for equity shares it recently offered in its company – shares offered with the assistance of Defendant Churchill and its subsidiary Defendant Churchill Capital III.

69. Defendant Churchill assisted in MultiPlan's investor presentations, and other presentations and communications, which had the purpose and effect of further entrenching, facilitating, and overtly enhancing the conduct at issue in this Complaint for Defendant Churchill's own profit.

70. The better MultiPlan's financial performance and business outlook, the more Defendant Churchill could get for MultiPlan's shares when taking it public.

71. As the unlawful gains from Defendants' unlawful conduct bloated their coffers, it deprived non-profit hospitals, including Verity's, and other providers of that same money.

72. Verity and other providers needed that money to provide valuable care to the patients and communities they served.

73. They also needed it to improve their facilities, comply with seismic-safety standards, upgrade their equipment and technology to keep pace with medical standards of care, and maintain and enhance the quality of their patient care.

74. Indeed, Verity's non-profit hospitals St. Louise, St. Francis, St. Vincent, Seton, Seton Coastside, and O'Connor needed this money not only to meet these ends, but also to stay in business.

75. But Defendants unlawfully took these critical funds for themselves, feeding their corporate greed for profits, and consequently putting hospitals out of business, including Verity.

76. Defendants enjoyed difficult-to-imagine yet nonetheless real profits, while non-profit hospitals like Verity and other providers were forced into bankruptcy.

77. And Verity lost its valuable enterprise as a result of Defendants' conduct.

II. THE PARTIES

A. Verity

78. Plaintiff Verity, or VHS Liquidating Trust, is the bankruptcy liquidator for former California not-for-profit health care system Verity Health System of California, Inc., which filed for Chapter 11 bankruptcy in 2018.

79. The Verity Health System of California, Inc. operated six not-for-profit hospitals, several associated medical foundations, and other affiliates serving the San Francisco, Los Angeles, and San Jose metropolitan areas.

80. Those six hospitals – Seton Medical Center in Daly City, Seton Coastside in Moss Beach, St. Vincent Medical Center in Los Angeles, O'Connor Hospital in San Jose, St. Louise Regional Hospital in Gilroy, and St. Francis Medical Center in Lynwood – had 1,650 patient beds, six active emergency rooms, a trauma center, and a host of medical specialties including tertiary and quaternary care.

81. The Verity Health System of California, Inc. was the sole owner of these six hospitals and their associated medical foundations and affiliates.

82. The Court, laws, and bankruptcy plan in the Verity Health System of California, Inc. case assigned all of its claims, including those at issue in this Complaint, to Verity Liquidating Trust, *i.e.*, Verity.

83. Neither Verity nor anyone else has released, assigned, or sold those claims.

84. Thus, Verity controls claims of St. Louise, St. Francis, St. Vincent, Seton, Seton Coastside, and O'Connor hospitals, their affiliated medical foundations and affiliates, and Verity Health System of California, Inc.

85. Verity has the right and standing to bring the claims at issue in this Complaint.

B. Defendants Churchill/MultiPlan and Affiliated Entities: the "Hub"

86. Defendant Churchill Capital III ("Churchill III") was a special purpose acquisition company created to raise funds to take a private company public. It and related entities acquired MultiPlan, Inc. and its related entities in October 2020, and renamed the combined company MultiPlan Corporation. Churchill III is incorporated in Delaware and is headquartered in New York.

a. Defendant MultiPlan Corporation is a provider of healthcare data and analytics products and services incorporated in Delaware and headquartered in New York. It claims to use algorithms and data analytics to provide repricing and other services to health insurers and other customers.

b. Defendant Viant, Inc. is a healthcare payment solutions company incorporated in Delaware and headquartered in Illinois. It offers to commercial and public health insurance customers in the United States auditing and reimbursement for medical claims and costs, as well as pre-payment services such as facility bill review and professional negotiation. MultiPlan acquired Viant, Inc. in 2010.

c. Defendant Viant Payment Systems, Inc. is a healthcare payment solutions company incorporated in Delaware and headquartered in Illinois. MultiPlan acquired it in 2010.

d. Defendants National Care Network, LP and its affiliate National Care Network, LLC are healthcare cost management companies incorporated in Delaware and headquartered in Texas. MultiPlan acquired them in 2011.

e. Defendant Data iSight was a part of National Care Network when MultiPlan acquired it in 2011. It provides reimbursement pricing information to health insurers and other payers and customers, and it claims to utilize a patented methodology in evaluating health care reimbursement claims when doing so. Data iSight also is a trademark of National Care Network, LLC.

87. Collectively, MultiPlan Corporation, MultiPlan, Inc., Churchill III, Viant, Inc., Viant Payment Systems, Inc., National Care Network LP, National Care Network, LLC, Data iSight, and their affiliates comprise and are referred to as "MultiPlan" the "Hub" in this Complaint.

88. Defendant Churchill Capital Corp. ("Churchill") was the parent company of Churchill III. It is an investment banking and special purpose acquisition company incorporated in Delaware and headquartered in New York. Churchill launched Churchill III in February 2020.

C. Defendant Commercial Health Insurers: the "Spokes"

89. The major commercial health insurers enter into vertical contracts for commercial out-of-network repricing from MultiPlan, the "Hub," and form the "spokes" of Defendants' "hub, spoke, and rim" arrangement.

90. Defendant Aetna Health of California, Inc. is a California corporation qualified to do business in California. It is one of the state's largest health insurance companies and a subsidiary of Defendant Aetna, Inc., one of the nation's largest health insurance companies, and CVS Health Corporation, one of the nation's largest companies. Aetna, Inc. is a Delaware corporation.

91. Defendant Anthem is the trade name of, or doing business as, Blue Cross of California, a California corporation qualified to do business in California. It is one of the state's largest health insurance companies and is a subsidiary of Defendant Anthem, Inc., one of the nation's largest companies. Anthem, Inc. is an Indiana corporation.

92. Defendants Blue Shield of California / California Physicians' Service and Blue Shield Life & Health Insurance Company are California corporations qualified to do business in

California and affiliated with Defendant Blue Cross and Blue Shield Association, an Illinois corporation. They are among the state's largest health insurance companies.

93. Defendant Cigna Healthcare of California, Inc. is a California corporation qualified to do business in California. It is one of the state's largest health insurance companies and a subsidiary of Defendant Cigna Corporation, one of the nation's largest companies. Cigna Corporation is a Delaware corporation.

94. Defendant Health Net of California is a California corporation qualified to do business in California. It is one of the state's largest health insurance companies and a subsidiary of Defendant Centene Corporation, one of the nation's largest companies. Centene Corporation is a Delaware corporation.

95. Defendant United Healthcare is a Minnesota corporation, and Defendant United Healthcare Services, Inc. is a California corporation qualified to do business in California. They are among the largest health insurance companies in California and subsidiaries of Defendant UnitedHealth Group, Inc., one of the nation's largest companies. UnitedHealth Group, Inc. is a Delaware corporation.

96. Defendants Humana Health Plan of California, Inc. is a California corporation qualified to do business in California. It is among the largest health insurance companies in California and a subsidiary of Defendant Humana Inc., one of the nation's largest companies. Humana, Inc. is a Delaware corporation.

D. Defendant Commercial Health Insurer-Like "SFPs"

97. Defendant Wells Fargo & Company, which includes its former subsidiary Wells Fargo Third Party Administrators, Inc., is a diversified financial services company incorporated in Delaware with its principal place of business and headquarters in the City and County of San Francisco, California. It is a "self-funded employer," also known as a "self-funded payer" or "SFP," because it pays the costs of health care services provided by Verity and other providers to its enrollees out of its own pockets. As a SFP, Defendant Wells Fargo acts in a role similar to a commercial insurer by reimbursing, *i.e.*, paying, San Francisco metropolitan area and other hospitals for services they provided to patients covered by Wells Fargo.

98. Defendants Esurance Holdings, Inc. and Esurance Insurance Services, Inc. are California corporations with their principal place of business and headquarters in San Francisco County, California (collectively, "Esurance"). Esurance is a SFP and pays the costs of hospital services provided by Verity and other providers to Esurance enrollees out of its own pockets. It acts in a role similar to a commercial insurer in reimbursing, *i.e.*, paying, San Francisco metropolitan area and other hospitals for services they provided to patients covered by Esurance.

99. Defendant Warner Bros. Theatre Ventures is a California corporation and Defendant Warner Bros. Entertainment Inc. is a Delaware corporation, which both have their principal place of business and headquarters in Los Angeles County, California (collectively, "Warner Brothers"). Warner Brothers is a SFP and pays the costs of hospital services provided by Verity and other providers to Warner Brothers' enrollees out of its own pocket. It acts in a role similar to a commercial insurer in reimbursing, *i.e.*, paying, Los Angeles metropolitan area and other hospitals for services they provided to patients covered by Warner Brothers.

100. Defendant INPHI Corporation is a Delaware corporation with its principal place of business and headquarters in Santa Clara County, California. It is a SFP and pays the costs of hospital services provided by Verity and other providers to INPHI enrollees out of its own pockets. It acts in a role similar to a commercial insurer in reimbursing, *i.e.*, paying, San Jose metropolitan area and other hospitals for services they provided to patients covered by INPHI.

III. JURISDICTION AND VENUE

101. This action is brought under the Cartwright and Unfair Competition Acts, Cal. Bus. & Prof. Code §§ 16720 *et seq.* & 17200 *et seq.* for monetary relief due to Defendants' unlawful conduct.

102. This Court has subject matter jurisdiction over this action because of the amount in controversy and nature of the dispute, and personal jurisdiction over Defendants because they and their affiliates do business in California and the claims asserted herein arise from conduct occurring in California.

103. Venue is proper in the City and County of San Francisco, pursuant to Cal. Bus. & Prof. Code § 16750 and Cal. Code Civ. Pro. §§ 395 and 395.5, because the Defendants do

business there, multiple Defendants make it their principal place of business and headquarters, service may be obtained on them there, and they have agents who reside and are found there, much of the conduct at issue and many of the obligations and liabilities at issue in the Complaint arose there, and many of the acts giving rise to the claims asserted herein were committed there.

IV. FACTS

A. Background

1. Hospital Services in the United States, California, and the San Francisco, Los Angeles, and San Jose Metropolitan Areas

104. Hospitals are essential community assets that provide indispensable services. They affect the lives of essentially every person in the United States.

105. Consumers value hospital services. They visit doctors and hospitals more than one billion times a year and spend more than $3 trillion on health care in the United States each year.

106. The same is true in California, including its major metropolitan areas of San Francisco, Los Angeles, and San Jose. Californians spent $292 billion on health care in 2014, and hospitals in these three metropolitan areas provide vital services for the communities and people they serve.

107. Verity's hospitals and other hospitals have served the people of the San Francisco, Los Angeles, and San Jose metropolitan areas by providing them with valuable health care services during the entire time period at issue in this Complaint.

108. Verity's hospitals and other hospitals in these three metropolitan areas have differentiated themselves from other health care providers based on a number of interdependent factors, including functionality, breadth of clinical services and specialties, number of beds, location, ownership, and affiliation. They also have differentiated themselves based on whether they serve a non-profit or for-profit mission.

109. Numerous laws, rules, and regulations, such as limitations on how non-profit hospitals may raise funds to improve their services, further differentiate hospital providers.

110. Despite these differences, U.S. antitrust enforcement officials and courts generally have grouped general acute care hospital services together when defining hospital service markets.

111. Similarly, they have grouped hospital outpatient services together in assessing hospital service and product markets.

112. Verity and other hospitals provided Services to their patients and the communities they served.

113. They did so during the entire time from 2012 – 2020.

2. Commercial Health Insurers in the United States, California, and the San Francisco, Los Angeles, and San Jose Metropolitan Areas

114. A small number of very large commercial health care insurers dominate the U.S. health insurance markets in which they operate.

115. According to MultiPlan, "[t]he health insurance sector has consolidated to [the] four top insurers." (Ex. 5 at 24.)

116. United, Cigna, Anthem, Centene (Health Net), and Humana are the 7th, 13th, 29th, 42nd, and 52nd largest for-profit companies in the United States according to the Fortune 500. Aetna, itself a large health insurer, is a subsidiary of the 5th largest company in the U.S.

117. Blue Shield of California is part of the large, national Blue Cross and Blue Shield Association and is one of the largest commercial insurers in California.

118. The profits made by these large insurers have long been excessive, and they have become even more excessive due to their activities during the pandemic. For example, the publicly reported profits of United, Anthem, and Humana doubled during the first part of the pandemic, and their profits averaged well over $1 billion per year each prior to the pandemic.

119. Just eight large health insurers dominate the California commercial health insurance markets in which they operate, including the San Francisco, Los Angeles, and San Jose metropolitan area markets.

120. They do not face significant competition from other commercial health insurers or others in these markets.

121. Approximately 95% of all Californians enrolled in commercial healthcare insurance in 2015 were enrolled in one of these eight insurers' products.

122. And one of these eight health insurers – itself a significant MultiPlan customer – operates a "closed" system in which its reimbursements for hospital and other health care services go almost entirely from itself as a commercial insurer to itself as a provider.

123. This unique "closed" system structure highlights the strength and collective power the remaining seven commercial health insurers, *i.e.*, Defendant Insurers, have in the provision of commercial out-of-network reimbursements to providers who are not part of a "closed" system.

124. Defendant Insurers collectively have "seller power" – also known as "monopoly power" – over commercial insurance buyers in California's health insurance markets, which include the City and County of San Francisco.

125. In addition, Defendant Insurers collectively have mirror-image "buyer power" – also known as "monopsony power" – over hospitals in direct economic relationships with them for the provision of hospital Services in California's markets for inclusion in the commercial insurance products sold by these insurers to their customers, which include the City and County of San Francisco.

126. Commercial insurance buyers and Services sellers in the San Francisco, San Jose, and Los Angeles metropolitan areas must deal with Defendant Insurers.

3. Commercial-Insurer and SFP Reimbursements vs. Other Reimbursements for Hospital Services

127. Various entities reimbursed Verity and other health care providers for the services they provided to their patients. Those entities include Defendant Insurers and SFPs, and government payers, like Medicare and Medi-Cal.

128. The valuable health care services Verity and others provided to their patients and the communities they serve depend very heavily on Defendant Insurers and SFPs reimbursing them for their provision of those services to their patients.

129. Some large employers choose to self-insure and contract with companies like Defendant Insurers to assist them in doing so. These employers are called "self-funded employers," "self-funded payers," and/or "SFPs." They too reimbursed Verity and others for the

health care services they provided to their patients. And these reimbursements also are important to Verity and other health care providers.

130. The amounts Verity and other providers received for their services varied dramatically by payer. This is true even for the exact same services, during the exact same time frame, from the exact same facilities and clinicians using the exact same equipment.

131. Some payers simply reimburse providers far less than others. For example, a hospital that spends $1,000 to treat a patient in urgent need of a life-saving procedure may receive only $500 in reimbursement from a government payer, like Medicare or Medi-Cal, if that patient is enrolled in one of those government insurance programs.

132. Reimbursements from Medicare and Medi-Cal often do not cover California hospitals' costs for providing those services.

133. But commercial insurers and SFPs typically reimburse California providers, including Verity, for at least the cost of providing services to patients with commercial insurance.

134. Consequently, Medicare, Medi-Cal, and other government payer reimbursements are not viable alternatives for, and not reasonably interchangeable with, commercial-insurer and SFP reimbursements for California hospitals and others in the markets to be reimbursed for providing health care services.

135. Federal courts and antitrust enforcement officials who have considered this issue have recognized this distinction repeatedly in various geographic markets throughout the country, including those at issue in this lawsuit.

136. Commercial-payer and government-payer reimbursements for Services are in distinct and separate markets.

4. Out-of-Network and In-Network Reimbursement

137. Commercial insurers negotiate and enter into contracts with Verity and other providers in which the hospitals agree to lower reimbursements for certain services in exchange for better access to serve the commercial insurers' members. Although these reimbursements are volume discounted, they still cover the hospitals' costs of providing the care.

138. Many hospitals in California, including Verity, serve primarily patients whose care is paid for by Medicare or Medi-Cal. Medicare and Medi-Cal reimbursements for these patients' care does not cover the cost of their care.

139. This is particularly true in the San Francisco, San Jose, and Los Angeles metropolitan area markets. Hospitals in these markets could not sustain their continued operations by serving only these patients.

140. The consequent necessity for a sufficient volume of commercially insured patients to fund basic operations drives hospital-commercial insurer agreements, including those between Verity and Defendant Insurers.

141. Reimbursement agreements between commercial insurers and hospitals, including Verity, typically define the specific services for which the hospital has agreed to accept lower reimbursements from the insurer (*e.g.*, as a percentage discount off the applicable bill) as "in-network" services.

142. The specific "in-network" hospital services in a contract differ from agreement to agreement. Thus, the negotiations between commercial insurers and hospitals focus on what services will be "in-network" and how much the hospital will be reimbursed for those services, as well as other prices and terms.

143. The remaining services hospitals provide to commercially insured patients are commonly described as "out-of-network" services.

144. Many hospital contracts with commercial insurers, including Verity's contracts with Defendant Insurers, do not provide any discount or payment for – or even address – "out-of-network" services.

145. Consequently, in these instances, neither a contractual, negotiated discount nor specific reimbursement amount applies to the out-of-network services that hospitals, including Verity, provide to commercially insured patients.

146. In these instances, commercial insurers and SFPs are bound to reimburse hospitals, including Verity, for the Services those hospitals provided to their commercially insured patients.

147. These commercial insurer and SFP reimbursements for providers' Services are not interchangeable with reimbursements for in-network provider services.

148. The two types of reimbursements – in-network and out-of-network – are in separate and distinct markets.

149. Commercial insurers and SFPs market their health insurance products to employers and individuals based on assurances that their insurance products will cover enrollees' medical care, even in the event that they need certain out-of-network care. And commercial insurers continue to provide these assurances even after enrollment.

150. Health care providers, including Verity, often provide Services to the customers of commercial insurers and SFPs following these assurances.

151. They provide these Services in advance of payment and submit claims for reimbursement to commercial insurers and SFPs for the valuable Services they already provided.

152. In a competitive market, but for the Defendants' conduct, Verity and other providers would have received up to 100% of the amounts they billed for their Services or arguably, in some instances, no less than what is the usual and customary reimbursement in the area for such Services.

153. This Complaint addresses, among other things, Defendants' schemes to reduce commercial out-of-network reimbursement payments to Verity and other providers far below competitive market rates.

154. Defendants' schemes have had the anticompetitive effect of significantly reducing commercial insurer and SFP out-of-network reimbursement payments to Verity and other providers, stabilizing those reimbursements at artificially low levels. Defendants' schemes have denied Verity fair compensation for the valuable health care Services it provided to commercially insured patients in need.

5. Collective Commercial Out-of-Network Reimbursement Claim "Repricing" and the Commercial Insurers' Similar Ingenix Scheme

155. Commercial health insurers and SFPs profit more when they reimburse hospitals and other providers less for the Services those hospitals and other providers have rendered to

commercially insured patients.

156. Defendant Insurers are primarily for-profit corporations driven to maximize profits for their shareholders.

157. Defendant Blue Shield differs, but only in form and not in the substance of its actions. It, too, seeks to minimize to the greatest extent possible the amounts it must reimburse Verity and other providers for their Services.

158. Ideally, commercial health insurers would compete with each other on all aspects of their relationships with Verity and other providers, and particularly on pricing in their relationships with hospitals.

159. Federal antitrust officials have emphasized in court that "commercial health insurers" typically do, and should, "***compete*** to sign up … hospitals … for their networks" by "offering healthcare providers access to greater numbers of patients, more generous reimbursement terms, better service, and more innovative collaborations." Case No. 1:16-cv-01493, Dkt. 1 at 24 ¶ 64 (D.D.C. filed July 21, 2016) (emphasis added).

160. Federal courts support this analysis and have held that "Defendant[health insurers] participate in the market for the purchase of goods and services from healthcare providers…. The purchase of goods and services from healthcare providers by commercial buyers … is a relevant product market," as is "the purchase of goods and services from healthcare facilities," like Verity's.

161. Further, federal courts have held that government payers may be plausibly excluded from these markets "because [doing so] reflects the reality that 'the substitution between commercial buyers and other payors is low, as reflected in measures such as a low cross elasticity of demand.'" 2017 WL 2797267 at *5 - *6 & *9, 2017-1 Trade Cases P 80,043 (N.D. Ala. June 28, 2017); *see also* 2015 WL 1399299 at *7, 2015-1 Trade Cases P 79,133 (C.D. Ill. Mar. 25, 2015) ("access to privately-insured patients is critical to a healthcare provider's long-term sustainability in light of the comparatively low prices providers are required to charge patients covered by government plans for the same services…. [such] that" "the Court cannot find" that

"the sales of inpatient hospital and outpatient surgical services to commercial health insurers are interchangeable with the sales of these same services to government payors.")

162. The nature of commercial insurers' competition to sign up hospitals for their networks is multi-faceted, and those facets are interrelated.

163. Concessions made by insurers to, and received from, hospitals in one aspect of their relationships influence other aspects of those relationships.

164. The nature of commercial insurers' competition to sign up hospitals for their networks is influenced by the amount of out-of-network reimbursements (or "price") for Services provided by hospitals to their commercially insured patients.

165. The same is true for the mirror-image nature of competition between commercial insurers for enrollees – commercial insurers compete to provide more credible assurances to prospective enrollees and their employers about enrollee access to hospital services.

166. Starting at an unknown time and up and until the late 2000s, commercial insurers did not compete on price for out-of-network reimbursements to hospitals for the Services those hospitals provided to their patients.

167. Instead, the commercial insurers unlawfully coordinated their pricing with each other through a then-United Healthcare subsidiary, called Ingenix, in the provision of out-of-network reimbursements to hospitals and other health care providers.

168. New York State law enforcement officials found out and opened an investigation into this conduct.

169. Their investigation, which included an evaluation of that conduct in New York state and more broadly, led to a significant 2009 New York Attorney General's Office Report and enforcement action.

170. The Report identified the healthcare insurers – including the same ones still prevalent nationally and in California's markets – as "giant" and their markets as "consolidated."

171. The Report described the core conduct under investigation to include commercial insurers' "use of schedules compiled by Ingenix … in determining reimbursement rates for out-of-network care. Ingenix gathers billing data from the largest health insurers in the country … and

then sends back schedules to these health insurers and others, based on the pooled data, which the insurers use … to set their reimbursement rates."

172. It noted that "the Ingenix databases understate [the] market rate by up to 28 percent across the state [of New York]. This translates to at least hundreds of millions of dollars in losses for consumers over the past ten years across the country."

173. The New York Attorney General's Office:

a. forced United to shut down Ingenix;

b. supported and helped to eventually pass a New York law prohibiting commercial insurers' use of "repricing" businesses that are affiliated with commercial insurers;

c. obtained $95 million in settlements from the insurers for their conduct;

d. obtained assurances from the insurers that they would no longer work with Ingenix; and

e. used the $95 million from the commercial insurers to set up an "independent" database, called "Fair," to replace Ingenix in repricing provider claims for commercial out-of-network reimbursements.

174. As a consequence of the New York enforcement action, various groups of class-action plaintiffs filed lawsuits and obtained settlements from the insurers, including Defendants in this case, totaling more than $2 billion – all stemming from the core conduct identified in the New York Attorney General's Office 2009 Report.

175. Unfortunately, as reported by the New York Times in 2012, "[t]hough the [the New York Attorney General's Office] settlement required the companies to underwrite the new ["Fair"] database with $95 million, it did not obligate them to use it."

176. And they did not use the "Fair" database.

177. Instead of opting for the "Fair" database, the major U.S. commercial health insurers pursued greater profits and shortly thereafter continued essentially the same conduct through MultiPlan, an "independent" and for-profit repricing business that emphasizes its economic interests are "completely aligned" with the commercial insurers' and applicable SFPs' economic interests in reducing reimbursement payments from payers to providers.

6. Collective Commercial Out-of-Network Reimbursement Claim "Repricing" Through MultiPlan, According to MultiPlan

178. Following the 2009 New York Attorney General's enforcement action against the commercial insurers, MultiPlan, which was already in the "independent" for-profit repricing business, consolidated its position by purchasing its actual and potential competitors.

179. MultiPlan acquired Viant in 2010.

180. Then MultiPlan acquired Data iSight and its parent company National Care Network in 2011.

181. Viant and Data iSight were meaningful competitors of MultiPlan and one another.

182. MultiPlan uses the Viant and Data iSight brands in its repricing business.

183. Upon information and belief, these acquisitions were done with the specific intent to provide MultiPlan with a dominant market position, reducing the remaining repricing competitors to also-rans.

184. And MultiPlan has since made several more acquisitions of actual and potential competitors to further entrench its position and eliminate all meaningful commercial out-of-network repricing competition.

185. Further, upon information and belief, commercial insurers valued a common provider to consolidate and best use their extensive claims data and other information for repricing, and to stabilize markets for their benefit, further increasing the probability that MultiPlan would succeed in establishing a dominant market position.

186. MultiPlan, like Ingenix before it, claims to develop reimbursement prices for use by commercial insurers in the same way detailed in the 2009 New York Attorney General's Office report: "in determining reimbursement rates for out-of-network care[MultiPlan] gathers billing data from the largest health insurers in the country … and then sends back [prices] to these health insurers and others, based on the pooled data, which the insurers use … to set their reimbursement rates."

187. MultiPlan also claims it takes a variety of information into account, including geographic differences, in determining how it reprices hospital and professional provider claims.

7. Fraudulent Concealment

188. But MultiPlan has fraudulently concealed its conduct at issue in this Complaint, including its actual repricing mechanism.

189. At least prior to late 2020, when it began to publicly reveal some of its unlawful conduct, MultiPlan concealed the true nature of its conduct at issue in this Complaint, including its involvement in the horizontal commercial-insurer price-fixing and unlawful information exchange agreements.

190. Prior to then, neither MultiPlan nor any of the Defendants revealed their involvement in the price-fixing conduct detailed in this Complaint.

191. Prior to then, neither MultiPlan nor any of the Defendants revealed even the horizontal agreements among commercial health insurers detailed in this Complaint.

192. MultiPlan concealed the nature of its conduct, and continues to do so to this day.

193. Only the recent statements made by MultiPlan and Churchill to investors beginning in 2020, began to sufficiently reveal the true nature of MultiPlan's business and the conduct at issue in this Complaint.

194. Subsequent MultiPlan and Churchill statements have solidified the basis for this Complaint.

195. The MultiPlan-Churchill statements, which also reflect statements from other Defendants, are binding co-conspirator and party admissions, and are quoted extensively in this Complaint. *See* Exs. 1-8 to this Complaint.

196. The recent discovery of these statements forms the core of this Complaint.

197. Defendants fraudulently concealed their unlawful conduct until late 2020.

198. Verity could not have discovered it through the exercise of due diligence.

199. Further, Defendants continue to conspicuously and fraudulently conceal the nature of the conduct at issue and the full extent of their wrongdoing remains to be discovered.

200. For example, MultiPlan has not followed even the explicit statements on its own website about the information it purports to take into account when repricing provider claims.

201. MultiPlan's website and other statements allege MultiPlan reprices reimbursement claims by taking into account geographic differences; but these statements and others are inaccurate as detailed in a recent lawsuit against United Health. Case No. 1:19-cv-01195 at Doc. 1, pp. 30 – 32 (M.D. Pa. filed July 11, 2019).

202. There, the plaintiffs sampled MultiPlan's subsidiary and brand Data iSight repricing for CPT code 99284 (an emergency department examination and moderately complex medical decision) in seven different locations, with five of those samples coming from within a 20-day window. The seven regions were California, Kansas, New Hampshire, New Mexico, Oklahoma, Pennsylvania, and Wyoming.

203. If MultiPlan's allegations about how it repriced provider claims were accurate, then the repriced reimbursements it reported for those seven samples would have been different, to account for significant differences in these significantly different geographic regions.

204. Indeed, the billed amounts for these seven samples from the seven different regions reflected those geographic differences and ranged from $778 - $1,094.

205. But MultiPlan's Data iSight repriced all of them to exactly $413.39 … the exact same price notwithstanding the different geographies and billed amounts in the claims.

206. The fact that MultiPlan's alleged repricing formula produced the exact same price for the same CPT code claim during essentially the same time period, given the significantly different geographic regions, makes it implausible – if not impossible – that MultiPlan always follows its stated repricing formula.

207. Upon information and belief, the extent of Defendants' fraudulent concealment extends well beyond the covering up of price fixing and other antitrust violations at issue in this Complaint, going even to the core of MultiPlan's claims about its repricing mechanism.

8. The Relationship Between Insurer Reimbursements, Hospital Sustainability, and Health Care Services in Northern California

208. Health care providers like Verity cannot sustain themselves and all of their valuable services unless they are paid enough to cover the costs of providing those services today and in the future.

209. Clinical standards of hospital care are ever-increasing in the United States, in California, and in the San Francisco, Los Angeles, and San Jose metropolitan areas.

210. Any hospital that does not advance with these standards of care and improve both its physical facilities, including complying with new building and seismic-safety standards, and its technology will fall behind the competition, suffer a reduction in its relative quality of care, and lose patients, which are essential to continued operations.

211. Any hospital that does not advance with standards of care and maintain and improve its physical facilities and technology for a prolonged period of time will go bankrupt.

212. Compounding this pressure to improve and meet ever-increasing hospital standards of care is the simple fact that approximately three out of every four reimbursements from payers to California hospitals come from Medicare or Medi-Cal.

213. The percentage of patients at Verity with Medicare or Medi-Cal as insurance was even higher than for many other California hospitals.

214. Verity and other California providers lose money on all or nearly all of the Medicare and Medi-Cal patients they treat because the costs of that treatment far exceed the amount they receive in reimbursement for such care.

215. Further, approximately 10% of California hospital patients have no insurance at all. Verity and other California hospitals provided these patients with services, but received effectively no reimbursement for those services.

216. Thus, approximately 85% of California hospitals' patient care, including at Verity, is unprofitable, which makes it very difficult for them to sustain themselves and all of their valuable services unless they are able to make up the difference through their provision of care to commercially insured patients.

217. Commercial insurers and SFPs reimburse California hospitals, including Verity, for in-network services at what is intended to be a substantially higher rate than government payers.

218. Even the negotiated in-network discounts those commercial insurers and SFPs obtain for their enrollees are intended to provide California hospitals, including Verity, with some profit margin on their services.

219. California hospitals, including Verity, sustain their operations, to the extent possible, only through profitable reimbursements for services provided to commercially insured patients.

220. When commercial insurers and SFPs unlawfully reduce those reimbursements, hospitals' continued operations, including Verity's, are at risk of service and/or quality reductions and/or bankruptcy.

221. None of Verity's contracts with the major commercial insurers included a specified discount for Services. And there often are no contracted discounts in insurer-provider contracts for Services.

222. In a competitive market free from Defendants' unlawful conduct, hospitals like Verity would be reimbursed at competitive market rates for their Services, and those reimbursements should be substantially higher than those for in-network services.

223. Commercial out-of-network reimbursements, therefore, are among the most critical reimbursement revenue sources for California hospitals, including Verity.

224. Verity and other providers suffered artificially reduced commercial out-of-network reimbursements for its Services due to Defendants' unlawful conduct at issue in this Complaint.

225. Further, Defendants' conduct detailed in this Complaint contributed to hospital bankruptcies, including Verity's.

9. MultiPlan's Acquisitions of Actual and Potential Competitors, and Leveraging of Its Dominant Position Into Other Markets

226. MultiPlan acquired actual and potential competitor Viant in 2010. Viant, like MultiPlan, was an independent commercial out-of-network repricer, and it was a significant MultiPlan competitor. MultiPlan uses the Viant brand to the present day.

227. MultiPlan acquired actual and potential competitors Data iSight and National Care Network in 2011. Data iSight, like MultiPlan, was an independent commercial out-of-network repricer, and it was a significant MultiPlan competitor. MultiPlan uses the Data iSight brand to the present day.

228. MultiPlan acquired actual and potential competitor Medical Audit & Review Solutions in 2014. Medical Audit & Review, like MultiPlan, sought to use analytics to reduce commercial insurer customer reimbursements to hospitals, such as Verity, through "payment integrity" and other mechanisms, and Medical Audit & Review was a significant MultiPlan competitor.

229. Upon information and belief, MultiPlan's only other significant competitor following these acquisitions was Zelis.

230. But, according to Zelis, MultiPlan and Zelis entered into a "partnership" at some point in or before 2020.

231. MultiPlan currently has no meaningful, actual commercial out-of-network reimbursement repricing competitors.

232. MultiPlan, in combination with Churchill and others, sought to offer an equity stake in itself to investors on the New York Stock Exchange.

233. The agreements to pursue this result began at an unknown time, to be determined through discovery, and continued through the successful sale of equity to the public in October 2020.

234. In investor materials prepared in connection with that equity sale, Churchill and MultiPlan disclosed and admitted much of MultiPlan's and the other Defendants' anticompetitive conduct.

235. MultiPlan has had and continues to have the specific intent to leverage its market position into other markets, expand its service offerings though acquisitions, and pursue other acquisitions to improve its already "dominant" market position.

236. MultiPlan made good on those intentions by acquiring potential competitor HST in 2020. HST was, among other things, a reference-based repricer and offered a complimentary solution to MultiPlan's then-existing products and services.

237. MultiPlan sought and seeks to leverage its existing market position into markets previously served by HST.

238. MultiPlan also made good on its intentions to leverage its market position when it acquired potential competitor Discovery Health Partners in 2021. Both MultiPlan and Discovery Health Partners offered payment integrity products and services.

239. Discovery Health Partners' products and services were targeted, in part, to Medicare and Medicaid markets, two markets the Churchill – MultiPlan investor presentations identified as targets for its leveraging strategy.

B. Relevant Markets

1. Relevant Service Markets: the (a) Reimbursement Market and (b) Repricing Markets

240. The relevant service markets include the market for reimbursement of out-of-network general acute care inpatient hospital services and outpatient hospital services from commercial insurers and SFPs to hospitals, which is effectively the provider-side view of the market for the purchase of out-of-network general acute care in-patient and out-patient hospital services by commercial insurers ("Reimbursement Market").

241. Verity and other providers render these services to insured patients when those patients are in-network, and when those patients are out-of-network under the patient's insurance plan and the reimbursement amount for such out-of-network services is not established by the insured's plan.

242. Verity and other providers were and are in direct economic relationships with Defendant Insurers in the Reimbursement Market and functionally "direct sellers," the mirror image equivalent of "direct purchasers," in those markets for purposes of antitrust analysis.

243. The Hub of the conduct at issue is MultiPlan.

244. MultiPlan is a monopolist in the markets for providing the reimbursement amounts, data, and information that commercial insurers and SFPs use to pay hospitals for their Services to commercially insured patients (the "Repricing Markets").

245. According to MultiPlan, it "has been in business for more than three decades. We serve all of the major insurers in the U.S., we serve more than 16 million people and work with 1.2 million providers."

246. MultiPlan serves all of the major commercial health insurers, including Defendant Insurers, in every metropolitan area at issue in this Complaint, leaving providers without any sufficient option other than to accept its repriced commercial out-of-network reimbursements provided by MultiPlan.

247. Verity was in an indirect economic relationship with MultiPlan in the Repricing Markets and functionally an "indirect seller," the mirror image equivalent of "indirect purchasers," in those markets for purposes of antitrust analysis.

248. In-network and out-of-network hospital service prices differ significantly and those prices distinguish each type of service. This Complaint focuses only on commercial out-of-network reimbursements from commercial insurers and SFPs to hospitals and other providers, which was the target of Defendants' unlawful agreements, and is where Verity's antitrust injuries occurred.

2. Relevant Geographic Markets: the (a) San Francisco Metropolitan Area, (b) Los Angeles Metropolitan Area, and (c) San Jose Metropolitan Area

249. The relevant geographic markets for the Reimbursement Market are the San Francisco, Los Angeles, and San Jose metropolitan areas.

250. These are the areas where Verity's hospitals were located and where they cared for their patients.

251. Other metropolitan areas outside of California and even within California are not reasonably interchangeable with these relevant geographic markets. For example, payers, including Defendant Insurers and SFPs, cannot reasonably substitute between the San Francisco and San Diego metropolitan area hospital markets in their purchase of hospital services because their enrollees require that those hospital services generally be provided close to home.

252. Similarly, hospitals cannot reasonably substitute between these metropolitan areas in their provision of services.

253. Federal antitrust officials have emphasized the same analysis in court, stating "[t]he purchase of healthcare services by commercial health insurers in each of the 35 metropolitan areas identified [which include "San Francisco-Oakland-Hayward," "San Jose-Sunnyvale-Santa Clara,"

and "Los Angeles-Long Beach-Anaheim," as well as many others throughout California and the United States] satisfies the hypothetical monopsonist test and constitutes a relevant geographic market." Case No. 1:16-cv-01493, Dkt. 1 at 26 ¶ 68 (D.D.C. filed July 21, 2016) (referencing p. 16 ¶ 41).

254. They expanded to explain that "[t]he markets for the purchases of these services are local because in the vast majority of cases patients seek care from doctors and hospitals in the same area where they live and work." *Id.* at 26 ¶ 68.

255. Federal Courts support this analysis and have held that the San Francisco, Los Angeles, and San Jose Metropolitan areas "are valid geographic markets" in this context. 236 F. Supp. 3d 171, 254 – 256 (D.D.C. Feb. 21, 2017) (referencing the same geographic markets federal antitrust officials set forth in their analysis detailed above, and the same geographic markets alleged in this Complaint).

256. The payments from Defendant Insurers and SFPs to Verity and other providers for their care in the Reimbursement Market should have been at competitive market rates for the relevant geographic markets.

257. But, as shown by this Complaint, Defendants' agreements reduced those reimbursements to artificially low and anticompetitive levels.

258. The relevant geographic markets for the Repricing Markets are similarly focused and include the San Francisco, Los Angeles, and San Jose metropolitan areas, as MultiPlan's price, data, and information products and services differ based on geographic region.

259. The characteristics of each of these different geographic markets differ enough from other metropolitan areas such that they are not sufficiently interchangeable with each other, or other separate metropolitan areas, for commercial insures and SFPs.

C. Market Power

1. Oligopoly and Collective Market Power in the Reimbursement Market

260. The oligopolistic structure of the Reimbursement Market and the fact of collective commercial-insurer market power in it is circumstantial evidence of the horizontal agreements detailed in this Complaint.

261. In each relevant market, those involved in the collective conduct at issue have far more than sufficient market power to support the claims in this Complaint.

262. In the Reimbursement Market and its corresponding relevant geographic markets, 95% or more of the available commercial insurers (by enrollment) collectively participate in the conduct at issue in this Complaint and have collective market power.

263. Further, Defendant Insurers have collective market power in these same markets.

2. Monopoly "Dominance" in the Repricing Markets

264. In the Repricing Markets and their corresponding relevant geographic markets, MultiPlan's admissions establish its dominance even without reference to its precise market share.

265. MultiPlan has "created a competitive moat around [its] company that drives high recurring revenues."

266. MultiPlan's high recurring recuring revenues produce "best-in-class [profit] margins" that "have been in excess of 70% and in many cases in the high 70%s" over a period of many years. (Ex. 1 at 22.)

267. Multiplan is "unique" in the Repricing Markets by being "deeply embedded" and "wired into [its customers'] claims adjudication platforms." (Ex. 1 at 42.)

268. MultiPlan admits: "Today, we focus primarily on the $1.3 trillion commercial market, and within that segment, primarily in the commercial out-of-network space, which is about 10% of that or about $130 billion of medical spend. We are the largest player in the commercial out-of-network space and work with payers offering both fully insured and self-insured business. We serve health care payers that account for at least 80% of all commercial covered lives in the U.S." (Ex. 4 at 9.)

269. Churchill and MultiPlan made multiple public presentations about MultiPlan's dominance and the conduct that further entrenched and facilitated MultiPlan's market position and the Defendants' conduct.

270. Representations in those presentations include: "MultiPlan has a large and sticky customer base of 700+ payers, including all large national carriers. Many relationships, including

its largest customers, span decades. Top 10 customers have been customers for an average of 25 years. Contracts with large customers generally have terms of 2 to 5 years." (Ex. 5 at 17.)

271. As they further explained, MultiPlan receives claims data from those "over 700" payers and processes "360,000 claims a day, 7 days a week, 365 days a year" – and the vast majority of it through direct technological integration.

272. This treasure trove of data MultiPlan controls, and its technological integration with commercial payers, are two of the many reasons why overwhelming barriers to entry protect MultiPlan's dominant position.

273. MultiPlan admits: "Once the claim hits [its] front door, all the pipes and infrastructure exist for the eligible claims to be processed within 5 seconds and delivered back to the customer." (Ex. 1 at 19.)

274. In 2019 alone, MultiPlan admits it received "135 million claims and $106 billion in charges," and MultiPlan has the "ability to process 5 times the current volume without any material investment." (Ex. 1 at 5.)

275. MultiPlan admits it "serve[s] all of the major insurers in the U.S.": "[O]ur contracts with the large payers are multiyear. United has been under multiyear contracts with us since 1994, Cigna, since 1992, Aetna, since 1994, as an example. The contracts, multiyear, they're automatically renewable." (Ex. 4 at 15.)

276. Churchill and MultiPlan admitted that "MultiPlan's solutions are integral to Payers' claims adjudication processes (*e.g.*, switching costs are high)." (Ex. 5 at 47 and Ex. 6 at 20.)

277. MultiPlan admits and describes its function as a "mission-critical component to our payers' day-to-day business, we are electronically connected and deeply embedded in their processes and their claims' processing platforms." (Ex. 1 at 9.)

278. And MultiPlan went further, admitting: "I think in almost every case, the out-of-network business, MultiPlan is in that first position and receives almost all of the out-of-network claims. So we get first look at all the out-of-network claims." (Ex. 4 at 16.)

279. MultiPlan uses its "technology foundation" of "3.5 petabytes of data," an "incomparable" database of 1 billion claims, proprietary IP and algorithms; with a modern high-

scale platform" "proprietary data and algorithms to . . . [']advise[']the payer to pay an amount [allegedly] supported by our claims data and algorithms." (Ex. 1 at 3.)

280. Since MultiPlan's revenues are "based almost entirely on a percentage of savings that [it] helps [its] customers achieve," MultiPlan is incentivized to recommend reimbursement rates as close to rock bottom as possible. (Ex. 1 at 15.)

281. MultiPlan admits that it has "for decades, has enjoyed a market-leading position with impressive scale and a market differentiated date [sic] advantage. Mission-critical nature of our product really has created a competitive moat around our company that drives high recurring revenues. And the attractive financial [sic] we have gives [sic] us strong cash conversion and best-in-class margins." (Ex. 4 at 20.)

282. MultiPlan admits its abnormal profit margins: "[O]ver the last 4 years, [our] margins have been in excess of 70% and in many cases in the high 70%s." (Ex. 1 at 22.)

283. MultiPlan has recently confirmed that it not only enjoys a market dominant position but also that its position is durable, despite claims to the contrary: "The first assertion made by the short seller is that UnitedHealthcare is planning to exit the relationship with MultiPlan and, in effect, in-source what we've been doing and what we've been using, and they plan to use a reference pricing tool with a consumer advocacy service called Naviguard. That is absolutely false. Our business with UnitedHealthcare continues to grow every quarter." "[O]ur relationship with United is as strong as it's ever been, and in fact, it's expanding and not shrinking." "Second, . . . that MultiPlan's relationship with large payers is deteriorating, leading to a reduction of our pricing by 50% over the last 4 years. This, again, is absolutely false. Our business is growing with our top customers." "Our customers' commitments to partner with MultiPlan ha[ve] never been more robust." (Ex. 4 at 3 & 4.)

284. Churchill Chairman and Chief Executive Officer Michael Stuart Klein summarized his company's analysis as follows: "we view this company as what it truly is, which is … some might say, dominant." (Ex. 1 at 26.)

285. These Churchill and MultiPlan admissions establish that MultiPlan is a "dominant" monopolist in the Repricing Markets and is surrounded by a deep and wide "moat" of barriers to entry that collectively drive durable anticompetitive margins in excess of 70% annually.

286. The express purpose of the conduct detailed in this Complaint, as MultiPlan admits, is to reduce hospital reimbursements in the Reimbursement Market with respect to "out-of-network expense," which it identified as a "pain point" and "major area of concern for our customers." (Ex. 1 at 5.)

287. The actual effect of the conduct detailed in this Complaint, according to MultiPlan, is to actually and significantly reduce hospital and other provider reimbursements in the Reimbursement Market.

288. Upon information and belief, MultiPlan's reimbursement reduction estimates significantly understate the actual reductions experienced by California hospitals, including Verity.

289. MultiPlan repeatedly emphasizes that its own goals match the goals of Defendant Insurers and other commercial payers: "Our incentives are completely aligned with theirs." (Ex. 4 at 9.)

290. As MultiPlan admits, it gets paid "mostly volume-related and/or high single-digit to double-digit percentages" of the "savings" it generates for its payer customers. (Ex. 4 at 5.)

D. Defendants' Anticompetitive Conduct

1. Unlawful Horizontal "Hub, Spoke, and Rim" Agreements

a. To Fix Prices

291. Defendant Insurers agreed with each other to fix their prices to Verity and other providers for the Services they provide.

292. MultiPlan served as the key conduit and mechanism for the communications, assurances, and actions needed to establish and maintain this agreement.

293. The agreement is a traditional "hub, spoke, and rim" agreement, in which Defendant Insurers are the spokes and MultiPlan is the Hub.

294. The "rim" of the agreement is detailed further in section IV.D.1 & 3 below, and elsewhere in this Complaint.

295. MultiPlan admitted to extensive direct and circumstantial evidence of this horizontal "hub, spoke, and rim" agreement among the major U.S. insurers, facilitated through communications funneled through MultiPlan.

296. The Churchill – MultiPlan investor presentations reflect MultiPlan's:

a. continual communications (assisted recently by Churchill) to Defendant Insurers, and other participants to the horizontal agreement, that all of the significant health insurers in the U.S. and in the Reimbursement Market would participate, and continue their participation, in the horizontal agreement and conduct at issue in this Complaint;

b. continual communications (assisted recently by Churchill) to Defendant Insurers, and other participants to the horizontal agreement, that all of the significant health insurers in the U.S. and in the Reimbursement Market were actually following the MultiPlan-set Defendant-fixed reimbursement prices at least 87% of the time "without any human touch";

c. continual and actual setting of the exact future prices that all of the significant health insurers in the U.S. and in the Reimbursement Market including Defendant Insurers and SFPs, as parties to this horizontal agreement, actually followed in nearly every instance;

d. continual communications (assisted recently by Churchill) to Defendant Insurers and others of sufficient information to facilitate the Defendants' monitoring of each other's compliance with the horizontal agreement;

e. monopoly position in the Repricing Markets and assessment that the Reimbursement Market are oligopolistic in nature;

f. continual communications (assisted recently by Churchill) to Defendant Insurers and others about its "sticky" 2 – 5 year automatically renewing contracts with each significant commercial health insurer in the U.S. and in the Relevant Geographic Markets;

g. continual communications (assisted recently by Churchill) to Defendant Insurers and others about its long history with Defendant Insurers and the presence of well-known customary patterns, formulas, and leadership in the conduct at issue;

h. continual communications (assisted recently by Churchill) to Defendant Insurers and others about Defendant Insurers' "completely aligned" interests to carry out the conduct at issue in this Complaint; and

i. assessment that there are high barriers to entry in the Relevant Markets, for example the "competitive moat" it admits it dug around itself, and that there is an absence of significant fringe competition in the Relevant Markets.

297. Communications and facts like these make it easier to establish, monitor, and maintain a durable horizontal price fixing agreement like the one at issue in this Complaint.

298. Communications and facts like these stabilized the Relevant Markets for Defendants.

299. Further, each Defendant Insurer that entered into a contract with MultiPlan to follow its artificially low out-of-network reimbursement rates for 2 – 5 years acted against its rational economic self-interest in the absence of a horizontal agreement among the other significant health insurers.

300. A rational significant commercial health insurer would not effectively make its purchasing so significantly less competitive to hospital sellers for such a long period of time (effectively raising its price) without reasonable assurances, along the lines of those from MultiPlan detailed above, from the other significant commercial health insurers that those others would do the same thing.

301. Further still, each Defendant Insurer understood that they all needed to engage with MultiPlan in the scheme to reduce reimbursement payments to providers to maximize their collective results, and they did so.

302. When they did so, Defendant Insurers acted against their individual economic self-interest in the absence of reasonable assurances to maintain the secrecy of the core conduct at issue, in light of the New York Attorney General's Office enforcement action and the resulting

private lawsuits, by accepting the potential legal and economic risks and jointly continuing their Ingenix-like conduct through MultiPlan.

303. All of the factors detailed above contributed to the success of the horizontal agreement at issue in this Complaint.

304. Defendant Insurers are horizontal competitors in the Reimbursement Market, yet they agreed with each other not to compete and to collectively fix prices in this market instead.

305. Direct communications and indirect communications are each independently sufficient bases to establish Defendant Insurers' horizontal agreements with each other.

306. The other Defendants in this case all participated in this horizontal agreement by entrenching, facilitating, or otherwise acting in furtherance of this price-fixing agreement.

b. To Allocate Markets

307. Through the same "hub, spoke, and rim" conduit and mechanism, the major U.S. health insurers, including Defendant Insurers, further agreed with each other to stabilize their oligopsony and allocate the Services markets in which they should compete.

308. MultiPlan admitted to extensive direct and circumstantial evidence of this horizontal "hub, spoke, and rim" agreement among the major U.S. health insurers, facilitated through communications funneled through MultiPlan.

309. These horizontal agreements had the purpose and effect of maintaining, stabilizing, and entrenching an oligopsony, and allocating markets, among the major U.S. commercial health insurers, including Defendant Insurers.

c. To Exchange Competitively Sensitive Business Information

310. These horizontal agreements, as reflected in the Churchill – MultiPlan investor presentations and this Complaint, also included commitments to submit massive amounts of competitively sensitive data and information from Defendant Insurers and SFPs, and others, to MultiPlan.

311. In return, Defendant Insurers and SFPs, and others, received as the output of the exchange granular future pricing information for their use in extracting more money from Verity

and other providers through lower out-of-network reimbursements for the Services those hospitals provided.

312. As MultiPlan explains and admits, it provides a "much better mechanism by which payers can reduce the cost of healthcare versus doing it themselves" because MultiPlan can "see data across 700 payers" – "data [that] is much, much larger and more diverse than what any single payer has within their systems." "It is very, very different than what any single payer can do on their own, which is why they all come to MultiPlan." (Ex. 1 at 40 & 41 and Ex. 4 at 20.)

313. Direct communications and indirect communications are each independently sufficient bases to establish Defendant Insurers' horizontal agreements with each other.

2. Unlawful Vertical Agreements

a. Exchange Competitively Sensitive Business Information

314. Defendants engaged in the same conduct detailed above through vertical agreements MultiPlan has with its Defendant Insurers and SFPs, and other customers.

315. These vertical agreements are evidenced in the attached Churchill – MultiPlan investor presentations. These presentations establish: (a) Defendant Insurers and SFPs submit competitively sensitive business information to produce granular prices for Defendant Insurers and SFPs, and others; (b) the information exchange output from MultiPlan to its customers of granular prices and other information; (c) the near universal adherence of MultiPlan's customers to those prices; and (d) Defendant Insurers long-term adherence to the Defendant-fixed MultiPlan-set commercial out-of-network reimbursement prices.

316. These vertical agreements also provide for automatic renewals, and they have been renewed repeatedly over the span of multiple decades.

317. In addition, these vertical agreements provide for direct technological integration to make more efficient the flow of competitively sensitive claims data from MultiPlan's customers, including Defendant Insurers and SFPs to MultiPlan.

318. Further, these vertical agreements provide mechanisms to allow Defendant Insurers and SFPs to automatically implement the MultiPlan-set prices at least 87% of the time "without any human touch." (Ex. 5 at 43and Ex. 1 at 20.)

319. MultiPlan admits that "the percent of claims that require manual handling has decreased by more than 60% using [this] technology" since its technology allows it to be "wired into [the insurer's] claims adjudication platforms." (Ex. 1 at 20.)

320. Further, MultiPlan explains, when human touch is taken into account, its customers, including Defendant Insurers and SFPs, implement the MultiPlan-set prices approximately 99% to 100% of the time.

321. Of this amount, 87% is automatic without human touch and provider acceptance; another 7% to 8% involves human touch but also provider acceptance; and providers appeal the fixed-prices in the "4% to 5% range going back to 2011." (Ex. 4 at 17.)

322. According to MultiPlan's public admissions, hospitals and others that must deal with MultiPlan's insurer, SFP, and other customers accept the MultiPlan-set Defendant-fixed prices nearly all of the time.

323. Hospitals have no choice but to accept those prices, given the conduct at issue in this Complaint, as resistance would be futile.

324. Defendants all participated in these vertical agreements either directly or indirectly by entrenching, facilitating, or otherwise acting in furtherance of these agreements.

b. To Further Entrench, Facilitate, and Otherwise Overtly Act in Furtherance of MultiPlan's Monopolization, Maintenance of Its Monopoly, Leveraging of Its Monopoly Into Other Markets, and Attempted Monopolization

325. Similarly, these vertical agreements further entrenched, facilitated, and otherwise constituted overt acts in support of MultiPlan's unlawful monopolization of the Repricing Markets, maintenance of its monopoly position as a "critical force" in the Repricing Markets, leveraging of its monopoly position into other markets, and attempted monopolization.

326. Defendants, and other commercial insurance payers, all benefitted from a strong and stable MultiPlan which is viewed as "critical and essential" by its insurer customers. MultiPlan "enjoys a market-leading position with real size and scale" due to its "incomparable database" of claims data, which has made their conduct more efficient and effective, and made it

more likely that their reimbursement payments to Verity and other providers would be lower than they otherwise would have been. (Ex. 1 at 45.)

327. Shortly after its establishment, Defendants could have used the "Fair" database.

328. Instead, they acted in furtherance of MultiPlan's monopolization, maintenance of its monopoly, monopoly leveraging, and attempted monopolization, including through the vertical, "revenue-sharing agreements" and through their assistance in establishing barriers to entry for other Repricing Market companies.

329. MultiPlan's services are viewed by its top customers as "extraordinarily powerful" and "critical to their operation" as "the gold standard in terms of [claims] pricing," which has led their customers to make and keep promises of "providing more of their internal and external business to MultiPlan over the coming years." (Ex. 1 at 25.)

330. These actions were for Defendants' own gain and at the expense of Verity and other providers.

331. MultiPlan willfully acquired and maintained its monopoly power in the Repricing Markets through its series of acquisitions of actual and potential competitors.

332. As reflected in its investor presentations with Churchill, MultiPlan's appetite for potential competitors, and to leverage its monopoly position into other markets, has continued.

333. Defendants willfully maintained MultiPlan's monopoly power in the Repricing Markets through their vertical agreements with MultiPlan, establishment of significant barriers to entry in the Repricing Markets, and other conduct detailed in this Complaint.

334. Defendants knew a strong and stable hub for their conduct enhanced the value of their schemes.

335. And they took numerous overt and willful steps to entrench, facilitate, and otherwise support MultiPlan's market position and maximize the reduction in reimbursements for valuable healthcare Services rendered by Verity and other providers.

336. Defendant Insurers and SFPs' overt and willful steps include their direct technological integration with MultiPlan and submission to it of extraordinarily large volumes of competitively sensitive business information.

337. MultiPlan admits it has "built deep integration into 700-plus payers and their archaic legacy systems over the course of decades, replicating these integrations would be a herculean task," so it "not surprising to see such . . . high customer retention figures." (Ex. 1 at 20.)

338. The collective actions of the powerful Defendant Insurers, in particular, and all major U.S. commercial health insurers, substantially enhanced the likelihood that Defendants would succeed in establishing MultiPlan as a stable monopolist.

339. As admitted by Churchill, it is "compelling" that MultiPlan has "100% contracted revenues" because its "customers have long-term relationships, 75% of which are more than three years in terms of contract length, but all of them have long and deep historical relationships." (Ex. 1 at 25.)

340. As reflected in the attached Exhibits, these actions were done with the specific intent of achieving MultiPlan's stable monopoly position and with a dangerous possibility of success, with Defendant Insurers' collective help.

341. Defendant Insurers helped stabilize and further entrench MultiPlan's position, such that MultiPlan would end up in the position it is today.

342. MultiPlan describes itself as now having "a competitive moat around [its] company that drives high recurring revenues" with "robust EBITDA margins" "in excess of 70%." (Ex. 4 at 20.)

3. Direct and Circumstantial Evidence of Defendants' Agreements

a. Direct Evidence of the Vertical Agreements

343. MultiPlan provided direct evidence of the vertical agreements at issue in this Complaint in connection with its public offering investor materials.

344. It described in those materials not only the existence of its vertical agreements with each of Defendant Insurers, and all the major commercial health insurers in the Relevant Markets, but also specific terms in those agreements.

345. According to MultiPlan, those terms include the parties to the agreements (with each Defendant Insurer specifically named), duration (2 – 5 years, depending on the payer), scope

(to include MultiPlan's commercial out-of-network repricing), insurer commitments (to include the submission of detailed competitively sensitive business information in the forms of claims data), and MultiPlan commitments (to use the information submitted and other information to produce a single granular future price per provider for each CPT code at any particular time).

346. MultiPlan did not specify in its investor materials that its contracts with each insurer "require" adherence to MultiPlan's repriced amounts.

347. But MultiPlan did specify in those same materials and subsequent public calls with investors that its commercial out-of-network repricing customers follow the MultiPlan-set and Defendant-fixed prices 99% to 100% of the time.

348. No inference of agreement is required to establish the existence of these vertical agreements. The statements speak for themselves.

b. Direct Evidence of Defendant Insurers' Horizontal Agreements with Each Other: the "Rim," Part 1

349. MultiPlan also provided direct evidence of the horizontal agreements at issue in this Complaint in connection with its public offering investor materials reflecting tacit commercial-insurer agreements in which those insurers reach agreement with each other through publicly stated intentions made in an established forum and through subsequent transparent acts in substantial conformance with those stated intentions.

350. MultiPlan's investor materials name each major U.S. insurer, including all of California's big insurers, as engaged in this very conduct.

351. Unlawful horizontal antitrust agreements may be either express or tacit.

352. Tacit agreements include those involving publicly stated intentions and subsequent actions in substantial conformance with those intentions.

353. Those tacit agreements are more clear and durable when the publicly stated intentions are made through an established forum for those communications, for example, a "hub."

354. Those tacit agreements are more clear and durable when the subsequent actions in substantial conformance with those intentions are more transparent, for example, when published by a "hub."

355. Whether a communication about an unlawful horizontal antitrust agreement is transmitted between competitors face-to-face or through an intermediary, for example, a "hub," is irrelevant to its status as direct evidence of that communication.

356. As detailed in this Complaint, MultiPlan is the "hub" in Defendants' arrangement, and Defendant Insurers communicate and act through it to establish, effectuate, and maintain their unlawful agreement.

357. This type of arrangement is often described as a "hub, spoke, and rim" agreement.

358. A recent example of direct evidence of the tacit horizontal hub, spoke, and rim agreements at issue in this case is reflected in the public admissions of Churchill's Klein.

359. These statements provided substantial assurances about MultiPlan's commercial out-of-network repricing to prospective investors and also to Defendant Insurers and other significant MultiPlan customers.

360. In connection with his research and diligence into directing billions of dollars into MultiPlan and its future, Churchill's Klein met with MultiPlan's largest health insurance customers to discuss their commitment to MultiPlan's commercial out-of-network repricing business.

361. He reported in a public admission: "I had the good fortune of speaking to the senior executives, at customers that represent about 65% of the revenue base of MultiPlan. And what they came back with in terms of their responses…. They indicated that MultiPlan was critical to their operation, and that MultiPlan's business was the gold standard in terms of pricing [and] …. that the required the tools of MultiPlan…. MultiPlan was critical to them, was valuable to them, and was a company that they would be providing more of their internal and external business to MultiPlan over the coming years now." (Ex. 4 at 25.)

362. Upon information and belief, those insurer customers inquired in these conversations about the commitment of their would-be competitors to MultiPlan's commercial-out-of-network repricing.

363. Upon information and belief, Churchill's Klein and his colleagues answered those questions and provided the requested assurances privately, just like he later did publicly to investors and the same insurer customers.

364. Churchill's Klein went on to admit and explain that MultiPlan "has 100% contracted revenues…. [and] customers have long-term relationships, 75% of which are more than three years in terms of contract length, but all of them have long and deep historical relationships." (Ex. 1 at 25.)

365. These assurances are critical to MultiPlan's existence as a business.

366. MultiPlan regularly obtains these assurances from the major U.S. health insurers, including Defendant Insurers, for its own business planning, and the maintenance of the goal of maximizing the reduction in reimbursements to Verity and other providers for the Services they provided.

367. As the statements from Churchill's Klein highlight, assurances like these are critical for anyone seeking to evaluate the wisdom of entering into long-term commercial out-of-network repricing contracts with MultiPlan.

368. In this instance and others, Churchill's Klein, MultiPlan, and others acting on MultiPlan's behalf have knowingly made these assurances publicly.

369. All major U.S. health insurers, including Defendant Insurers, have access to these public statements.

370. And, since all major U.S. health insurers, and Defendant Insurers, depend heavily on MultiPlan's "critical" and "required … tools," they follow these assurances closely.

371. Upon information and belief, MultiPlan and others acting on its behalf regularly provide these assurances to the major U.S. health insurers and Defendant Insurers in private, and as part of MultiPlan's marketing efforts.

372. No major U.S. health insurer would rationally enter into a long term contract to, effectively, substantially raise its price to its customers (here, technically lower its repricing for its inputs) unless it had reasonably strong assurances like these that all of its significant would-be competitors would do the same thing.

373. Otherwise, any health insurer with which MultiPlan sought to contract would have to do so fearing that its would-be competitors may actually compete on price (here, technically by offering more favorable out-of-network reimbursements to enhance their business relationships with providers and consequent offerings to actual and prospective enrollees).

374. If those would-be competitors did so, they would obtain better access to health care providers for their actual and prospective enrollees, over the long term.

375. That better access would enhance the would-be competitors' health insurance offerings to actual and potential enrollees and increase the would-be competitors' comparative revenues, over the long term.

376. In this hypothetical, any insurer that entered into one of MultiPlan's long-term contracts – with its would-be competitors free to compete aggressively – would be at a disadvantage in negotiating for access to providers for its enrollees and end up with less favorable health insurance offerings for actual and potential enrollees, and less revenue compared to the competing health insurers, as a result.

377. Assurances that the other major U.S. health insurers are firmly committed to MultiPlan's commercial out-of-network repricing are "critical" to all of its customers, and particularly Defendant Insurers; and MultiPlan provides such assurances regularly to solve this challenge.

378. Any insurer that entered into a long-term contract with MultiPlan would be at a disadvantage with a competitive insurer who did not contract with MultiPlan, because the non-MultiPlan insurer would have a competitive advantage in negotiating with providers by offering better out-of-network benefits, which would result in increased revenue for the competitive insurer.

379. MultiPlan's repricing output to insurers is designed to produce only one "price," which does not differ by insurer.

380. For example, for a specific CPT code claim on any particular day, MultiPlan does not produce different prices for the same hospital for each insurer. Instead, each insurer with a

claim from that hospital for that CPT code on that day receives exactly the same repricing result from MultiPlan.

381. MultiPlan is transparent about its commercial out-of-network repricing mechanism.

382. This transparency is reflected in MultiPlan's marketing materials and elsewhere; and MultiPlan, thus, routinely informs each participating commercial health insurer that if it enters into a commercial out-of-network contract with MultiPlan, then all others who also contract with MultiPlan for commercial out-of-network will receive the exact same price from MultiPlan.

383. This transparency also reveals MultiPlan's assurances to the major U.S. health insurers, and Defendant Insurers, that all others who contract with MultiPlan will be similarly submitting their competitively sensitive claims data to MultiPlan in exchange for MultiPlan's granular prices.

384. In addition, MultiPlan repeatedly makes public statements that its customers, including all of the major U.S. health insurers, and all of Defendant Insurers, act in substantial conformance with its repriced commercial out-of-network amounts – following them in 99% to 100% of all instances.

385. Therefore, according to MultiPlan's own public admissions, each major U.S. health insurer, and all of Defendant Insurers, knows – at least from MultiPlan's public statements – that all of its would-be competitors: (a) are under long-term commercial out-of-network repricing contracts with MultiPlan; (b) submit their competitively sensitive claims data to MultiPlan regularly; and (c) follow MultiPlan's specific granular prices for commercial out-of-network reimbursements 99% to 100% of the time (most often without even any human touch), such that they can rely on the assurances from MultiPlan that all of their significant would-be competitors are "in on it" too.

386. MultiPlan's public statements here reflect communications among the would-be competing health insurers of their publicly stated intentions through an established forum and subsequent transparent acts in substantial conformance with those stated intentions.

387. Upon information and belief, MultiPlan repeats these statements in private too.

388. MultiPlan's communications of this nature not only stabilize the commercial out-of-network reimbursement market, they also are direct evidence of a tacit agreement reflecting among the major U.S. health insurers and Defendant Insurers.

389. No inference of agreement is required to establish the existence of these tacit agreements. MultiPlan provided direct evidence.

390. This evidence, and the circumstantial evidence below, establishes the rim of Defendants' "hub, spoke, and rim" arrangement.

c. Circumstantial Evidence of Defendant Insurers' Horizontal Agreements with Each Other: the "Rim," Part 2 / "Plus Factors"

391. MultiPlan and others also provided circumstantial evidence of the horizontal agreements at issue in this Complaint in connection with its public offering investor materials.

(i) Actions Against Rational Economic Self-Interest

392. A health insurer's choice to contract with MultiPlan and follow its prices over such a long-term period effectively rejects profitable opportunities in the absence of a horizontal agreement with its competitors, and ordinarily would be precarious economically.

393. MultiPlan's business is structured in a way that makes that choice *much* less precarious.

394. MultiPlan allows its commercial payer customers to communicate their agreements to (a) contract with MultiPlan, (b) submit competitively sensitive claims data to MultiPlan in exchange for granular future pricing information, and (c) follow MultiPlan-set "prices" more transparently, thereby making their own "prices" transparent to other commercial payers because MultiPlan publishes one commercial out-of-network reimbursement "price" for each provider at any given time that does not differ by commercial payer.

395. MultiPlan's admissions on just how much it has reduced commercial out-of-network reimbursements vary. In some instances, it suggests about 18% (*i.e.*, $19 billion in savings on $106 billion in claims, per its investor materials), and in others it suggests about 50% (on its website). (Ex. 1 at 5 & 10.)

396. The reimbursement reductions created by Defendants' scheme are very substantial and any provider that could, including Verity, would seek to avoid them and choose substantially higher reimbursements if the option was available.

397. The rationale for this straightforward provider preference includes that the volume of commercial out-of-network claims and the amount of money subject to repricing are tremendously impactful for a provider's continued operations.

398. This rationale applies even more strongly to California hospitals, including Verity, given the amount of losses they face due to low government-payer reimbursements.

399. Each of the major U.S. health insurers, and Defendant Insurers, are large and profitable enough that they could very effectively take advantage of the opportunity presented by one or more of their would-be commercial out-of-network reimbursement competitors – by itself or themselves – effectively "increasing" commercial out-of-network reimbursement "prices" to providers for 2 – 5 years (*i.e.*, the effect of entering into a contract with MultiPlan to reduce commercial out-of-network reimbursements to providers).

400. The lone major U.S. insurer that entered into a MultiPlan commercial out-of-network repricing contract in that instance would lose money in the long run.

401. Consequences for that insurer would include the other would-be competing health insurers enticing providers, including California hospitals, to give them and their enrollees better access to their care, in any one or more of a variety of ways in which health insurers and providers deal with each other.

402. The major health insurers in this hypothetical would not only improve their business and economic relationships with providers through better commercial out-of-network reimbursements, and improve their enrollees' and prospective enrollees' access to care, they also would in the long run be in a position to market those advantages to their actual and prospective enrollees.

403. The marketing advantage the major health insurers would gain to actual and potential enrollees – stemming from competition on commercial out-of-network reimbursements –

would significantly impact their bread-and-butter business: providing the most attractive health insurance plans possible to individuals and employers.

404. But, entering into the type of contract MultiPlan describes in detail in its investor materials without sufficient assurances that all significant would-be competitors would too, would require a health insurer to act against its rational economic self-interest -- that is, in the absence of an agreement among its significant would-be competitors to do the same thing.

405. Most of the major U.S. health insurers are for-profit businesses with obligations to their shareholders to make money.

406. All of the major U.S. health insurers and Defendant Insurers are similarly incentivized to make money, and are sophisticated businesses, particularly when it comes to acting in their economic self-interest.

407. It would be economically irrational for any of these insurers to enter into the type of contract MultiPlan describes in its investor materials and presentations in the absence of the precise assurances detailed by Churchills' Klein and MultiPlan's public investor materials.

408. MultiPlan serves, as the "hub," to effectuate the unlawful hub, spoke, and rim agreement among the major U.S. health insurers that forms the core of the horizontal agreements at issue in this Complaint.

(ii) The Information Exchange Itself

409. As detailed in the paragraphs above, MultiPlan and Churchill make clear in the investor materials and presentations that all of the major U.S. health insurers and Defendant Insurers submit their competitively sensitive claims data to MultiPlan.

410. MultiPlan emphasizes that it receives 370,000 claims a day, 365 days a year, and that it has done so for many years, accumulating an insurmountable database of information from more than 700 payers and all of the major U.S. insurers, including Defendant Insurers. (Ex. 1 at 18.)

411. MultiPlan highlights that it receives 98% of these claims through direct technological integration. (Ex. 5 at 47 and Ex. 6 at 20.)

412. MultiPlan also makes clear that it uses the claims data to produce for each of its payer customers granular future commercial out-of-network reimbursement "prices," *i.e.*, repriced reimbursement amounts for use in paying providers' commercial out-of-network claims.

413. And, as noted, MultiPlan's commercial out-of-network repricing customers, including those that represent effectively all of the health insurers in the Reimbursement Market, follow those prices 99% to 100% of the time.

414. This type of information exchange itself is circumstantial evidence of "the rim," here a horizontal agreement among the health insurers.

415. Information exchanges like these facilitate horizontal agreements among would-be competitors and make those agreements more durable.

(iii) Statements of Aligned Motive and Intent

416. The MultiPlan and Churchill investor materials and presentations, as detailed elsewhere in this Complaint, reflect emphatic assurances that the major U.S. insurers, and Defendant Insurers, are engaged in the conduct at issue in this Complaint.

417. And MultiPlan describes in these instances its own interests in detail: the core purpose of its commercial out-of-network repricing business, sole method of making money in this business, and reason for the existence of this business, is to reduce commercial payers out-of-network reimbursements.

418. MultiPlan and Churchill describe that all of MultiPlan's payer-customers' "interests are completely aligned" with MultiPlan's. (Ex. 4 at 9.)

419. And these statements are based on MultiPlan and Churchill's discussions with MultiPlan's payer customers, including the major U.S. health insurers and Defendant Insurers.

420. MultiPlan describes itself as a "core" and "key strategic partner" of the major U.S. health insurers and Defendant Insurers, and that its interests are "directly aligned with Payers' incentives." (Ex. 5 at 24; Ex. 8 at 8; and Ex. 6 at 20.)

421. These statements, and other MultiPlan and Churchill statements, reflect statements of the major U.S. insurers and Defendant Insurers.

(iv) The Monopolistic and Oligopolistic Structures of the Relevant Markets

422. The predictability and stability of each major U.S. insurers' commercial out-of-network repricing is enhanced by the structure of the Relevant Markets detailed above.

423. The Repricing Markets are dominated by MultiPlan.

424. MultiPlan is a monopolist in these markets.

425. Further, the markets for commercial out-of-network reimbursements are in MultiPlan's own words, highly "consolidated." (Ex. 1 at 12 and Ex. 5 at 22 & 24.)

426. These markets, including the Reimbursement Market, are oligopolistic.

427. In the insurer conduct at issue in this Complaint, 95% of the Reimbursement Market is acting in concert and exercising monopoly-like power.

428. These facts are supported by the high barriers to entry and low likelihood of new entry in both the Repricing Markets and the Reimbursement Market.

(v) High Barriers to Entry and the Low Likelihood of New Entry

429. Barriers to entry are high in the Repricing Markets, as detailed elsewhere in this Complaint.

430. MultiPlan admits to these barriers, including by highlighting them colorfully as a "competitive moat" that drives high and durable recurring margins over many years. (Ex. 4 at 20.)

431. MultiPlan's extensive collection of data, technological infrastructure, and intellectual property alone give it a near-insurmountable advantage.

432. Its direct technological integration with the major U.S. health insurers, which allows it to produce repricing results for payers in less than 5 seconds, enhances its position.

433. In the words of Churchill's Klein, MultiPlan has achieved "payer lock." (Ex. 1 at 29.)

434. Barriers to entry are high in the Reimbursement Market too.

435. The provision of health insurance requires a large scale, a well-developed network of access to health care providers, regulatory approval, and deep pockets.

436. It is very unlikely that any business could enter the Repricing Markets or Reimbursement Market in a timely, likely, or sufficient way to meaningfully impact the durability of the conduct at issue in this Complaint.

(vi) The Absence of Significant Fringe Competition

437. There are simply no significant competitors on the fringe of the relevant service markets.

438. Any company that attempted to enter any of the Repricing Markets or the Reimbursement Market would need to overcome the inherent barriers to entry detailed in this Complaint.

439. Any company that attempted to enter could not do so in a timely, likely, and sufficient manner to defeat a hypothetical price increase of even insubstantial size (effectuated in this context in the form of a reimbursement decrease).

440. In describing how MultiPlan views the likelihood of its customers building their own solutions, MultiPlan stated that what it does is "very, very different than what any single payer can do on their own, which is why they all come to MultiPlan." (Ex. 4 at 20.)

441. MultiPlan went on to emphasize that no other commercial out-of-network repricer gives it any concern because, even though "[t]here are many, many products that are on the market today, and they have been forever … what might be getting lost a little bit in the translation is that we're talking about apples and oranges here." (Ex. 4 at 20.)

442. MultiPlan knows that, in this sense, it "sit[s] in that unique space and [is] deeply embedded into [its customers'] claims platforms." (Ex. 1 at 42.)

443. MultiPlan emphasized repeatedly to potential investors its "unique" and "deeply embedded" position with its payer customers. (*E.g.*, Ex. 1 at 3, 5, 25, 30, 38 & 42.)

444. In the words of Churchill's Klein, MultiPlan has achieved "payer lock."

445. In the words of Churchill's Klein, his company "view[s] [MultiPlan] as what it truly is, which is … some might say, dominant." (Ex. 1 at 26.)

(vii) The Presence of Customary Patterns, Formulas, and Leadership

446. Stability in communications, assurances, the Reimbursement Market and similar markets throughout the country, and reimbursement repricing are all substantially enhanced by MultiPlan's long history as the Hub of the arrangement.

447. MultiPlan's business follows well-known customs that are literally built into the major U.S. insurers' businesses, and Defendant Insurers' businesses, through substantial, direct technological integration with MultiPlan at high-fixed costs.

448. The insurers are "deeply embedded" with MultiPlan customs, and they all follow the same pattern and formula.

449. MultiPlan's continued, consistent conduct provides "critical" leadership for the arrangement.

450. In this instance, the Defendant Insurers have a well-functioning conduit, leader, and manager that not only implements the arrangement but helps to monitor it and facilitate communications, actions, and assurances about it.

451. The stable long-term structure of the relevant service markets also makes the agreement at issue more likely and effective.

452. The major U.S. health insurers have been stable for many years, and those same companies have been involved in the conduct described in this Complaint for many years.

453. The Reimbursement Market has been a stable oligopoly for some time too.

454. Further, MultiPlan has been in a dominant position for nearly a decade.

455. And MultiPlan admits its relationships with the major U.S. health insurers span decades.

456. The business practices that comprise the unlawful and other arrangements at issue in this Complaint are more than just customary; they are actively led by the MultiPlan hub, deeply entrenched, high-fixed cost, and built-in components of the businesses of the major U.S. insurers and Defendant Insurers.

(viii) Opportunities to Conspire

457. A California federal court looking at the Ingenix scheme concluded that plaintiffs challenging the hub's relationship with many of the same commercial-insurer defendants in this Complaint sufficiently alleged a *per se* horizontal price-fixing agreement.

458. In doing so, it relied in part on the commercial-insurer defendants' opportunities to conspire.

459. The evidence it found persuasive was that "participating insurers have 'ample' opportunities to communicate and have communicated, among themselves about the conspiracy," "'routinely' at HIAA/AHIP conferences and board meetings." 865 F.Supp.2d 1002, 1026 (C.D. Cal. 2011).

460. HIAA and AHIP have merged into one entity.

461. The same health insurers involved in the 2011 Central District of California Federal Court case continue to participate in HIAA/AHIP conferences and board meetings today as reflected in detail on the HIAA/AHIP website.

462. Tellingly, those health insurers, including Defendant Insurers, participate in private closed-door meetings through HIAA/AHIP that are not open to the public.

463. The regular in-person HIAA/AHIP programs include extensive collaborative learning and networking opportunities among the competitors.

464. As HIAA/AHIP states, it "plays an important role in bringing together member companies and facilitating dialogues to advocate on shared interests."

(ix) Market-Stabilizing Conduct

465. The direct and circumstantial evidence detailed above has a stabilizing effect on the Reimbursement Market.

466. It has a stabilizing effect on the Repricing Markets too.

467. And market-stabilizing conduct itself, when effective, as it is here, is circumstantial evidence of a horizontal agreement because it makes the agreement easier for its participants to consummate and continue; it makes the agreement more durable.

468. When businesses engage in high-stakes conduct like that detailed this Complaint, it is not the place for instability, erratic, or significantly differentiated conduct.

469. The market-stabilizing conduct that MultiPlan and Churchill demonstrate in their investor materials and presentations is just what the participants to the horizontal agreements at issue want to help their agreements work well.

(x) A Clean and Consistent Break from the Default

470. Following the New York Attorney General's Office forced break-up of the Ingenix scheme, the major U.S. health insurers and Defendant Insurers faced instability and had no well-established hub yet in place.

471. MultiPlan filled that role fairly quickly.

472. Upon information and belief, commercial out-of-network reimbursements briefly returned to a more competitive level for providers.

473. But by 2012, MultiPlan had completed its acquisitions of Viant and Data iSight, and it was firmly in place as the new commercial out-of-network repricing hub.

474. And commercial out-of-network reimbursement "prices" then decreased significantly in favor of commercial payers and against health care providers.

475. Even if they did not, a hub, spoke, and rim based commercial out-of-network reimbursement "price" differs from the default.

476. The default involves a health care provider rendering a service to a commercially insured patient at a previously stated price.

477. The default involves, in instances where those services are "out-of-network" in the patient's commercial insurance plan, the provider sending the bill to the patient's commercial insurer in the form of a claim.

478. The default involves that commercial insurer owing the provider either the full billed amount, or the percentage of that amount it is required to pay according to the commercial insurer's contract with the patient and other laws.

479. In some instances, the default involves a payment at a "usual and customary" or similar amount.

480. But in no instances does the default, in the absence of the repricing scheme detailed in this Complaint, involve the commercial insurer basing its payment on the provider's claim on MultiPlan repricing.

481. In all instances, the MultiPlan repriced amount is substantially lower than the default and is a clean and consistent break from the default.

482. As MultiPlan and Churchill trumpet in their investor materials and presentations, the MultiPlan-set Defendant-fixed "prices" have cleanly and consistently broken from the default to the tune of approximately $10 billion per year from 2012 – 2020.

E. The Anticompetitive Purpose and Effects of Defendants' Conduct

483. The attached Churchill – MultiPlan investor presentations make clear Defendants' purpose with the conduct at issue in this Complaint: reduce commercial out-of-network payments from commercial insurers and SFPs, including Defendant Insurers and SFPs, to health care providers, including Verity.

484. MultiPlan and Churchill also make clear that Defendants were very successful in achieving these aims. Churchill and MultiPlan admit that from 2012 – 2020, Defendants' conduct caused approximately $10 billion in reductions per year to Verity and other providers.

485. As Churchill and MultiPlan admit: Defendant Insurers and SFPs interests were, and remain, "completely aligned" with MultiPlan's. When Defendant Insurers and SFPs make money, so does MultiPlan, and in the same way. (Ex. 4 at 9.)

486. Defendants intended for their unlawful agreements to significantly increase their profits at the expense of Verity and other providers.

487. Defendants were aware of their substantial "success" in repricing and the consequent financial rewards for them, as well as the consequences for Verity and other providers.

488. They continued siphoning off money from hospitals, including Verity, and other providers through their unlawful conduct, despite the harm their conduct plainly caused.

489. Defendants' unlawful conduct detailed in this Complaint reduced the competitiveness and quality of care at numerous hospitals.

490. The significant losses Defendants caused by significantly reducing the badly needed reimbursements due to Verity and other providers for the valuable Services they had provided to their commercially insured patients kept hospitals, including Verity, from providing the level of care that they otherwise could have.

491. The same conduct kept hospitals, including Verity, from competing at the same level that they otherwise could have.

492. Defendants' unlawful conduct detailed in this Complaint contributed to hospital bankruptcies, including the unfortunate bankruptcies of non-profit hospitals St. Louise, St. Francis, St. Vincent, Seton, Seton Coastside, and O'Connor in the San Francisco, Los Angeles, and San Jose Metropolitan Area communities.

493. But for the conduct at issue in this Complaint – which Churchill and MultiPlan claim reduced critical commercial out-of-network reimbursements from large commercial insurers and SFPs to Verity and other providers by substantial amounts – Verity's competitiveness and financial position would have been significantly better, and it would not have suffered the severe financial and other consequences it has endured.

F. Verity's Antitrust Injuries and Antitrust Standing

494. Defendant Insurers committed years ago to MultiPlan's methodology, which promised them substantial "savings" on their commercial out-of-network reimbursement expenses.

495. Defendant Insurers adhered to their commitments as MultiPlan grew and eliminated competition through acquisitions and moat building, viewing MultiPlan not as "a technology or services provider" but as "an important partner" that is "invited to the strategic table to help deepen their competitive advantage." (Ex. 1 at 12.)

496. The elimination of Repricing Market competitors that could offer higher reimbursement rates to out-of-network hospitals, and leveraging of MultiPlan's market position, eliminated any competition among themselves for those services and assured Defendant Insurers of the rewards of MultiPlan's artificially reduced commercial out-of-network reimbursement rates.

497. Defendants' combination was necessary to effectuate the artificially reduced reimbursement rates for Services provided by Verity and other providers.

498. This agreement resulted in anticompetitively reduced reimbursement payments to Verity and other providers for Services they provided to their commercially insured patients.

499. Defendants' conduct at issue in this Complaint artificially depressed commercial out-of-network reimbursements to Verity and produced the same anticompetitive effects as unlawful agreements to raise prices, namely: reduced output; diminished quality; reduced innovation; allocative inefficiencies; and higher prices for consumers in the long run.

500. These anticompetitive effects constitute antitrust injuries to Verity.

501. Defendants' agreements controlled and set those amounts at unreasonably low, anticompetitive levels to increase Defendants' profits to the detriment of Verity and other providers.

502. Defendants cannot defend their unlawful agreements with the sophist argument that the artificially lowered reimbursements would allow them to reduce insurance premiums, and, therefore, there were no antitrust injuries.

503. The antitrust laws' central purpose is to foster competition; they do not countenance agreements that fix or artificially "raise prices" to either buyers or sellers.

504. Verity and other providers were and are direct sellers – the mirror image equivalent of "direct purchasers" – in the Reimbursement Market.

505. Defendants' conduct to reduce reimbursement rates to Verity and these other providers directly caused the harm and injuries to Verity that are the basis of this lawsuit.

506. Verity's harm and injuries from Defendants' price fixing and unlawful restraints of trade are exactly the types of harm and injuries that the antitrust laws were designed to prevent.

507. It was entirely foreseeable to Defendants that the conduct at issue would cause the harm and injuries to Verity detailed in this Complaint due to the long history of California and U.S. antitrust enforcement to stop and remedy this type of activity, and the Ingenix cases and settlements.

508. Further, the harm and injuries Verity suffered were the intended result and the exact purpose of Defendants' unlawful conduct.

509. The Defendants' conduct was "successful," and that "success" directly caused Verity the anticompetitive harm and injuries at issue in this lawsuit.

510. Counts One – Five below do not reflect "indirect purchaser" challenges.

511. Instead, these challenges reflect injuries that flow from the Reimbursement Market, in which Verity and other providers were and are "direct sellers," the legal equivalent of "direct purchasers."

512. Counts One – Five below reflect "direct purchaser" challenges.

513. Verity and other providers were and are indirect sellers – the mirror image equivalent of "indirect purchasers" – only in the Repricing Markets.

514. Counts Six – Nine of this Complaint involve an "indirect purchaser" economic relationship.

515. This "indirect" economic relationship is significant in some parts of the U.S., following the U.S. Supreme Court decision in *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977), but it is not significant in California.

516. California passed a law shortly after the *Illinois Brick* decision, now enacted in Business and Professions Code Section 16750(a), to effectively repeal *Illinois Brick* in California, as held by the California Supreme Court in *Union Carbide Corp. v. Superior Court*, 36 Cal. 3d 15, 20 (1984).

517. Thus, as detailed above, Verity has a sufficient basis to sue Defendants for all of the direct and indirect antitrust offenses detailed in this Complaint.

G. Where Applicable, Defendants' Conduct Caused More Anticompetitive Harm Than Any Resulting Beneficial Effects Defendants Could Reasonably Claim

518. No procompetitive justification, beneficial effect, or redeeming virtue is relevant, at all, to the horizontal price-fixing claim in this lawsuit.

519. Further, where an analysis involving a balance of any beneficial and anticompetitive effects resulting from Defendants' conduct may be relevant to this Complaint, Defendants have limited options and too much anticompetitive effect to overcome.

520. The attached Churchill – MultiPlan investor presentations reflect admissions from MultiPlan, verified by Churchill, that Defendants' conduct detailed in this Complaint reduced commercial out-of-network reimbursements from payers to providers, including Verity, by $10 billion per year from 2012 – 2020.

521. $10 billion per year worth of anticompetitive harm is substantial.

522. It is extraordinarily unlikely that Defendants will be able to prove that any reasonably claimed beneficial effects resulting from the conduct at issue (if any) outweigh $10 billion per year worth of anticompetitive harm.

523. Indeed, there are no resulting beneficial effects or redeeming virtues Defendants could reasonably claim that would outweigh this level of anticompetitive harm, let alone other anticompetitive effects resulting from their unlawful conduct.

524. U.S. antitrust laws, as interpreted by multiple Federal Appellate Courts and federal antitrust enforcement officials, do not permit defendants to even attempt to defend and justify their conduct with claims that their lower commercial out-of-network reimbursements have beneficial effects and redeeming virtues because they allow payers to reduce insurance premiums.

525. The antitrust laws' central purpose is to foster competition; they do not countenance agreements that fix or artificially "raise prices" to either buyers or sellers.

526. If Defendants make this argument it would, in the words of federal antitrust officials, in a context analogous to this one, and the U.S. Supreme Court: "'confirm[ ] rather than refute[ ] the anticompetitive purpose and effect" of the conduct at issue. Case No. 1:16-cv-01493 (D.D.C. filed July 21, 2016) Doc. 410 at 4 (quoting *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 693 (1978)).

527. Indeed, the only then-D.C. Circuit Court Judge to address this question in the context of the analogous case referenced above reached largely the same conclusion. 855 F.3d 345, 377 – 378 (J. Kavanaugh, dissenting).

528. The Judge's conclusion was that the Court should *permit* the proposed Anthem-Cigna merger on the grounds at issue in the majority opinion, *but challenge the merger further* on the question of whether it may lead to unlawful health insurer monopsony power over health care providers, including hospitals. *Id.* (the majority opinion did not reach this question, stopping short because it affirmed, blocking the merger on other grounds.)

529. As that opinion explained, "the exercise of monopsony power to temporarily reduce consumer prices does not … justify an otherwise anticompetitive" action, and even Anthem and Cigna "concede[d] that the [conduct] would be unlawful" if it led to lower provider prices through "monopsony power in the upstream market." *Id.* (quoting Tr. of Oral Arg. at 85).

530. In the context of this Complaint, Defendant Insurers' collective actions – comprising 95% of the applicable markets – in their relationships with Verity and other providers reflect the exercise of monopsony power.

531. 95% of the market collectively acting to reduce health insurer commercial out-of-network reimbursement rates to Verity and other providers is not procompetitive. It is anticompetitive.

532. Defendants cannot seek to justify their conduct by arguing that their deliberate actions to substantially reduce commercial out-of-network reimbursements reflect beneficial effects.

H. Where Applicable, Defendants' Conduct Is Not Reasonably Necessary to Achieve Any Reasonably Claimed Resulting Benefits (If Any), and Can Be Accomplished Through Less Restrictive Means

533. An analysis of the reasonable necessity of Defendants' conduct to achieve any claimed beneficial effects, and whether those effects can be achieved through less restrictive alternatives, is entirely irrelevant to the horizontal price-fixing claim in this lawsuit. Such an analysis would only apply in limited circumstances and only to other claims in this lawsuit.

534. Further, where this analysis is applicable, *e.g.*, if there were reasonable resulting beneficial effects from the conduct at issue in this lawsuit other than horizontal price fixing, the conduct at issue is not reasonably necessary to achieve any resulting beneficial effects and there are less restrictive ways to accomplish the same objectives.

535. For example, even if it were a relevant defense, there are many ways Defendant Insurers could reduce their premiums to their enrollees without siphoning off essential commercial out-of-network reimbursement funds from non-profit hospitals, including Verity. They could use some of their excessive profits to lower enrollee premiums, or support essential community hospitals, including Verity. They also could reduce their internal costs, which seems easily attainable with the excessive funds at their disposal and the large scale of their operations.

V. VIOLATIONS OF LAW

FIRST COUNT:

Horizontal Price Fixing

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

536. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

537. At least as early as 2012 and continuing from then until present day, Defendant Insurers entered into a horizontal combination, agreement, and/or contract with each other to unreasonably restrain trade in violation of the Cartwright Act.

538. This combination, agreement, and/or contract consisted of a continuing agreement, understanding, or concert of action by Defendant Insurers to enter into an agreement with each other and through MultiPlan, whereby MultiPlan would act as a "hub" to fix, set, establish, and control the reimbursement amounts paid by the Defendant Insurers and SFPs, and others, for Services to Verity and other providers.

539. Defendant SFPs and others joined this combination, agreement, and/or contract, engaged in the unlawful submission of competitively sensitive information in exchange for granular prices, declared their intentions to follow those prices and acted in substantial conformance with those intentions, and caused hospitals, including Verity, and other providers substantial harm.

540. Defendants' conduct was a substantial factor in causing Verity's harm.

541. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

542. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their price-fixing conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

543. All of the Defendants participated in this unlawful agreement, including through their vertical agreements with MultiPlan, and other conduct that further entrenched, facilitated, and otherwise constituted overt acts in support of Defendants' price fixing.

544. Defendants' continuing agreements, understandings, or concerted actions are evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

545. The intent, purpose, and effect of Defendants' agreement to fix and set reimbursement rates through MultiPlan was to cause under-reimbursement for commercial Services, and thereby minimize reimbursement payments made on such claims by Defendant Insurers and SFPs, and others.

546. Through this price-fixing agreement, Defendants have fixed and set reimbursement rates for Services from Verity and other providers at unreasonably low anticompetitive levels and caused a decrease in reimbursements, *i.e.*, payments for Services that would not have occurred but for their anticompetitive conduct.

547. Defendants' anticompetitive conduct is a *per se* violation of the Cartwright Act that cannot be excused – as a matter of California law – by any claimed beneficial effect(s), reasonable stated purpose(s), or business purpose(s), or any similar claim(s).

548. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

549. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

550. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and seeks to recover those damages, and other relief detailed below, at trial.

SECOND COUNT:

Horizontal Market Allocation

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

551. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

552. At least as early as 2012 and continuing from then until present day, Defendant Insurers entered into a horizontal combination, agreement, and/or contract with each other to unreasonably restrain trade in violation of the Cartwright Act.

553. This combination, agreement, and/or contract consisted of a continuing agreement, understanding, or concert of action by Defendant Insurers to enter into an agreement with each other and through MultiPlan, whereby MultiPlan would act as a "hub" to fix, set, establish, and control the reimbursement amounts paid by the Defendant Insurers and SFPs, and others, for Services to Verity and other providers, and stabilize, maintain, and entrench the oligopolistic nature of the Relevant Markets.

554. Defendant SFPs and others joined this combination, agreement, and/or contract, engaged in the unlawful submission of competitively sensitive information in exchange for granular prices, declared their intentions to follow those prices and acted in substantial conformance with those intentions, and caused Verity and other providers substantial harm.

555. Defendants' conduct was a substantial factor in causing Verity's harm.

556. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

557. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct

described by MultiPlan, the absence of any legitimate business purpose for their price-fixing conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

558. Defendants continuing horizontal agreements, understandings, or concerts of action are evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

559. The intent, purpose, and effect of the agreements to fix and set reimbursement rates through MultiPlan, and stabilize, maintain, and entrench the oligopolistic nature of the Relevant Markets, was to cause under-reimbursement for Services, and stabilize, maintain, and entrench the oligopolistic nature of the Relevant Markets, thereby minimizing reimbursement payments made on such claims by Defendant Insurers and SFPs, and others.

560. Through the agreements, Defendants have in fact formed, stabilized, maintained, and entrenched an oligopsony, and fixed and set reimbursement rates at unreasonably low anticompetitive levels, causing a decrease in reimbursement or payments for Services that would not have occurred but for their anticompetitive conduct.

561. Defendants' anticompetitive conduct is a *per se* violation of the Cartwright Act that cannot be excused – as a matter of California law – by any claimed beneficial effect(s), reasonable stated purpose(s), or business purpose(s), or any similar claim(s).

562. If there are any resulting beneficial effects from Defendants' anticompetitive conduct, they do not outweigh the harm caused by Defendants' conduct and can be reasonably accomplished through less restrictive means.

563. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

564. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

565. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and seeks to recover those damages, and other relief detailed below, at trial.

THIRD COUNT:

Horizontal Unlawful Exchange of Competitively Sensitive Business Information

(Cal. Bus. & Prof. Code §§ 16720 *et seq.*)

566. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

567. At least as early as 2012 and continuing from then until present day, Defendant Insurers entered into a horizontal combination, agreement, and/or contract with each other to unreasonably restrain trade in violation of the Cartwright Act.

568. This combination, agreement, and/or contract consisted of a continuing horizontal agreement, understanding, or concert of action by Defendant Insurers and SFPs, and others, to enter into agreements with each other and through MultiPlan, whereby MultiPlan would act as a "hub" to facilitate the submission of competitively sensitive business information, including competitively sensitive claims data, in exchange for analyses of that data and granular prices.

569. Defendants' conduct was a substantial factor in causing Verity's harm.

570. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

571. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

572. The exchange had the purpose and effect of fixing, setting, establishing, and controlling the reimbursement amounts paid by the Defendant Insurers and SFPs, and others, for Services to Verity and other providers.

573. These continuing horizontal agreements, understandings, or concerts of action are evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

574. The intent, purpose, and effect of this unlawful exchange of competitively sensitive information was to cause under-reimbursement for Services, and thereby minimize reimbursement payments made on such claims among Defendant Insurers and SFPs, and others.

575. The exchange of competitively sensitive information actually caused reimbursement rates to drop to unreasonably low anticompetitive levels and caused a decrease in reimbursement or payments for Services that would not have occurred but for their anticompetitive conduct.

576. Defendants' anticompetitive conduct is a *per se* violation of the Cartwright Act.

577. The effects of Defendants' anticompetitive conduct outweigh any resulting beneficial effects on competition; and, if there are any resulting beneficial effects, they can be reasonably accomplished through less restrictive means.

578. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

579. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

580. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and seeks to recover those damages, and other relief detailed below, at trial.

FOURTH COUNT:

Vertical Unlawful Exchange of Competitively Sensitive Business Information

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

581. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

582. At least as early as 2012 and continuing from then until present day, Defendants entered into vertical combinations, agreement, and/or contracts with each other to unreasonably restrain trade in violation of the Cartwright Act.

583. These combinations, agreement, and/or contracts consisted of continuing agreements, understandings, or concerts of action by Defendant Insurers and SFPs to enter into agreements with MultiPlan, whereby MultiPlan would act as a "hub" to facilitate submission of competitively sensitive business information, including competitively sensitive claims data, in exchange for analyses of that data and granular prices.

584. Defendants' conduct was a substantial factor in causing Verity's harm.

585. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

586. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

587. The exchange had the purpose and effect of fixing, setting, establishing, and controlling the reimbursement amounts paid by the Defendant Insurers and SFPs, and others, for Services to Verity and other providers.

588. These continuing vertical agreements, understandings, or concerts of action are evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

589. The intent, purpose, and effect of this unlawful exchange of competitively sensitive information was to cause under-reimbursement for Services, and thereby minimize reimbursement payments made on such claims by Defendant Insurers and SFPs, and others.

590. The exchange of competitively sensitive information actually caused reimbursement rates to drop to unreasonably low anticompetitive levels and caused a decrease in reimbursement or payments for Services that would not have occurred but for their anticompetitive conduct.

591. The effects of Defendants' anticompetitive conduct outweigh any resulting beneficial effects on competition; and, if there are any resulting beneficial effects, they can be reasonably accomplished through less restrictive means.

592. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

593. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

594. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and other relief detailed below, at trial.

FIFTH COUNT:

Vertical Agreements to Monopolize /

Serial Acquisition of Actual and Potential Competitors

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

595. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

596. MultiPlan willfully acquired monopoly power in the Repricing Markets through the intentional and unlawful acquisition of actual and potential competitors, through its contractual arrangements with commercial out-of-network reimbursement payers and others, and otherwise, in violation of the Cartwright Act.

597. MultiPlan's possession and unlawful use of monopoly power in this market is evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

598. For the purpose of unlawfully acquiring monopoly power, MultiPlan has acquired its leading actual and potential competitors, including:

a. Viant, Inc. in 2010;

b. National Care Networks and Data iSight in 2011;

c. Medical Audit & Review Solutions in 2014;

d. HST in 2020; and

e. Discovery Health Partners in 2021.

599. For the purpose of unlawfully acquiring and maintaining its monopoly power, MultiPlan entered into agreements with commercial out-of-network reimbursement payers and others described in this Complaint, and other agreements.

600. The Churchill – MultiPlan investor presentations reflect MultiPlan's current and prior intent to pursue these aims and expansion.

601. The intent, purpose, and effect of MultiPlan's acquisition of its actual and potential competitors was to give MultiPlan control over the Repricing Markets and exclude competition.

602. Defendants' vertical agreements further entrenched, facilitated, and otherwise constituted overt acts in support of MultiPlan's unlawful monopolization and serial acquisition of actual and potential competitors.

603. Defendants' conduct was a substantial factor in causing Verity's harm.

604. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

605. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

606. The effects of Defendants' anticompetitive conduct outweigh any resulting beneficial effects on competition; and, if there are any resulting beneficial effects, they can be reasonably accomplished through less restrictive means.

607. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

608. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

609. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and seeks to recover those damages, and other relief detailed below, at trial.

SIXTH COUNT:

Vertical Agreements to Maintain a Monopoly

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

610. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

611. MultiPlan willfully acquired monopoly power in the Repricing Market through the intentional and unlawful acquisition of actual and potential competitors, through its contractual arrangements with commercial out-of-network reimbursement payers and others, and otherwise, in violation of the Cartwright Act.

612. MultiPlan's possession and unlawful use of monopoly power in this market is evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

613. MultiPlan unlawfully maintains its monopoly power in the Repricing Markets through the anticompetitive acts described in this Complaint, including by acquiring its actual and potential competitors, through its contractual arrangements with commercial out-of-network reimbursement payers and others, through creating insurmountable barriers to entry and competition (*e.g.*, "moat" digging), and otherwise, to control the Repricing Markets and exclude competition.

614. Defendants' vertical agreements further entrenched, facilitated, and otherwise constituted overt acts in support of MultiPlan's unlawful monopoly maintenance.

615. Defendants' conduct was a substantial factor in causing Verity's harm.

616. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

617. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

618. The effects of Defendants' anticompetitive conduct outweigh any resulting beneficial effects on competition; and, if there are any resulting beneficial effects, they can be reasonably accomplished through less restrictive means.

619. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

620. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

621. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and other relief detailed below, at trial.

SEVENTH COUNT:

Vertical Agreements to Leverage a Monopoly Position

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

622. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

623. MultiPlan unlawfully leveraged its position in the Repricing Markets to obtain power in other markets, including Medicare, Medicaid, Medicare Advantage, in-network and other reimbursement markets, in violation of the Cartwright Act.

624. MultiPlan's possession and unlawful use of monopoly power in these markets are evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

625. Defendants' vertical agreements further entrenched, facilitated, and otherwise constituted overt acts in support of MultiPlan's leveraging of its monopoly position.

626. Defendants' conduct was a substantial factor in causing Verity's harm.

627. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

628. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

629. The effects of Defendants' anticompetitive conduct outweigh any resulting beneficial effects on competition; and, if there are any resulting beneficial effects, they can be reasonably accomplished through less restrictive means.

630. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

631. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

632. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and seeks to recover those damages, and other relief detailed below, at trial.

EIGHTH COUNT:

Vertical Agreements to Attempt Monopolization

(Cal. Bus. & Prof. Code. §§ 16720 *et seq.*)

633. Plaintiff repeats, realleges, and incorporates each of the prior paragraphs.

634. MultiPlan intentionally and willfully attempted to acquire monopoly power in the Repricing Markets through the acquisition of actual and potential competitors, and its unlawful contractual arrangements with commercial out-of-network reimbursement payers and others, designed to build barriers to entry (a "moat") and exclude and suppress competition in the Repricing Markets, in violation of the Cartwright Act.

635. The allegations in this Complaint evidence a dangerous probability of MultiPlan gaining monopoly power unless Defendants' conduct is halted.

636. MultiPlan's attempt to possess and unlawfully use monopoly power in this market is evidenced by, among other things, the detailed allegations reflected in this Complaint and supported in no small part by Defendants' admissions in the attached Exhibits.

637. MultiPlan unlawfully attempted to monopolize in the Repricing Markets through the anticompetitive acts described in this Complaint, including by acquiring its actual and potential competitors, to control the Repricing Markets and exclude competition.

638. It has the specific intent to monopolize the Repricing Markets with a dangerous probability of success, particularly with Defendant Insurers' commitments to help it achieve these ends because of the "completely aligned" incentives of MultiPlan and Defendant Insurers.

639. Defendants' vertical agreements further entrenched, facilitated, and otherwise constituted overt acts in support of MultiPlan's attempted monopolization.

640. Defendants' conduct was a substantial factor in causing Verity's harm.

641. Defendants actively participated in and benefitted from the unlawful conduct at issue in this Complaint.

642. All Defendants knew they were joining in the unlawful conduct at issue in this Complaint, even if they were not all aware of all of its aspects, as evidenced by the nature of their acts, their economic relationships, their communications concerning the subject of the conduct described by MultiPlan, the absence of any legitimate business purpose for their conduct, and the fact that their actions in joining the horizontal agreement described in this Complaint are contrary to their economic best interests in the absence of a horizontal agreement among their significant would-be competitors in the provision of commercial out-of-network reimbursements.

643. The effects of Defendants' anticompetitive conduct outweigh any resulting beneficial effects on competition; and, if there are any resulting beneficial effects, they can be reasonably accomplished through less restrictive means.

644. As a result of the wrongful conduct alleged in this Complaint, Verity and other providers received lower reimbursements for Services than they would have received but for Defendants' anticompetitive conduct.

645. Through the wrongful conduct alleged in this Complaint, Defendants diminished the value of Verity's enterprise and drove it into bankruptcy.

646. Verity has been injured in its business or property, suffered damages in an amount to be determined at trial, which are in the hundreds of millions of dollars or more, and seeks to recover those damages, and other relief detailed below, at trial.

NINTH COUNT:

Unfair Competition

(Cal. Bus. & Prof. Code §§ 17200 *et seq.*)

647. Verity incorporates by reference and realleges each and every allegation set forth in the preceding paragraphs of this Complaint.

648. Verity brings this claim under Cal. Bus. & Prof. Code §§ 17203 and 17204 to obtain restitution and disgorgement of all monetary gains that resulted from acts that violated Cal. Bus. & Prof. Code §§ 17200 *et seq.*, commonly known as the UCL.

649. Verity has standing to bring this action under the UCL because it has suffered injury as a result of Defendants' anticompetitive conduct.

650. Verity has been denied fair and reasonable reimbursement payments for health care Services rendered to Defendants' out-of-network insured patients as a result of Defendants' anticompetitive conduct to drive down reimbursement payments to unreasonably non-competitive low levels.

651. Defendants have committed and continue to commit acts of unfair competition, as defined by Cal. Bus. & Prof. Code §§ 17200 *et seq.*, by engaging in the acts and practices described above.

652. Defendants' anticompetitive behavior constitutes a common and continuing course of conduct of unfair competition by means of unfair, unlawful, and/or fraudulent business acts or practices within the meaning of Cal. Bus. & Prof. Code §§ 17200 *et seq.*, including, but not limited to, violations of Cal. Bus. & Prof. Code §§ 16720 *et seq.*, as set forth above.

653. Defendants' anticompetitive behavior, as described above, is unfair, unconscionable, unlawful, and fraudulent, and in any event it is a violation of the policy or spirit of the Cartwright Act because it significantly harms and threatens competition.

654. As a proximate result of Defendants' unlawful and unfair business practices, Verity has been injured in violation of the UCL by being paid anti-competitive low reimbursement prices for health care Services rendered to patients who were out-of-network under their health insurance policies.

655. Defendants' anticompetitive behavior and unfair business practices are part of an ongoing practice, and any purported utility of its conduct is outweighed by the gravity of the consequences to Verity.

656. Verity has standing against Defendants, including to pursue an order restitution and disgorgement of the monetary gains that Defendants obtained from their unfair competition.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff Verity prays this Court enter judgment on its behalf against Defendants, jointly and severally, adjudging and decreeing that:

1. Defendants have engaged in trusts, contracts, combinations, or agreements in violation of Cal. Bus. & Prof. Code §§ 16720 *et seq.*, and Verity has been damaged and injured as a result and is entitled to relief under Cal. Bus. & Prof. Code § 16750(a);

2. The unlawful conduct, contracts or combinations alleged in this Complaint be adjudged and decreed to be:

a. Unlawful efforts to maintain, control, reduce, or tamper with reimbursement prices in violation of the Cartwright Act;

b. A *per se* unlawful horizontal price-fixing violation of the Cartwright Act;

c. Unreasonable restraints of trade in violation of the Cartwright Act;

d. Unlawful agreements to attain, maintain, and/or leverage monopoly power in violation of the Cartwright Act; and

e. Unlawful, unfair, and/or fraudulent business practices within the meaning of California's Unfair Competition Act, Cal. Bus. & Prof. Code §§ 17200 *et seq.*

3. Judgment shall be entered against Defendants and in favor of Verity for damages arising from Defendants' unreasonable restraints of trade as determined to have been sustained by them, in an amount to be trebled to the extent permitted by law, together with the costs of suit, including reasonable attorneys' fees;

4. Judgment shall be entered against Defendants and in favor of Verity for restitution and disgorgement of ill-gotten monetary gains determined to have been obtained by them, as allowed by law and equity, together with the costs of suit, including reasonable attorneys' fees;

5. Judgment shall be entered against Defendants and in favor of Verity for damages arising from Defendants wrongful conduct diminishing the value of Verity's enterprise and driving it into bankruptcy;

6. Verity be awarded monetary damages (trebled as appropriate), restitution, and disgorgement of the monetary gains obtained by Defendants as a result of their acts of unfair competition;

7. Verity be awarded pre- and post-judgment interest as provided by law, and that such interest be awarded at the highest legal rate from and after the date of service of the initial Complaint in this action;

8. Verity shall recover its costs of suit, including reasonable attorneys' fees, as provided by law; and

9. Verity have such other, further, and different relief as the case may require and the Court may deem just and proper under the circumstances.

DATED: September 8, 2021

BARTKO ZANKEL BUNZEL & MILLER
A Professional Law Corporation

PATRICK M. RYAN
PATRICK E. O'SHAUGHNESSY
JOHN F. MCLEAN
OLIVER Q. DUNLAP
SEAN R. MCTIGUE

By: /s/ Patrick E. O'Shaughnessy
Patrick E. O'Shaughnessy
Attorneys for Plaintiff
VHS LIQUIDATING TRUST

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

DATED: September 8, 2021

BARTKO ZANKEL BUNZEL & MILLER
A Professional Law Corporation

PATRICK M. RYAN
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By: /s/ Patrick E. O'Shaughnessy
Patrick E. O'Shaughnessy
Attorneys for Plaintiff
VHS LIQUIDATING TRUST

25-1167-cv

United States Court of Appeals

for the

Second Circuit

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiffs-Appellant,

- v –

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK, INC., *AS PROGRAM ADMINISTRATOR FOR THE EMPIRE PLAN MEDICAL / SURGICAL PROGRAM*, AND MULTIPLAN INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

JOINT APPENDIX VOLUME 6

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Preventing Inappropriate and Excessive Costs in the New York State Health Insurance Program

A Summary of Audits Identifying Out-of-Network Providers Engaged in Routine Waiving

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

2016-D-1 | MAY 2018

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Executive Summary

The New York State Health Insurance Program (NYSHIP), administered by the State Department of Civil Service (Civil Service), is one of the nation's largest public sector health insurance programs. NYSHIP covers over 1.2 million active and retired State, local government and school district employees, and their dependents. In 2017, NYSHIP cost the State, other government employers, and NYSHIP members $9.2 billion.

Members of NYSHIP have the opportunity to select various plans for coverage. The Empire Plan is by far the most popular plan, covering 1.1 million people, or 89 percent of NYSHIP's members, at an annual cost of $8.4 billion. Civil Service contracts with UnitedHealthcare (United) to administer the medical/surgical portion of the Empire Plan. United processes and pays medical and surgical claims submitted by health care providers on behalf of Empire Plan members. United contracts with a large network of health care providers who agree to be reimbursed at rates established by United. Members also pay a nominal co-payment to the in-network provider.

Empire Plan members may also choose to receive medical and surgical services from out-of-network providers. United's reimbursements for out-of-network services are usually higher than reimbursements for the same services provided in-network. Also, when Empire Plan members elect to use an out-of-network provider, they are required to pay higher out-of-pocket costs (deductibles and co-insurance). After members reach their annual deductible, United will generally reimburse the member 80 percent of the 'reasonable and customary' charge for the out-of-network service. The member remits United's payment to the provider, and is responsible for paying the remaining 20 percent.

In 2017, United processed claim payments totaling almost $2.9 billion. Of that amount, $1 billion (37 percent) was for out-of-network services.

Starting in 2007, the Office of the New York State Comptroller (OSC) conducted a series of audits to determine whether out-of-network providers routinely waived (did not collect) members' out-of-pocket costs. OSC found that this practice caused United to make overpayments on claims for out-of-network services.

Between 2007 and 2017, OSC completed 35 audits and found that 32 of 35 out-of-network providers routinely waived Empire Plan members' out-of-pocket costs, which caused $22.8 million in overpayments. Because a claim should reflect the provider's actual charge (the amount the provider intended to accept as payment-in-full) for the service, if an out-of-network provider waives a member's out-of-pocket costs, the provider should reduce its claim to United by the waived amount. Failing to do so can result in United paying 80 percent of an inflated charge.

To illustrate, a provider who charges $1,000 for a service and collects $800 in payments by United should collect $200 from the Empire Plan member. In the event that the provider does not collect (waives) the member's out-of-pocket

cost of $200, it has actually provided a medical service for $800, not $1,000, and United should have paid only $640 (80 percent of $800) of that cost, resulting in an overpayment of $160 ($800 - $640).

The submission of an insurance claim with false information, such as inaccurate service charges, may constitute insurance fraud pursuant to State Law. The State Insurance Department (now the New York State Department of Financial Services) has concluded that it may be a fraudulent billing practice and violation of the State Insurance Law when a provider routinely waives out-of-pocket cost obligations and accepts amounts from the insurer as payment-in-full. In November 2016, the Department of Health and Department of Financial Services sent a joint letter to New York State physicians reminding them that, by regulations, they must charge all patients the same price for the same service.

As a result of OSC's audits, the New York State Insurance Department conducted its own investigation into the issues identified by OSC, and in 2010 reported that New York State recouped over $11.5 million in restitution from 13 providers found to be routinely waiving members' out-of-pocket costs. In addition, some providers agreed to discontinue the practice of waiving and join the Empire Plan network, which has led to significant additional savings over the years subsequent to the audits. Between November 2016 and March 2017, OSC referred three audit reports to the Department of Financial Services to determine whether routine waiving would violate insurance law.

OSC's follow-up reviews of seven providers who joined the Empire Plan network as a result of the audits identified over $70 million in subsequent NYSHIP savings due to United paying the providers at in-network rates as opposed to higher out-of-network rates.

Recent trends show that the cost of providing out-of-network services under the Empire Plan is growing at a faster rate than in-network services: from 2012 to 2017, total annual out-of-network costs grew at a higher rate (38.9 percent) than in-network costs (26.4 percent), and average claim costs grew at a higher rate out-of-network (44.5 percent) than in-network (18.3 percent). Out-of-network providers who do not collect members' out-of-pocket costs negate Empire Plan members' financial incentive (lower out-of-pocket costs) to use in-network providers. Given that out-of-network services cost more compared to the same services provided in-network, waiving undermines the State's health insurance program and drives up health care costs for New York State taxpayers.

Based on our audit findings, we determined significant cost savings to NYSHIP would occur if more out-of-network providers who improperly waive members' out-of-pocket costs discontinued this practice and joined the Empire Plan network. Additionally, out-of-network providers who join the Empire Plan benefit plan members by expanding the number of in-network providers from which members can choose. We recommend that a course of action be taken to recover overpayments and prevent out-of-network providers from improperly waiving members' out-of-pocket costs.

Introduction

The Office of the New York State Comptroller (OSC) conducted a series of 35 audits from 2007 to 2017 that examined payments made by UnitedHealthcare (United) on behalf of the State for services provided by non-participating (out-of-network) medical providers to members of the Empire Plan of the New York State Health Insurance Program (NYSHIP). OSC's audits found out-of-network health care providers who routinely failed to collect ("waived") members' out-of-pocket costs, and OSC identified $22.8 million in overpayments for services rendered by 32 out-of-network providers as a result of this practice.

Additionally, OSC audits reported that out-of-network services are significantly more expensive compared to providing the same services in-network. Waiving cost-sharing obligations negates a member's incentive to use lower-cost in-network providers, which results in additional costs to the State. This practice drives up the cost of health care, risking higher premiums for members, while increasing costs for taxpayers who support these benefits. In fact, trends over the past several years (2012–2017) show that both total Empire Plan costs and average claim costs are growing at a faster rate for out-of-network services than for in-network services.

OSC determined significant savings can be achieved when providers who routinely waive members' out-of-pocket costs stop improper waiving and join the Empire Plan network. In the past, State insurance regulators examined providers engaged in routine waiving, and negotiated settlements in which providers agreed to refund overpayments and stop improper waiving. In addition, many providers subsequently joined the Empire Plan's participating (in-network) provider network.

Background

The New York State Health Insurance Program

NYSHIP was established in 1957 under the provisions of Chapter 461 of the Laws of 1956, which added Article 7 (renumbered Article 11) to the Civil Service Law. Outside of the federal government, NYSHIP is one of the largest public sector health insurance programs in the nation, covering over 1.2 million active and retired State, local government and school district employees, and their dependents. The New York State Department of Civil Service (Civil Service) is the State agency responsible for administering NYSHIP.

In 2017, NYSHIP cost the State, other government employers, and NYSHIP-covered members $9.2 billion. The Empire Plan, the primary health plan option in NYSHIP, accounted for $8.4 billion of this cost, and several health maintenance organization (HMO) options accounted for the remaining costs at $823 million. For the Empire Plan, the State's share of these costs was $4.3 billion and other government employers' share was about $4.1 billion.

Currently, New York State government employers pay a share of members' health insurance premiums, and members pay the balance. For example, for many employees, the State pays 84 percent of the cost of their coverage and 69 percent of the cost of their dependents' coverage.[1]

The Empire Plan

As of December 2017, the Empire Plan covered 1.1 million members, or 89 percent of NYSHIP's members, including about 281,000 active employees, about 224,000 retirees, and about 551,000 dependents. The remaining 11 percent of NYSHIP members were covered through various HMOs.

The Empire Plan provides its members with four types of health insurance coverage: medical/surgical, hospital, prescription drugs, and mental health and substance abuse. To administer the Empire Plan, Civil Service contracts with four vendors, one for each type of coverage. Each vendor is responsible for establishing a network of participating providers, establishing reimbursement rates, processing and paying claims from both participating and non-participating providers, and ensuring compliance with the requirements of the Empire Plan. Under the Empire Plan, each vendor is reimbursed by Civil Service for the claims they process and pay. Additionally, Civil Service pays each vendor an administrative fee.

1 The Public Employees Federation, AFL-CIO and the State of New York Professional, Scientific and Technical Services Unit, 2011-2015 Agreement, Article 9 (Health Insurance), 9.2 (h).

Civil Service contracts with United to administer the medical/surgical portion of the Empire Plan. Medical/surgical benefits cover a range of services including, but not limited to: office visits, surgery, diagnostic testing, physical therapy, chiropractic services, home care services, and durable medical equipment. United processes and pays claims for these services to, or on behalf of, Empire Plan members. In 2017, United made Empire Plan claim payments totaling almost $2.9 billion. Within United's Empire Plan participating provider network, members have access to a wide choice of health care professionals in various specialties. United contracts with in-network health care providers who agree to accept payments at rates established by United to furnish medical services to Empire Plan members. United remits payments directly to in-network providers based on claims submitted for services provided. Members pay a nominal co-payment amount to the in-network provider for the services rendered.

Empire Plan members may also choose to receive services from out-of-network providers. United's payments for out-of-network provider services are generally higher than the rates in-network providers agree to accept for the same services. If a member decides to select an out-of-network provider, the member is required to pay significantly higher out-of-pocket costs (deductibles and co-insurance). This cost-sharing arrangement is designed to serve as a disincentive for selecting out-of-network providers. Once members reach their annual deductible amount, United will generally reimburse the member 80 percent of the claim, and the patient is responsible for paying the provider for the service, including any out-of-pocket costs owed. In 2017, United paid $1 billion (37 percent of United's total payments) for out-of-network services.

United bases its payments of out-of-network provider claims on the reasonable and customary charge (R&C) for the service. The R&C charge is the lowest of the provider's actual charge for the service, the provider's usual charge for the same or similar service, or the usual charge of other providers in the same or similar geographic area for the same or similar service.

How Does Waiving Work?

In accordance with the Empire Plan's requirements, when United processes claims for services by an out-of-network provider, it is with the understanding that members are liable for a portion of the claimed amount, representing the members' out-of-pocket cost obligations. Waiving occurs when an out-of-network provider fails to collect or pursue collection of a member's out-of-pocket costs—such as deductibles and co-insurance.

An out-of-network provider's claim to United should reflect the provider's actual charge for the service (the amount the provider intends to accept as payment-in-full). After the member meets his or her annual deductible, United pays 80 percent of the R&C charge. However, if a provider waives the member's portion of the charge and accepts United's payment as payment-in-full, and the claim to United does not reflect the provider's actual (reduced) charge for the service, United is at risk for making an overpayment based on an inflated charge stated on the claim.

To illustrate, an out-of-network provider submits a claim to United, charges $1,000 for a service, collects $800 in payments by United (or 80 percent of $1,000), and should collect $200 from the Empire Plan member as the member's out-of-pocket co-insurance. However, if the provider waives the member's out-of-pocket cost of $200 and accepts United's $800 payment as payment-in-full, the provider's actual charge is $800, not $1,000, and United should only pay $640 of that charge (or 80 percent of $800). In this example, United would have made an overpayment on the claim of $160 ($800 - $640).

A 2016 OSC audit of an orthopedic provider (2015-S-29) illustrates an actual instance of waiving identified by OSC auditors:

> *The provider charged $19,289 on a claim, which United used as the basis for allowing $8,665 as the reasonable and customary rate for the service. As a result, United paid $6,932 (80 percent of $8,665) on the claim and the member's out-of-pocket portion of the claim should have been $1,733 (20 percent of $8,665). However, the provider accepted the $6,932 as payment-in-full and waived the $1,733 due from the member. The provider wrote off the $1,733 as an "Insurance Adjustment." Because the provider accepted $6,932 as the full payment, United should have only paid $5,546 (80 percent of $6,932) on the claim. This resulted in an overpayment by United of $1,386 ($6,932 - $5,546).*

The following scenario demonstrates waiving from the perspective of an Empire Plan member:

An Example of Out-of-Network Waiving

Bob, a 45-year-old man enrolled in the Empire Plan, needs a common knee surgery.

Bob goes to a local orthopedic surgeon for the operation.

Bob has his knee surgery. His surgeon is an out-of-network provider.

Bob's doctor's office submits a claim to United for $10,000. United processes and pays the claim on behalf of the Empire Plan member.

United processes the claim, allowing $10,000 for the procedure. After applying Bob's required 20% co-insurance, United issues a check to Bob for $8,000 as reimbursement for the cost of the operation.

Bob gets United's $8,000 check in the mail.

Waiving

Bob remits the $8,000 payment from United to his surgeon. The surgeon waives Bob's required $2,000 out-of-pocket co-insurance.

The surgeon credits Bob's account for $8,000.

The surgeon does not collect Bob's out-of-pocket-costs ($2,000).

No further billing activity occurs.

Had the provider submitted a claim to United for its actual charge of $8,000, United would have paid $6,400 (80% of $8,000) instead of $8,000 (80% of $10,000) and avoided an overpayment of $1,600.

Non-Waiving

Bob remits the $8,000 payment from United to his surgeon. Bob uses his personal funds to pay the remaining $2,000 out-of-pocket costs (his co-insurance) to his surgeon.

The doctor credits Bob's account for $10,000.

No further billing activity occurs.

Note: The In-Network Alternative

Had Bob gone to a surgeon who was in the Empire Plan's network, United would have paid a lower rate ($3,000 for example, as opposed to $8,000) and Bob's out-of-pocket costs (co-payment) would have been $20.

Results from OSC Audits

Pursuant to the State Comptroller's authority under Article V, Section I of the State Constitution and Article II, Section 8 of the State Finance Law, OSC regularly conducts audits on all aspects of NYSHIP, including claim payments made under the Empire Plan. In 2009, two out-of-network health care providers challenged the Comptroller's authority to examine their billing records in connection with the Comptroller's audits of United's payments for services provided to Empire Plan members. During several years of litigation, OSC suspended its audits of United's payments for out-of-network services. However, in May 2014, the New York State Court of Appeals affirmed the Comptroller's authority to examine the billing records of out-of-network providers, and OSC resumed its audits.[2]

1. Audits Found Providers Routinely Waived Empire Plan Members' Out-of-Pocket Costs

Between 2007 and 2017, OSC conducted a series of 35 audits of United's payments for out-of-network services to determine whether out-of-network providers routinely waived Empire Plan members' out-of-pocket costs, resulting in excess payments for claims. These audits found out-of-network providers have systemically waived members' out-of-pocket cost-sharing obligations: 32 of the 35 providers routinely waived Empire Plan members' cost-sharing obligations. See Appendix A for a complete list of OSC waiving audits and findings.

2. Audits Identified Substantial Overpayments

Between 2007 and 2017, OSC's audits have found $22,796,368 in overpayments on out-of-network providers' claims.

To determine the amount of overpayments, auditors reviewed claims for out-of-network services. Auditors selected random samples of claims, reviewed the providers' financial records for those claims, and determined if the providers waived all or a portion of the Empire Plan members' out-of-pocket costs.

Auditors then analyzed the overpaid claims in more detail. In some cases, providers wrote off the outstanding balances (i.e., members' out-of-pocket cost obligations) from the patients' accounts. In other cases, providers' patient account records indicated the members had an outstanding balance due, but upon closer examination auditors found that many of the balances had been outstanding for several years. Furthermore, the providers' financial records did not note attempts to collect the outstanding balances on these claims, indicating the providers likely intended to accept the amounts already paid by United as payment-in-full, and effectively waive the outstanding balances.

2 *Handler, M.D., P.C. v. DiNapoli*, 23 N.Y.3d 239 (2014).

A 2016 audit of an orthopedic provider (2015-S-29) illustrates this issue. OSC auditors found the provider waived the members' out-of-pocket costs on 176 of 215 (82 percent) of the sampled claims. For 130 of the 176 claims (74 percent), the provider wrote off the members' out-of-pocket costs. For the remaining 46 overpaid claims, the provider's patient account records indicated the members had an outstanding balance due. However, auditors determined 83 percent (38 of 46) of the claims in question had been outstanding for a year or more. Auditors' review of the provider's financial records found no attempt to collect the outstanding balances, indicating that the provider likely intended to accept the amounts already paid as payment-in-full, and effectively waive the outstanding balances for the 46 claims. See Table 1.

TABLE 1

Breakdown of Outstanding Balances in OSC Audit: 2015-S-29		
Length of Time That Balance Was Outstanding From Date of Service Until Audit	**Number of Claims**	**Percentage of Claims**
Less than one year	8	17%
Between one and two years	23	50%
Between two and three years	12	26%
More than three years	3	7%
Total Number of Sampled Claims With Outstanding Balances	**46**	**100%**

3. Audit Concludes Out-of-Network Services Are Significantly More Expensive

New York State has seen significant increases in the cost of providing health care for government employees under the Empire Plan, with increases of over $1.8 billion from 2010 through 2016 according to the Empire Plan's Annual Financial Settlement Reports. It's apparent that out-of-network costs are contributing to this significant increase more than in-network costs. A 2009 OSC audit, *Cost of Out-of-Network Benefits* (2009-S-34), determined that out-of-network services generally cost more than in-network services. As shown in Table 2, out-of-network services continue to be more costly than in-network services. As the table shows, United's average payment for out-of-network services was nearly three times the average payment for in-network services in 2017.

TABLE 2

Comparison of United's In-Network and Out-of-Network Payments for 2017			
	In-Network	**Out-of-Network**	**Total**
Number of Claims Submitted to United	19,342,288	3,828,659	23,170,947
Total Amount Paid	$1,803,782,356	$1,058,053,342	$2,861,835,698
Average Amount Paid	$93	$276	$124

In addition, audit 2009-S-34 also found that the costs of out-of-network services were increasing at a faster rate than those of in-network services. For example, the audit found that the average cost of an out-of-network procedure increased from $49 to $89 from 2001 to 2008 compared to an increase of $36 to $42 for the average cost of an in-network procedure for the same time period.

OSC's subsequent analysis of United's aggregate spending shows that this trend has continued. From 2012 to 2017, the annual costs of out-of-network services grew at a higher rate (38.9 percent) than in-network costs (26.4 percent), and average claim costs grew at a higher rate out-of-network (44.5 percent) than in-network (18.3 percent).

Auditors found that a primary factor that contributed to this significant cost differential is the manner in which out-of-network providers are reimbursed for their services. Under the Empire Plan, when a member chooses to use an in-network provider, United pays providers at contracted rates set by United. When a member chooses an out-of-network provider, United bases the reimbursement for services upon R&C rates. Because R&C rates are often significantly higher than the rates United pays to in-network providers, out-of-network services are more costly for the State. Taken from 2009-S-34, Table 3 illustrates in-network and out-of-network payment disparities and subsequent costs to the State.

TABLE 3

Higher Costs of Out-of-Network Procedures According to 2009 OSC Audit			
Procedure	**Out-of-Network Payment**	**Amount that Would Have Been Paid In-Network**	**Additional Cost for Using Out-of-Network Providers**
Procedure A	$34,244,806	$9,378,257	$24,866,549
Procedure B	$6,214,917	$2,021,191	$4,193,726
Procedure C	$6,594,639	$2,490,442	$4,104,197
Procedure D	$7,483,563	$3,934,019	$3,549,544
Procedure E	$6,183,474	$2,776,697	$3,406,777
Procedure F	$3,982,245	$596,463	$3,385,782

The audit found that savings could be achieved by taking steps to reduce the Empire Plan's out-of-network utilization. Elective non-emergency services by out-of-network providers represented over 92 percent of out-of-network expenditures. However, the audit also found there was virtually no shortage of in-network providers. Had the out-of-network services been delivered by in-network providers, costs could have been reduced by approximately $212 million (based on 100 percent in-network utilization). However, it is unrealistic to expect that all of these procedures would have been done with in-network providers. In 2009, the utilization rate of out-of-network services by Empire Plan members was 7.7 percent. We determined that some of United's other (non-NYSHIP) plans were able to keep their out-of-network utilization for these procedures as low as 3.2 percent. We therefore estimated annual cost savings of about $124 million if the rate of members' out-of-network utilization was reduced to 3.2 percent for the medical/surgical component of the Empire Plan.

Impact of OSC Audits

1. Routine Waiving Circumvents a Key Cost Control and Increases Health Care Costs

OSC's audits concluded that waiving members' out-of-pocket costs and accepting reimbursement amounts from the insurer as payment-in-full allows out-of-network providers to increase revenues significantly by negating Empire Plan members' financial incentive (i.e., lower out-of-pocket costs) to use in-network providers. This practice undermines the State's health insurance program and drives up health care costs for Empire Plan members and taxpayers.

To illustrate, for a common chest surgical procedure in 2017, United's average in-network reimbursement amount was $1,381, and members were responsible for a nominal co-payment, generally $20. In contrast, for the same procedure performed by an out-of-network provider, United's average reimbursement amount was $15,593 (over 11 times United's in-network payment), and members' average out-of-pocket costs were $1,062. If an out-of-network provider waives a member's out-of-pocket costs, the member's incentive to use an in-network provider is negated. Additionally, if the submitted claim is inflated by failing to show the waived out-of-pocket costs, the costs for NYSHIP, which are ultimately borne by taxpayers, are increased.

2. Significant Savings Result When Providers Join the Network

OSC's audits found the State achieves significant savings when out-of-network providers stop improper waiving and join the Empire Plan network. In 2010, OSC conducted follow-up reviews of five audits in which providers were found to be routinely waiving—four audits were issued in December 2007 and one was issued in February 2008. All five providers agreed to pay restitution and subsequently joined the Empire Plan network in 2008. OSC auditors estimated the Empire Plan realized recurring annual cost savings of $5.6 million as a result of the five providers joining the network, with cumulative cost savings of $53.5 million through the end of 2017.[3] See Table 4 for a summary of these five audits.

3 These savings were achieved due to United reimbursing providers at the lower in-network reimbursement rates. To estimate these savings, we calculated the difference between each provider's average claim cost in the year prior to joining the Empire Plan network and in the year after joining the network, and then multiplied each provider's average cost by their number of claims in the year after joining. This analysis was conducted between 2007 and 2015.

TABLE 4

Summary of Five OSC Audits and Analysis of Savings After Out-of-Network Providers Joined the Empire Plan				
Audit Report	**Audit Overpayment**	**Restitution Paid**	**Estimated Annual Savings After Provider Joined the Network**	**Estimated Cumulative Savings Through 12/2017**
2007-S-72, 2010-F-6	$2,412,416	$2,225,015	$1,478,084	$14,288,145
2007-S-87, 2010-F-7	$1,456,947	$1,332,120	$677,760	$6,438,720
2007-S-120, 2010-F-8	$1,461,856	$1,162,232	$362,917	$3,447,712
2007-S-86, 2010-F-9	$1,413,548	$1,165,000	$2,096,823	$19,570,348
2007-S-73, 2010-F-10	$2,686,856	$3,135,834	$996,272	$9,713,652
Total annual savings			**$5,611,856**	
Total cumulative savings				**$53,458,577**

In addition to the five providers, thirteen other providers joined the Empire Plan network (for a total of 18 of 32 providers which OSC found to be improperly waiving Empire Plan members' out-of-pocket costs). Our review of two providers who joined the Empire Plan network in 2017 found that this will result in an estimated $18.2 million in savings for NYSHIP over the following five-year period. We believe that additional savings—likely in the tens of millions of dollars—has occurred as a result of the remaining eleven other providers who joined the network, but which were not included in a follow-up analysis.

3. Routine Waiving May Violate State Insurance Law

OSC's audits concluded that providers who routinely waive out-of-pocket costs and inflate their billed amounts submitted to United by the amount of the waived member out-of-pocket costs, causes United to make excessive payments on these claims. The submission of an insurance claim with false information, such as inflated billed amounts, may constitute insurance fraud and violate the State Insurance Law.

In 2005, the Office of General Counsel of the New York State Insurance Department (currently the Department of Financial Services) issued an opinion stating that if a health care provider made waiving a common business practice, the health care provider may be guilty of insurance fraud.[4] In 2008, the Office of General Counsel issued an additional opinion stating that, depending on the circumstances, the waiver of otherwise applicable co-payments could constitute insurance fraud.[5]

In its 2009 annual report, the State Insurance Department strongly supported OSC's audits and the State Insurance Department conducted its own investigation into the issues identified by OSC.[6] As a result, New York State recouped $11,546,457 in restitution from 13 providers found to be routinely waiving and imposed $124,000 in fines through stipulations the State Insurance Department negotiated with these providers, as reported in the 2009 annual report. In addition, the providers agreed to discontinue the practice of waiving. Moreover, the State Insurance Department's support helped United bring many of the providers into the Empire Plan's participating provider network.

OSC suspended waiving audits in 2009 after litigation challenged the Comptroller's authority to examine out-of-network providers' billing records. Likewise, the State Insurance Department did not reach stipulations with any additional providers found to be routinely waiving by OSC audits. In May 2014, the New York State Court of Appeals affirmed the Comptroller's audit authority, and OSC has resumed its audits.

Between November 2016 and March 2017, OSC referred three audit reports to the Department of Financial Services to investigate the commission of fraudulent insurance activity and, if warranted, to take appropriate action to recoup overpayments. A renewed effort by the Department of Financial Services to seek additional recoveries and compel out-of-network providers to cease improper waiving and join the Empire Plan network could result in significant savings.

In November 2016, the Department of Financial Services and the Department of Health issued a joint letter to New York State physicians. The letter reminded physicians of the rules related to billing for patient co-insurance, and noted that routinely waiving co-insurance may be considered insurance fraud. Moreover, billing a patient's insurer for waived co-insurance is considered to be a fraudulent practice (see Appendix B).

4 New York State Insurance Department, Office of General Counsel, Opinions, Re: Co-Payment and Deductible, Waivers, April 8, 2005 at http://www.dfs.ny.gov/insurance/ogco2005/rg050407.htm.
5 New York State Insurance Department, Office of General Counsel, Re: Health Insurance, Waiver of Deductibles and Co-Insurance at http://www.dfs.ny.gov/insurance/ogco2008/rg080404.htm.
6 The Annual Report of the Superintendent of Insurance on the Activities of the Insurance Department to Investigate and Combat Health Insurance Fraud, 2009 Report, Section V, The Year in Review, Part B. Waiver of Co-Insurance, page 13 at http://www.dfs.ny.gov/reportpub/fraud/fd09hlthrp.pdf.

Tables 5 summarizes OSC's audit findings and the results of the State Insurance Department's investigation as of 2010:

TABLE 5

Summary of OSC Audit Findings and the State Insurance Department's Investigation							
Litigation Status	**Year Audit Report Issued**	**OSC Audits Issued**	**Total Overpayments**	**Providers Found Routinely Waiving**	**Providers Who Paid Restitution**	**Overpayments Recovered (Restitution)**	**Providers Who Joined the Empire Plan Network**
Pre-Litigation	2007	4	$7,969,767	4	4	$7,857,969	4
	2008	19	$5,828,284	17	8	$3,557,843	9
	2009	4	$2,423,669	4	1	$130,645	1
	2010	1	$0	0	0	$0	0
Totals		**28**	**$16,221,720**	**25**	**13**	**$11,546,457**	**14**

During 2016–2017, OSC issued seven audit reports that identified overpayments totaling $6,574,648. All seven providers were found to be improperly waiving out-of-pocket costs. As of December 2017, four of those providers have joined the Empire Plan network. See Appendix A for a complete list of waiving audits and a summary of key audit findings.

Conclusion

The cost of health care is a national concern. According to the National Conference of State Legislatures (NCSL), U.S. health care spending reached $3 trillion in 2014, accounting for 17.5 percent of the nation's gross domestic product.[7] Furthermore, the NCSL found health care spending is projected to grow faster than average economic growth for the period from 2013 through 2023, with the health care share of the gross domestic product expected to rise to 19.3 percent in 2023.

It is critical that New York State pursue all avenues to mitigate health care costs and lower Empire Plan premiums. Waiving, however, drives up costs, which can lead to higher premiums. Recent OSC audits found that out-of-network providers continue to routinely waive members' out-of-pocket costs, submitting inflated claims and causing overpayments. With health care costs on the rise, should waiving continue unabated, its impact will continue to add to rising costs for the State and local governments, their employees, and, ultimately, New York's taxpayers. Waiving also impacts consumer choice. When more out-of-network providers join the Empire Plan network, members have a greater number of in-network providers from which to choose.

The State Insurance Department examined providers based on prior OSC audits, and was successful in reaching settlement agreements with providers. As a result, overpayments were recovered, providers agreed to stop improper waiving, and several providers joined the Empire Plan's network of participating providers. In 2016 and 2017, OSC issued seven additional audits of United's payments for out-of-network services which identified about $6.6 million in overpayments.

OSC is moving to coordinate efforts with other oversight agencies and address the problem of improper waiving. OSC offers the following recommendations for consideration.

7 Health Finances Issues 12/2/2015 at http://www.ncsl.org/research/health/health-finance-issues.aspx.

Recommendations

To the New York State Department of Financial Services:

Continue efforts to help recover overpayments identified in OSC waiving audits and compel out-of-network providers to discontinue the practice of improperly waiving Empire Plan members' out-of-pocket costs.

To UnitedHealthcare:

Recover overpayments from providers found through OSC audits to be improperly waiving and refund the State accordingly.

Work with the Department of Civil Service to pursue an appropriate course of action designed to prevent out-of-network providers from improperly waiving Empire Plan members' out-of-pocket costs. This may include, but not be limited to: monitoring out-of-network providers' billing practices, educating providers about the consequences of improper waiving, recovering overpayments as appropriate, and taking steps to bring out-of-network providers into the Empire Plan's participating provider network.

Appendix A: Summary of OSC Audits from 2007 to 2017 in Descending Order by Overpayment

Report #	Date Issued	OSC Overpayment	Joined Network	Date Joined
2007-S-73	12/3/2007	$2,686,856	Yes	4/1/2008
2007-S-72	12/3/2007	$2,412,416	Yes	5/1/2008
2007-S-120	2/8/2008	$1,461,856	Yes	7/1/2008
2007-S-87	12/3/2007	$1,456,947	Yes	7/1/2008
2007-S-86	12/3/2007	$1,413,548	Yes	9/4/2008
2015-S-53[1]	5/5/2016	$1,378,178	Yes	2/2/2017
2014-S-70	5/5/2016	$1,258,855	No	N/A
2015-S-54	5/5/2016	$1,100,655	No	N/A
2008-S-11	4/24/2008	$1,004,415	Yes	2/1/2009
2009-S-23	11/19/2009	$903,563	No	N/A
2015-S-28	5/5/2016	$890,931	Yes	6/1/2017
2015-S-29[2]	5/5/2016	$872,373	Yes	5/1/2015
2008-S-173	5/5/2009	$787,134	No	N/A
2008-S-43	9/30/2008	$744,055	No	N/A
2008-S-28	9/30/2008	$624,278	Yes	12/1/2008
2016-S-17[3]	9/8/2016	$566,126	No	N/A
2009-S-24	11/19/2009	$542,317	Yes	3/1/2006
2008-S-44	9/30/2008	$507,786	Yes	2/1/2009
2016-S-8	3/1/2017	$507,530	Yes	11/1/2017
2008-S-33	9/30/2008	$214,520	Yes	6/1/2011
2008-S-32	9/30/2008	$200,216	No	N/A
2009-S-22	11/19/2009	$190,655	No	N/A
2008-S-34	9/30/2008	$178,633	No	N/A
2008-S-41	9/30/2008	$177,610	No	N/A
2008-S-35	9/30/2008	$140,656	Yes	5/1/2010
2008-S-39	9/30/2008	$117,451	No	N/A
2008-S-42	9/30/2008	$117,160	No	N/A
2008-S-30	9/30/2008	$104,202	Yes	1/1/2010
2008-S-36	9/30/2008	$98,418	Yes	5/1/2010
2008-S-40	9/30/2008	$77,946	No	N/A
2008-S-37	9/30/2008	$48,213	No	N/A
2008-S-10	9/30/2008	$10,869	No	N/A
2008-S-29	9/30/2008	$0	No	N/A
2008-S-31	9/30/2008	$0	Yes	4/1/2012
2009-S-98	2/10/2010	$0	No	N/A
2010-F-6	4/19/2010			
2010-F-7	4/19/2010			
2010-F-8	4/19/2010			
2010-F-9	4/19/2010			
2010-F-10	4/19/2010			
Totals		**$22,796,368**	**18**	

Referred to the New York State Department of Financial Services on [1]December 23, 2016; [2]March 1, 2017; and [3]November 28, 2016.

Appendix B: Department of Health and Department of Financial Services Letter to Physicians

NEW YORK STATE | Department of Health | Department of Financial Services

Howard A. Zucker, MD, JD
Commissioner

Maria T. Vullo
Superintendent

November 9, 2016

Dear New York State Physicians:

The Department of Financial Services (DFS) and New York State Department of Health (Department) have worked with all stakeholders – consumers, insurers, health care providers and practitioners – to ensure that New York's health insurance market is among the most robust in the nation.

Part of maintaining a robust market is making sure that all participants are playing by the same set of rules. We send this notice to remind all physicians of the rules related to billing for patient co-payment or co-insurance.

Providers are required by financial services regulations to charge all patients the same price for the same services, including the patient's co-payment or co-insurance. In some instances a provider may, due to unique circumstances, decide to waive a co-payment or co-insurance.

A physician may understandably and rightly occasionally waive a co-payment or co-insurance for an indigent patient, for example, or decide that prosecuting a patient for a co-payment or co-insurance is not cost effective. Routinely waiving co-payments or co-insurance, depending upon all of the facts and circumstances, may be considered insurance fraud. Furthermore, billing a patient's insurer for a waived co-payment or co-insurance is also considered to be fraudulent practice. Any physician who is determined to have engaged in fraudulent practice may be subject to professional misconduct penalties, including, but not limited to, revocation of his/her medical license. A patient misrepresenting a claim submitted for a co-payment or co-insurance that has been waived, is similarly at risk of committing insurance fraud.

DFS and the Department strongly encourage all physicians to review their current policies and practices related to patient co-payment and co-insurance and to ensure compliance with laws, regulations, and rules.

Sally R. Dreslin, M.S., R.N.
Executive Deputy Commissioner
New York State Department of Health

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiff,

v.

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM, MULTIPLAN INC.,

Defendants.

MEMORANDUM & ORDER
22-CV-04040 (HG)

HECTOR GONZALEZ, United States District Judge:

Defendants[1] have moved to dismiss Plaintiff's complaint, which asserts antitrust and unjust enrichment claims based on allegations that Defendants are using their market power to force out-of-network anesthesia practices in the New York metropolitan area to accept dramatically lower reimbursement rates for services provided to patients insured by the Empire Plan. ECF No. 1 (Complaint). For the reasons set forth below, the Court grants Defendants' motions to dismiss in full. *See* ECF Nos. 30 & 31 (Defendants' Motions to Dismiss).

FACTUAL BACKGROUND

Plaintiff Long Island Anesthesiologists PLLC ("LIA") is a private anesthesia services provider located in Suffolk County, New York. ECF No. 1 ¶¶ 1, 19. LIA provides anesthesia

[1] Although the docket lists The Empire Plan Medical/Surgical Program as a defendant, the Court's understanding is that Plaintiff's intent in its case caption was to name as a defendant United Healthcare Insurance Company of New York Inc., in its role as Program Administrator of the Empire Plan Medical/Surgical Program. Additionally, Plaintiff has only served United Healthcare Insurance Company of New York Inc. and Multiplan Inc. *See* ECF Nos. 3–4. Accordingly, references in this Order to "Defendants" refer to United Healthcare Insurance Company of New York Inc. and Multiplan Inc.

services to patients at Good Samaritan Hospital Medical Center in West Islip, New York, and at other physician offices and surgery centers throughout the New York metropolitan area. *Id.* ¶¶ 1, 19, 24. LIA, like many anesthesiology practices in the New York metropolitan area, has an out-of-network relationship with most health insurance providers. *Id.* ¶¶ 36–38. Defendant UnitedHealthcare Insurance Company of New York Inc. ("United") is a health insurer and health plan provider and a subsidiary of UnitedHealth Group Incorporated ("UHG"), a multi-national managed healthcare and insurance company and the world's second largest healthcare company by revenue. *Id.* ¶¶ 2–3, 39–43. United is also the administrator of the Empire Plan, a health plan in which roughly 1.2 million public-sector employees in the New York metropolitan area are enrolled. *Id.* ¶¶ 2–3, 64–71. Approximately 40% of LIA's revenue comes from the Empire Plan and LIA estimates that the Empire Plan makes up a similar share of revenue for other anesthesia groups in the New York metropolitan area. *Id.* ¶¶ 3, 78–79. Although Plaintiff's complaint does not include specific details about Defendant MultiPlan Inc. ("MultiPlan"), MultiPlan provides billing support services to United. ECF No. 30-1 (MultiPlan Motion to Dismiss) at 2.[2]

According to LIA, prior to January 2022, the Empire Plan reimbursed out-of-network physicians at amounts approximating the usual, customary, and reasonable ("UCR") rate for medical services in the geographic area in which the services were provided. ECF No. 1 ¶ 72. This practice did not change when, in March 2015, the Empire Plan began using the independent dispute resolution ("IDR") process established by the New York Surprise Bill Law to settle reimbursement disputes between health plans and out-of-network physicians. *Id.* ¶¶ 81–90.

[2] Because this fact is not alleged in the complaint, the Court is only setting it forth here to provide background on MultiPlan. It is not a necessary fact that affected the Court's decision.

However, in January 2022, after the Federal No Surprises Act took effect,[3] LIA alleges that the Empire Plan decreased the rates at which it reimbursed out-of-network providers by more than 80% after determining that it was not bound by the New York Surprise Bill Law. *Id.* ¶¶ 4, 94–117.

Plaintiff alleges that after the Empire Plan determined that it was not covered by the New York Surprise Bill Law's IDR process, MultiPlan began to communicate with LIA and other anesthesiology providers, identifying itself as working with United, in an effort to pressure providers into accepting the lower reimbursement rates offered by MultiPlan. *Id.* ¶¶ 4, 123–30. In these communications, MultiPlan allegedly demanded rapid response times and requested onerous and detailed documentation from providers related to reimbursement claims. *Id.* ¶¶ 125–33. Plaintiff alleges that these communications are designed to force anesthesia providers to abandon their challenges to the Empire Plan's newly-decreased reimbursement rates and that the tactic has been effective because practices lack the resources to pursue challenges to the reimbursement amounts. *Id.* ¶ 132–33.

According to LIA, the lower reimbursement rates will decrease the availability of high-quality anesthesia services in the New York metropolitan area and hamper the ability of out-of-network practices to recruit and retain new talent. *Id.* ¶¶ 5, 135–37. Because of United's size and market share, LIA alleges that its decision to lower the Empire Plan's reimbursement rate for anesthesia services will cause a significant number of anesthesia practices to leave the relevant market by going out of business or being forced to sell their practices. *Id.* ¶¶ 7, 143–46. LIA also alleges that lower reimbursement rates will force patients with high-deductible plans or

[3] According to Plaintiff, the IDR process under the Federal No Surprises Act provides for reimbursement at a substantially lower rate than the UCR. *Id.* ¶¶ 115–16.

plans with large cost-sharing requirements for out-of-network services to pay significantly more for medically necessary services. *Id.* ¶ 147.

LIA claims that United's actions in reducing reimbursement rates and pressuring anesthesia providers to accept these lower rates are intended to force anesthesia providers out of business to the benefit of another UHG subsidiary, Optum, which, through its OptumCare business, employs physicians, including anesthesia providers. *Id.* ¶¶ 7, 46–55, 142–44. According to LIA, OptumCare employs more than 50 anesthesiologists in the New York metropolitan area. *Id.* ¶ 54.

Plaintiff asserts five causes of action. First, it alleges that United and MultiPlan have engaged in an antitrust conspiracy to restrain trade in violation of Section 1 of 15 U.S.C. § 1 (the "Sherman Act"). ECF No. 1 ¶¶ 183–87. Next, LIA asserts that United possesses monopsony[4] power in the relevant market, that it is willfully maintaining that power through anticompetitive conduct, and that it is leveraging that power to gain an anticompetitive advantage in the relevant market, in violation of Section 2 of the Sherman Act. *Id.* ¶¶ 188–92. Third, LIA asserts that United has engaged in predatory or anticompetitive conduct in an attempt to acquire monopsony power and that it has a dangerous probability of achieving monopsony power, in violation of Section 2 of the Sherman Act. *Id.* ¶¶ 193–97. Fourth, LIA asserts that United and MultiPlan have engaged in an antitrust conspiracy to restrain trade in violation of New York's General Business Law §§ 340, *et seq*. (the "Donnelly Act"). *Id.* ¶¶ 198–203. Finally, LIA asserts that United and MultiPlan were unjustly enriched at LIA's expense by receiving fees and retaining reimbursement through their improper scheme. *Id.* ¶¶ 204–09.

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[4] A monopsony is a market dominated by a single buyer who controls the market. *See* Monopsony, Black's Law Dictionary (11th ed. 2019).

LEGAL STANDARD

A complaint must plead "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007).[5] "A claim is plausible 'when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.'" *Matson v. Bd. of Educ.*, 631 F.3d 57, 63 (2d Cir. 2011) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). "The purpose of a motion to dismiss for failure to state a claim under Rule 12(b)(6) is to test the legal sufficiency of [p]laintiff'[s] claims for relief." *Amadei v. Nielsen*, 348 F. Supp. 3d 145, 155 (E.D.N.Y. 2018). Although all allegations contained in a complaint are assumed to be true, this tenet is "inapplicable to legal conclusions." *Iqbal*, 556 U.S. at 678.

DISCUSSION

The Court dismisses each of Plaintiff's claims for the reasons described more fully below. Plaintiff has not sufficiently alleged an antitrust injury. Accordingly, Plaintiff's Sherman Act Section 1 claim alleging an antitrust conspiracy against United and MultiPlan and Plaintiff's Sherman Act Section 2 claim against United related to allegations of monopsony power are dismissed. Plaintiff's Sherman Act Section 1 claims against both Defendants are also dismissed because Plaintiff fails to state a plausible claim against MultiPlan. Finally, after dismissing Plaintiff's federal claims, the Court declines to exercise supplemental jurisdiction over Plaintiff's Donnelly Act and unjust enrichment claims.

[5] Unless noted, case law quotations in this order accept all alterations and omit internal quotation marks, citations, and footnotes.

I. Plaintiff's Sherman Act Claims Against United and MultiPlan

Plaintiff asserts three Sherman Act claims against United and one Sherman Act claim against MultiPlan. First, Plaintiff claims that United and MultiPlan engaged in an antitrust conspiracy to restrain trade in violation of Section 1 of the Sherman Act. ECF No. 1 ¶¶ 183–87. Next, Plaintiff alleges that United violated Section 2 of the Sherman Act because it possesses monopsony power that it is willfully maintaining through anticompetitive conduct. *Id.* ¶¶ 188–92. And, finally, Plaintiff alleges that United violated Section 2 of the Sherman Act because it has engaged in predatory or anticompetitive conduct in an attempt to acquire monopsony power. *Id.* ¶¶ 193–97.[6]

A. Plaintiff's Sherman Act Claims Against United and MultiPlan Fail Because Plaintiff Has Not Sufficiently Alleged Antitrust Injury

In an antitrust case, a private plaintiff must have constitutional standing under Article III, as well as antitrust standing. *See Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 535 n. 31 (1983). Antitrust standing is "a threshold, pleading-stage inquiry and when a complaint by its terms fails to establish this requirement [the court] must dismiss it as a matter of law." *Gatt Commc'ns Inc. v. PMC Assocs. L.L.C.*, 711 F.3d 68, 75 (2d

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[6] United also argues that Plaintiff's complaint should be dismissed or stayed under the *Colorado River* abstention doctrine and that Plaintiff's antitrust claims fail because the Empire Plan is not subject to New York's Surprise Bill Law. ECF No. 31-1 at 8–13. According to United, whether the Empire Plan is subject to New York's Surprise Bill Law or required to follow the Federal No Surprises Act is a threshold question on which the Court should abstain from ruling until the declaratory judgment action in New York Supreme Court regarding the same question is resolved. In supplemental letters submitted by the parties after the motions were briefed, the parties note that the New York Supreme Court has issued an opinion in the declaratory judgment action, which Plaintiff is appealing. ECF Nos. 48 & 49 (Supplemental Letters). However, because the Court finds that Plaintiff has not sufficiently pled antitrust injury regardless of whether the New York or Federal law controls the Empire Plan's reimbursements and because the parties have not briefed what, if any, preclusive effect they believe the New York Supreme Court's ruling has on this case, the Court does not need to reach the question of whether Plaintiff's claims fail because the Empire Plan is not subject to New York's Surprise Bill Law.

Cir. 2013). To establish antitrust standing with respect to both its Sherman Act Section 1 and Section 2 claims as a private plaintiff, LIA must do more than allege an injury causally related to unlawful conduct – it must allege plausible facts that it suffered "injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977); *see also Bologna v. Allstate Ins. Co.*, 138 F. Supp. 2d 310, 319–20 (E.D.N.Y. 2001) (analyzing plaintiff's Sherman Act Sections 1 and 2 claims together and dismissing both for failure to state an antitrust injury). Therefore, an injury does not constitute an "antitrust injury" unless "it is attributable to an anti-competitive aspect of the practice under scrutiny." *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 334 (1990). This requirement stems from the principle that the antitrust laws were "enacted for the protection of competition, not competitors." *Brown Shoe Co. v. United States*, 370 U.S. 294, 319 (1962); *see also Gatt*, 711 F.3d at 75 ("Absent such boundaries, the potent private enforcement tool that is an action for treble damages could be invoked without service to—and potentially in disservice of—the purpose of the antitrust laws: to protect competition.").

Therefore, to survive a motion to dismiss, a "plaintiff must plead specific facts demonstrating that the defendants' conduct injured the competitive structure of the market." *S.O. Textiles Co. v. A & E Prod. Grp., a Div. of Carlisle Plastics, Inc.*, 18 F. Supp. 2d 232, 242–43 (E.D.N.Y. 1998). "The antitrust injury requirement obligates a plaintiff to demonstrate, as a threshold matter, that the challenged action has had an *actual* adverse effect on competition as a whole in the relevant market; to prove it has been harmed as an individual competitor will not suffice." *Bologna* 138 F. Supp. 2d at 319 (emphasis in original).

To determine whether a plaintiff has antitrust standing, courts in the Second Circuit analyze "(1) whether the plaintiff suffered an antitrust injury, and then (2) whether any . . .

factors . . . prevent the plaintiff from being an efficient enforcer of the antitrust laws." *Winstar Comms. LLC, v. Equity Office Properties, Inc.*, 170 F. App'x 740, 742 (2d Cir. 2006); *see also Gatt*, 711 F.3d at 76 ("[W]e require a private antitrust plaintiff plausibly to allege (a) that it suffered a special kind of antitrust injury, and (b) that it is a suitable plaintiff to pursue the alleged antitrust violations and thus is an efficient enforcer of the antitrust laws."). To analyze whether a plaintiff has plausibly alleged an antitrust injury, courts in this Circuit "employ a three-step process for determining whether a plaintiff has sufficiently alleged antitrust injury." *Gatt*, 711 F.3d at 76. First, a plaintiff alleging that it has been injured must "identify the practice complained of and the reasons such a practice is or might be anticompetitive. Next, [the court] identif[ies] the actual injury the plaintiff alleges[, which] requires [courts] to look at ways in which the plaintiff claims it is in a worse position as a consequence of the defendant's conduct. Finally, [the court] compare[s] the anticompetitive effect of the specific practice at issue to the actual injury the plaintiff alleges." *Id.*

Here, conducting the requisite analysis necessarily leads to the conclusion that Plaintiff has not sufficiently pled an antitrust injury. According to LIA, it has been injured because "United, through its role as administrator of the Empire Plan, is abusing its monopsony power to drive down the out-of-network reimbursement rate for medical [sic] necessary anesthesia services and thereby cause [sic] significant anticompetitive effects and resulting antitrust injury in the market for the delivery of anesthesia services in the New York metropolitan area." ECF No. 42 at 9. LIA further alleges that MultiPlan assists United in its efforts by providing "substantial assistance to United to enable it to significantly reduce reimbursement rates to below competitive [levels]." *Id.* at 3–4. Plaintiff also attempts to assert injury by averring that because the Empire Plan reimbursements make up a significant portion of anesthesia practices' business

in the New York metropolitan area, the lower reimbursement rates will decrease the availability of high-quality anesthesia services in the New York metropolitan area, force some providers out of business, force other providers to curtail their services, and hamper the ability of out-of-network practices to recruit and retain new talent. ECF No. 1 ¶¶ 5, 78, 135–37. Plaintiff alleges that the effect of United and MultiPlan's anticompetitive behavior is to drive down the market rate for out-of-network providers to increase the share of business handled by anesthesiologists employed by OptumCare and to force providers like Plaintiff to go in-network. *Id.* ¶¶ 7, 46–55, 142–44.

i. Plaintiff Does Not Allege Facts Sufficient to Support a Finding that Competition as a Whole in the Relevant Market was Harmed

With respect to the relationship between the anticompetitive effect of the practice at issue and the actual injury Plaintiff alleges, even if the Court accepts that United has decision-making power over the rate at which the Empire Plan reimburses out-of-network providers, *see id.* ¶¶ 7, 46–55, 142–44, the Court finds that Plaintiff has not alleged an injury that the antitrust laws were intended to protect. Plaintiff has not done so because it has not alleged "an *actual* adverse effect on competition as a whole in the relevant market" but has merely alleged that "it has been harmed as an individual competitor[,which will not suffice]." *Bologna*, 138 F. Supp. 2d at 319 (emphasis in original).

As an initial matter, Plaintiff fails to state facts sufficient to support a finding that the consumers in the relevant market–patients–have been harmed by United and MultiPlan's actions. *See, e.g.*, *Balaklaw v. Lovell*, 14 F.3d 793, 798 (2d Cir. 1994) (finding that the market had remained unaltered when "[f]ron the consumers' point of view, nothing about the market has changed"). The complaint does not credibly allege that patients have had to or necessarily will have to pay more for anesthesia services as a result of the decreased reimbursement rates.

Instead Plaintiff relies on the argument that eventually decreased reimbursement rates will drive competitors to OptumCare out of business or force them to go in-network with the Empire Plan, which will eventually allow United to drive up costs. ECF No. 1 ¶¶ 5, 135–46

However, Plaintiff has failed to allege that the lower reimbursement rates have had an actual or likely adverse effect on competition among insurers in the insurance market. Plaintiff does not assert that OptumCare or in-network providers are recouping more lucrative reimbursements under the Empire Plan for their services[7] or that anesthesiologists are choosing to go in-network with respect to the Empire Plan or joining OptumCare rather than remaining independent, facts that might support a finding that competition in the market for delivery of anesthesia services was being harmed. *See, e.g.*, *Michael E. Jones, M.D., P.C. v. United Health Grp., Inc.*, No. 19-cv-7972, 2021 WL 4443142, at *5 (S.D.N.Y. Sep. 28, 2021) ("Plaintiff has not alleged that medical providers have joined Defendants' network because of the purported discrimination against out-of-network providers or that Defendants' share of the health insurance market has increased since . . . the year the supposed discrimination began" therefore "there are no allegations . . . that competition in the insurance market . . . has been affected by Defendants' actions vis-à-vis Plaintiff's claim for reimbursement."); *Korshin v. Benedictine Hosp.*, 34 F. Supp. 2d 133, 138 (N.D.N.Y. 1999) (finding that plaintiff had not established antitrust standing because he had "not alleged any change in the price of anesthesiology services, a decrease in quality or efficiency of care, or that the consumers of anesthesiology services, be they patients, referring physicians, or third-party payers, have less of a market choice . . . as a result of defendants' actions").

[7] In fact, Plaintiff acknowledges that if it were to choose to go "in-network," its reimbursement rate would likely be the same or less than it is now. ECF No. 42 at 15.

And the complaint contains no facts to support a finding that the competitive structure of the market for the delivery of anesthesia services in the New York metropolitan area has been affected by the decision of a single health insurance plan to reimburse out-of-network providers at lower rates to such an extent that providers are closing, thus decreasing the choices available to patients. *S.O. Textiles Co.*, 18 F. Supp. 2d at 242–43. Although the Court accepts as true LIA's assertion that "in the years leading up to 2022, Empire Plan represented approximately 40% of LI Anesthesia's revenues," the Court cannot credit LIA's assertion that "[u]pon information and belief," the Empire Plan represented "similar shares of revenues for other anesthesia groups in the New York metropolitan area." ECF No. 1 ¶¶ 78–79. "A litigant cannot merely plop 'upon information and belief' in front of a conclusory allegation and thereby render it non-conclusory. Those magic words will only make otherwise unsupported claims plausible when the facts are peculiarly within the possession and control of the defendant or where the belief is based on factual information that makes the inference of culpability plausible." *Citizens United v. Schneiderman*, 882 F.3d 374, 384 (2d Cir. 2018). Information about the percentage of other anesthesia providers' revenue that the Empire Plan represents is not information peculiarly within the possession and control of United. And, without any additional factual basis to support Plaintiff's allegation about other anesthesia practices, the Court cannot credit Plaintiff's conclusion that an insurance plan that covers only 1.2 million of the more than 19.5 million inhabitants of the New York metropolitan area[8] (roughly 6%) makes up more than 40% of revenues across the entire market for the delivery of anesthesia services. Accordingly, Plaintiff has not demonstrated that the lowered reimbursement rates under the Empire Plan are likely to drive out competition in the provider market.

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[8] *See* Census Reporter Data on New York-Newark-Jersey City, NY-NJ-PA Metro Area, available at https://perma.cc/XBQ4-K3GL (last visited November [X], 2023).

ii. Lowering Reimbursement Rates to a Physician Practice is Generally Insufficient to Establish Antitrust Injury

The parties agree that a health plan lowering reimbursement rates paid to a physician practice is generally insufficient to establish antitrust injury. *See* ECF No. 42 (LIA's Opposition) at 13; ECF No. 45 (United's Reply) at 3; *see also Westchester Radiological Associates P.C. v. Empire Blue Cross & Blue Shield, Inc.*, 707 F. Supp. 708, 717 (S.D.N.Y. 1989) ("The law does not prevent a buyer with market power from negotiating a good price, or from specifying what it will buy."); *Kartell v. Blue Cross Blue Shield of Mass., Inc.*, 749 F.2d 922, 925, 929 (1st Cir. 1984) (holding that "[a]ntitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold" and that "a legitimate buyer is entitled to use its market power to keep prices down"). However, LIA argues that antitrust injury can be established when a defendant's reduced reimbursements are accompanied by "something more," such as a conspiracy or differential treatment provided to different market participants based on their relationship with the defendant. ECF No. 42 at 13–15.

According to Plaintiff, the "something more" alleged here is that United engaged in a "horizontal conspiracy" with MultiPlan to competitively hobble LIA's practice to benefit OptumCare. *Id.* at 15. However, as discussed in Section I.B., *infra*, Plaintiff has not put forth sufficient facts to state a claim that United and MultiPlan were engaged in a conspiracy let alone a "horizontal" conspiracy, which requires an "agreement[] between two or more competitors." *Texaco Inc. v. Dagher*, 547 U.S. 1, 2 (2006). Additionally, because the complaint does not allege that United and MultiPlan are horizontal competitors (rather, the facts as alleged in the complaint support a conclusion that they are not horizontal competitors), Plaintiff's efforts to cite a "horizontal conspiracy" as the "something more" required to establish antitrust injury must necessarily fail. *See In re Aluminum Warehousing Antitrust Litig.*, No. 13-md-2481, 2014 WL

4277510, at *32 (S.D.N.Y. Aug. 29, 2014) ("Plaintiffs claim to have alleged a horizontal conspiracy in restraint of trade, but they do not allege that [the defendants] are horizontal competitors. In the absence of the latter, the former cannot be correct.").

In the absence of proof of a conspiracy or "something more," Plaintiff's arguments are insufficient to establish that it suffered an antitrust injury. *West Penn Allegheny Health System, Inc. v. UPMC*, 627 F.3d 85, 103 (3d Cir. 2010) (stating that if defendant had been acting alone, Plaintiff "would have little basis for challenging the reimbursement rates" because "[a] firm that has substantial power on the buy side of the market (*i.e.*, monopsony power) is generally free to bargain aggressively when negotiating the prices it will pay for goods and services."). Accordingly, Plaintiff's three Sherman Act claims against United and single Sherman Act claim against MultiPlan must be dismissed.

B. Plaintiff's Sherman Act Claim Against MultiPlan Must Also be Dismissed Because Plaintiff Does Not State a Plausible Claim Against MultiPlan

Even if Plaintiff's Sherman Act Section 1 claim against MultiPlan had sufficiently alleged an antitrust injury, the claim would be dismissed because Plaintiff's complaint does not plead "factual content that allows the court to draw the reasonable inference" that MultiPlan is "liable for the misconduct alleged." *Twombly*, 550 U.S. at 570. "To present a plausible claim, the pleading must contain something more than a statement of facts that merely creates a suspicion of a legally cognizable right of action." *Jorgensen v. Cnty. of Suffolk*, 558 F. Supp. 3d 51, 60 (E.D.N.Y. 2021).

LIA's complaint contains limited references to MultiPlan. LIA asserts that MultiPlan is helping United use its market power to force anesthesia providers to accept lower reimbursement rates by engaging in written and phone communications with providers in which MultiPlan engages in "bogus negotiations," asserts "unrealistic deadlines," and "bur[ies anesthesia]

practices in mountains of correspondence" related to reimbursement rates. ECF No. 1 ¶¶ 4, 140, 174–77. LIA also alleges that MultiPlan is a market participant as a payor for, or purchaser of anesthesia services "to the extent that it assists plans in terms of calculating reimbursement levels and facilitating reimbursement." *Id.* ¶ 167. These facts are not sufficient to state a claim that MultiPlan engaged in an antitrust conspiracy.

To survive dismissal of its Sherman Act Section 1 claim against MultiPlan, LIA must allege "a combination or some form of concerted action between at least two legally distinct economic entities" that constitutes "an unreasonable restraint of trade." *Primetime 24 Joint Venture v. NBC*, 219 F.3d 92, 103 (2d Cir. 2000). "Proof of unilateral action does not suffice," rather, the facts alleged "must reveal a unity of purpose or a common design and understanding, or a meeting of minds in an unlawful arrangement." *Anderson News, LLC v. Am. Media, Inc.*, 680 F.3d 162, 183 (2d Cir. 2012). This requires allegations of "direct or circumstantial evidence that reasonably tends to prove that [Defendants] had a conscious commitment to a common scheme designed to achieve an unlawful objective." *Id.* at 184. A complaint claiming conspiracy "must provide some factual context suggesting that the parties reached an agreement, not facts that would be merely consistent with an agreement." *Id.*

Beyond a bare assertion that MultiPlan is working with United to force lower reimbursement rates,[9] the complaint contains no allegations to support a finding that MultiPlan and United had a "conscious commitment to a common scheme." *Caithness Long Island II, LLC v. PSEG Long Island LLC*, No. 18-cv-4555, 2019 WL 6043940, at *4 (E.D.N.Y. Sept. 30, 2019). The complaint, for example, does not assert that MultiPlan knew the reimbursement rates it sought were lower than the rates that United had previously offered, that MultiPlan believed the

[9] ECF No. 1 ¶¶ 4, 134–35, 141, 175–77.

rates were below competitive levels, that MultiPlan had any role in helping United or the Empire Plan determine appropriate reimbursement rates, or that MultiPlan intended to help United drive out competition. The only plausible finding suggested by the facts alleged in the complaint is that MultiPlan contracted with United to handle direct communication with providers as part of the federal IDR process with respect to claims for reimbursement related to treatment provided to patients insured by the Empire Plan. LIA does not allege any facts suggesting that United and MultiPlan conspired or agreed to work together to restrain trade unlawfully. *Anderson News*, 680 F.3d at 183–84. Accordingly, Plaintiff's Sherman Act Section 1 claim against MultiPlan must be dismissed pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure.[10]

In its opposition brief, LIA asserts new allegations against MultiPlan, referencing MultiPlan's Annual Report and content from its website, and raises additional assertions about the relationship between MultiPlan and United, including that MultiPlan "receives a percentage of the 'savings' it generates through the reduction of reimbursement rates." ECF No. 42 at 18–20. However, it is well-settled that a complaint may not be amended by the brief in opposition to a motion to dismiss. *See, e.g.*, *Wright v. Ernst & Young LLP*, 152 F.3d 169, 178 (2d Cir. 1998) (finding that a party may not amend its pleadings through statements made in motion papers).

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[10] Because "[a]llegations merely consistent with unilateral action are insufficient" to make out a violation of Section 1 of the Sherman Act, if Plaintiff fails to state a claim for a Section 1 violation against MultiPlan, its Section 1 claim against United, MultiPlan's alleged co-conspirator, must necessarily fail. *In re Zinc Antitrust Litig.*, 155 F. Supp. 3d 337, 366 (S.D.N.Y. 2016) (dismissing plaintiffs' claims under Section 1 of the Shearman Act because plaintiff "failed to plausibly alleged unlawful concerted action or an anticompetitive agreement").

And, because the Court finds that Plaintiff's Sherman Act claims against United and MultiPlan must be dismissed for failure to plead antitrust injury, and that Plaintiff's Sherman Act Section 1 claims against United and MultiPlan must also be dismissed for failure to state a plausible claim as to MultiPlan, the Court does not need to reach the parties' remaining arguments regarding the sufficiency of Plaintiff's Sherman Act claims.

Accordingly, although the Court does not believe consideration of these facts would have altered its finding, the Court did not and could not consider these facts in reaching its conclusion.

II. Plaintiff's Donnelly Act and Unjust Enrichment Claims

Plaintiff also claims that United and MultiPlan engaged in an antitrust conspiracy to restrain trade in violation of the Donnelly Act and that United and MultiPlan were unjustly enriched by receiving fees and retaining reimbursement through their alleged scheme of improperly reducing LIA's reimbursement rates. "District courts may use their discretion in deciding whether to exercise supplemental jurisdiction over state law claims after dismissing a plaintiff's only federal claims, so long as the federal claims were not dismissed for lack of subject matter jurisdiction." *Probiv v. PayCargo LLC*, No. 22-cv-2907, 2023 WL 159788, at *5 (E.D.N.Y. Jan. 11, 2023); 28 U.S.C. § 1367(c)(3) (A district court "may decline to exercise supplemental jurisdiction" over a "state law claim[]" if the district court "has dismissed all claims over which it has original jurisdiction"); *see also Cangemi v. United States*, 13 F.4th 115, 134 (2d Cir. 2021). Having dismissed all of Plaintiff's federal claims, the Court declines to exercise supplemental jurisdiction over Plaintiff's Donnelly Act and unjust enrichment claims.[11]

III. Plaintiff May File a Motion Seeking Leave to Amend

In the final section of Plaintiff's brief, Plaintiff asks the Court to grant it leave to amend its complaint to cure any pleading deficiencies. ECF No. 42 at 34. The Second Circuit "strongly

[11] Although the Court declines to exercise supplemental jurisdiction over Plaintiff's Donnelly Act claims, the Court notes that the Donnelly Act "is modeled after the Sherman Act and should generally be construed in light of Federal precedent." *Biocad JSC v. F. Hoffman-La Roche*, 942 F.3d 88, 101 (2d Cir. 2019). Accordingly, "[t]he standard for a well-pleaded Donnelly Act claim is the same as a claim under Section 1 of the Sherman Act." *Nat'l Gear & Piston, Inc. v. Cummins Power Sys., LLC*, 861 F. Supp. 2d 344, 370 (S.D.N.Y. 2012). The Court has dismissed Plaintiff's Sherman Act claims against MultiPlan and United because they were not well-pled, *see supra* Section I. Accordingly, Plaintiff's Donnelly Act claims would also fail on the same grounds if the Court were to exercise supplemental jurisdiction over those claims.

favors liberal grant of an opportunity to replead after dismissal of a complaint under Rule 12(b)(6)." *Noto v. 22nd Century Grp., Inc.*, 35 F.4th 95, 107 (2d Cir. 2022); *see also Kopchik v. Town of East Fishkill*, 759 F. App'x 31, 38 (2d Cir. 2018) ("The opportunity to amend the complaint is appropriately presented *after* the district court rules on a motion to dismiss.").

The fact that Plaintiff's opposition brief provides no explanation about how it intends to amend its complaint is sufficient reason for the Court to deny leave to amend. *See Gregory v. ProNAi Therapeutics Inc.*, 757 F. App'x 35, 39 (2d Cir. 2018) (affirming denial of leave to amend where "plaintiffs sought leave to amend in a footnote at the end of their opposition to defendants' motion to dismiss" and "included no proposed amendments"). However, because Plaintiff has not previously sought to amend its complaint, Plaintiff may file a motion of no more than ten (10) pages seeking leave to file an amended complaint by December 12, 2023. Any such motion should include the proposed amended complaint as an exhibit as well as a redline comparing the proposed amended complaint to the current complaint. The brief should explain why leave to amend should be granted, including a discussion of how the proposed amended complaint cures the deficiencies identified herein and in Defendants' motions to dismiss. If Plaintiff chooses to file a motion and a proposed amended complaint, Defendants may file a joint opposition of no more than ten (10) pages on or before January 4, 2023. Unless otherwise requested by the Court, there will be no replies.

CONCLUSION

For the reasons set forth above, the Court GRANTS Defendants' motions to dismiss. *See* ECF Nos. 30 & 31. Plaintiff may file a motion seeking leave to amend its complaint, as described above, on or before December 12, 2023, and Defendants may file a joint opposition

brief by January 4, 2023. If Plaintiff does not seek leave to amend by December 12, 2023, judgment shall be entered, and the case closed.

SO ORDERED.

/s/ Hector Gonzalez
HECTOR GONZALEZ
United States District Judge

Dated: Brooklyn, New York
November 21, 2023

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, -against- UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	**NOTICE OF MOTION** Case No. 2:22-cv-04040-HG

PLEASE TAKE NOTICE that, upon the Declaration of Roy W. Breitenbach, dated February 2, 2024; the Exhibits annexed thereto; the accompanying Memorandum of Law; and all the prior proceedings herein, the Plaintiff, Long Island Anesthesiologists PLLC, will move this Court, before the Honorable Hector Gonzalez, United State District Judge, on a date and time to be fixed by the Court, at the United States Courthouse, 225 Cadman Plaza East, Courtroom 6A South, Brooklyn, New York 11201, for an Order pursuant Fed. R. Civ. 15(a) and in accordance with this Court's prior November 30, 2023 Order (ECF 50), grant Plaintiff leave to file an amended complaint, and for such other relief that the Court deems just and proper. Answering papers, if any, must be filed by the Defendants on or before March 4, 2024, in accordance with the Court's Order dated January 24, 2024 (ECF 53).

Dated: February 2, 2024
Uniondale, New York

HARRIS BEACH PLLC
Attorneys for Plaintiff

By: *Roy W. Breitenbach,Esq.*
333 Earle Ovington Boulevard
Uniondale, New York 11553
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TO: ALL COUNSEL OF RECORD

This is an automatic e-mail message generated by the CM/ECF system. Please DO NOT RESPOND to this e-mail because the mail box is unattended.

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U.S. District Court

Eastern District of New York

Notice of Electronic Filing

The following transaction was entered on 5/15/2024 at 11:50 AM EDT and filed on 5/15/2024

Case Name:	Long Island Anesthesiologists PLLC v. United Healthcare Insurance Company of New York Inc. et al
Case Number:	2:22-cv-04040-HG
Filer:	
Document Number:	No document attached

Docket Text:

ORDER GRANTING [54] Motion for Leave to File an Amended Complaint. The Court has reviewed Plaintiff's proposed Amended Complaint, *see* ECF No. [54-2] and its memorandum in support of its motion to amend, *see* ECF No. [55], as well as Defendants' memorandum in opposition to Plaintiff's motion, *see* ECF No. [57]. The Second Circuit "strongly favors liberal grant of an opportunity to replead after dismissal of a complaint under Rule 12(b)(6)," *see Noto v. 22nd Century Grp., Inc.*, 35 F.4th 95, 107 (2d Cir. 2022), because of its "strong preference for resolving disputes on the merits," *see Williams v. Citigroup*, 659 F.3d 208, 213 (2d Cir. 2011). Leave to amend should be "freely given" in the absence of factors such as "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party..., [and] futility of amendment." *Foman v. Davis*, 371 U.S. 178, 182 (1962). Here, Defendants argue that the Court should deny Plaintiff's motion because the proposed amendment would be

futile. *See* ECF No. [57] at 6. Upon a review of the proposed amended complaint and the parties' briefs, the Court disagrees. Plaintiff has pled additional facts that may be sufficient to overcome the defects that the Court identified in its Order granting Defendants' motion to dismiss, *see* ECF No. [50].

Plaintiff shall file and serve its amended complaint on or before May 28, 2024. Defendants shall answer or otherwise respond to the amended complaint on or before June 27, 2024. If Defendants intend to move to dismiss the Amended Complaint, they need not follow the process of filing a pre-motion letter required by Section IV.A of the Court's Individual Practices. Instead, Defendants shall file their papers in support of their motion to dismiss on or before June 27, 2024. Plaintiff shall file its opposition papers on or before July 29, 2024. Defendants' reply papers, if any, shall be filed on or before August 12, 2024. The parties are directed to review Section IV.B. of this Court's Individual Practices and to comply with the page limitations outlined therein. Ordered by Judge Hector Gonzalez on 5/15/2024. (ICP)

2:22-cv-04040-HG Notice has been electronically mailed to:

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2:22-cv-04040-HG Notice will not be electronically mailed to:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, -against- UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	**AMENDED COMPLAINT** **JURY TRIAL DEMANDED** Case No. 2:22-cv-04040-HG

Plaintiff, Long Island Anesthesiologists PLLC ("LIA") by its attorneys, Harris Beach PLLC, alleges for its Amended Complaint against the Defendants, UnitedHealthcare Insurance Company of New York Inc., as Program Administrator, The Empire Plan Medical/Surgical Program ("United") and MultiPlan Inc. ("MPI"), as follows:

INTRODUCTION

1. High-quality and easily accessible anesthesia services are vitally important for the health and well-being of the New York metropolitan area's 18 million residents. These services enable patients to undergo lifesaving and life-changing medical procedures safely and comfortably and manage their pain. Without anesthesia services, much modern medicine would be impossible. LIA is a high-quality anesthesia provider located in southwestern Suffolk County.

2. United – described by the New York Attorney General several years ago as a "behemoth" health insurer and plan provider – has significant market power in the New York metropolitan area. In addition to being a major commercial insurer and health plan provider, it

is also the administrator of the Empire Plan, which is the health plan for over 1 million public-sector employees.

3. United, as administrator of the Empire Plan, has significant market power. Anesthesiologists cannot choose their patients and cannot turn away patients because of their health coverage or other issues. Given the number of public employees in the New York metropolitan area, anesthesia providers are largely at the mercy of United. For LIA, and many other area anesthesia practices, approximately 40% of their revenue comes from the Empire Plan.

4. The Empire Plan historically reimbursed anesthesia providers at usual, customary, and reasonable rates. This changed in January 2022 when, at United's behest, it decreased reimbursement rates by more than 80%. United then enlisted MPI to assist it in a scheme to pressure and prevent anesthesia providers into accepting these rates while requiring onerous and burdensome documentation.

5. Thus, during a time of significant economic upheaval and inflation, vitally essential anesthesia providers are suffering an unsustainable and unending 80+% reimbursement cut. This will certainly decrease the availability of high-quality anesthesia services in the New York metropolitan area; many providers will be forced out of business entirely, and others will be forced to significantly curtail their services and recruitment and retention of well-trained clinicians.

6. But these savings are not being passed on to United's customers or Empire Plan enrollees. Far from it, United regularly seeks and imposes rate increases, even though it generates net earnings each year in the tens of billions.

7. Rather, United is reducing reimbursement rates by 80+% -- and pressuring anesthesia providers into accepting these rates – *to force these providers out of business.* As we explain below, eliminating LIA and other similarly situated anesthesia providers benefits United because it directly provides physician services – including anesthesia services – to patients throughout the United States, including in the New York metropolitan area. Thus, eliminating LIA and its fellow anesthesia practices is good for United's business; it removes competitors and harms competition in the market to United's advantage.

8. For these reasons, this Court must step in and immediately put an end to United's illegal, improper, and anticompetitive conduct.

PARTIES

9. Plaintiff, Long Island Anesthesiologists PLLC ("LIA"), is a New York professional limited liability company.

10. LIA's principal place of business is located at 1000 Montauk Highway, West Islip, New York.11795.

11. Defendant UnitedHealthcare Insurance Company of New York ("United") is licensed by the New York State Department of Financial Services to provide accident and health insurance in New York under New York Insurance Law § 1113(a).

12. Upon information and belief, United's principal place of business is located at 185 Asylum Street, Hartford, Connecticut 06103.

13. United is the Program Administrator of The Empire Plan Medical/Surgical Program.

14. Defendant MultiPlan, Inc. ("MPI") is a New York domestic business corporation.

15. Upon information and belief, MPI's principal place of business is located at 115 Fifth Avenue, 7th Floor, New York, New York 10003.

JURISDICTION AND VENUE

16. This Court has subject-matter jurisdiction over the Sherman Act claims in this lawsuit under 28 U.S.C. § 133, which provides original jurisdiction in this Court over "a claim or right arising under" the laws of the United States.

17. This Court has subject-matter jurisdiction over the New York state law claims in this lawsuit under 28 U.S.C. § 1367(a), which provides supplemental jurisdiction in this Court over "over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution."

18. Venue is proper in this District under 28 U.S.C. § 1391(b)(2) because the acts complained of have occurred within this District.

FACTUAL ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

LIA

19. LIA is a private anesthesiology practice located in West Islip, New York. It is owned by the anesthesiologists who provide services for the practice.

20. LIA's principal line of business is to provide the anesthesia services at Good Samaritan Hospital Medical Center in West Islip, New York. LIA has been providing these services since shortly after Good Samaritan opened in 1959.

21. LIA has no ownership interest in Good Samaritan; and Good Samaritan has no ownership in LIA. Good Samaritan is a not-for-profit hospital that is part of the Catholic Health system on Long Island.

22. During this time, Good Samaritan has grown from a 175-bed general hospital to a 537-bed tertiary care, Level II trauma center and teaching facility serving the diverse populations of central and south Long Island.

23. Good Samaritan has some of New York's highest volume emergency services, cardiac surgery services, a busy and active labor and delivery area, ambulatory and major surgery units including robotic surgery capabilities, adult and pediatric endoscopy suites, general and intensive care pediatric and neonatology units, advanced interventional cardiology, electrophysiology, and vascular suites, and dedicated surgical and medical intensive care units. LIA's anesthesiologists care for patients in all these areas.

24. In addition to its diverse practice at Good Samaritan, LIA additionally provides anesthesia services at physician offices and surgery centers around New York and Long Island.

25. Currently, LIA employs full-time anesthesiologists, trained at the nation's top academic medical centers. Almost all are board-certified by the American Board of Anesthesiology.

26. Many of these anesthesiologists have areas of focus or training in major anesthesiology subspecialties such as pediatrics, obstetrics, cardiothoracic anesthesia, neuroanesthesia, critical care, regional anesthesia for orthopedics, and pain management.

27. At all locations, LIA cares for patients with the same exacting standards. Its patients can be assured of care by highly qualified physicians with experience and expertise in complex perioperative management, from the pre-anesthesia assessment, through the delivery of anesthesia, to the alleviation of pain, and, when necessary, care for critical illness. LIA is committed to its patients having the best outcomes possible, and the best anesthetic experience available. LIA highly values the privilege of patient care amidst Long Island's unique and diverse patient population.

28. Unlike most medical specialties, anesthesiologists are unable to choose their patients or to turn away prospective patients. Anesthesiologists provide services to all patients

undergoing surgical or certain medical procedures at the facilities in which they work regardless of the patient's ability to pay or health coverage status.

29. This is certainly the case with LIA. Its agreements with Good Samaritan for example obligate it to provide anesthesia and related services to all patients, without exception, and without regard to the patient's ability to pay or health coverage status.

30. Accordingly, anesthesia practices in general – and LIA in particular – are at the mercy of health plans and other third-party payers of health care. Anesthesia practices such as LIA cannot choose what health plans to deal with or avoid treating patients of health plans that have low reimbursement rates or are otherwise difficult to deal with.

31. Accordingly, LIA must deal with all health plans and other third-party payers of health care.

Anesthesia Reimbursement

32. There are two types of relationships that medical practices have with health plans. The first is an "in-network" or "participating provider" relationship. The second is an "out-of-network" or "non-participating provider" relationship.

33. In an in-network relationship, the health plan accepts the practice's clinicians as credentialed participating providers, and the parties enter into a participating provider agreement.

34. The parties' participating provider agreement in an in-network relationship governs the amount that the health plan will reimburse the provider for covered services, how claims are submitted, how claims are paid, how disputes are resolved, and such issues as prior approval and pre-certification.

35. The advantages that a medical practice derives from an in-network relationship are (a) being listed in the health plans' material as a participating provider (and thereby increasing referrals of health plan members); and (b) receiving reimbursement directly from the carrier.

36. The other relationship that health plans have with medical practices is an out-of-network relationship. In that type of relationship, there is no contractual agreement between the health plan and the practice. Instead, whether, and to what extent, an out-of-network provider is reimbursed for services that out-of-network providers render to the health plan's members and beneficiaries is dictated by the terms of the health plan documents. Out-of-network providers have no say or control in the terms of these plan documents.

37. Historically, in-network reimbursement rates were lower than out-of-network reimbursement rates. This is because health plans contended that the lower rates were appropriate given the increased referrals the practices would obtain from being listed in health plan directories and other materials. Health plans also contended that the lower rates were appropriate because network participating providers were receiving payment directly from the health plans, which was quicker and easier than what occurs with out-of-network providers.

38. LIA, like most anesthesia practices in the New York metropolitan area, typically derives no benefit from being listed in participating provider directories, and accordingly has traditionally chosen to remain out of network with health plans.

United's Size

39. United is a subsidiary of UnitedHealth Group Incorporated (UHG), which is a multi-national managed healthcare and insurance company based in Minnetonka, Minnesota.

40. As of the 2022, UHG was the world's eighth largest company by revenue, and the second largest health care company by revenue (only CVS Health is larger). It was the largest insurance company in the United States by net premiums.

41. UHG's 2021 revenues were $287.597 billion, a 12% increase over 2021. Its 2021 net earnings were $17.285 billion.

42. In 2022, UHG's revenues were $324.162 billion, yet another 12% increase from the prior year. UHG also increased its operating margin.

43. In 2023, UHG's revenues were $371.6 billion, representing a 15% year-over-year income.

44. As the New York Attorney General stated in 2022, UHG is a "behemoth in the healthcare industry." It has purchased over 35 healthcare companies in the last decade.

45. UHG operates, among other things, the largest health insurance company in the United States; a large network of physician groups, outpatient surgical centers, and other healthcare providers, including over 90,000 physicians across 2,200 locations; a pharmacy benefits manager that handles over a billion prescriptions every year; and a healthcare technology business that facilitates the transmission, analysis, and review of health insurance claims.

46. UHG has been subject to significant antitrust and related scrutiny in the last several years because of its size and anticompetitive conduct. *See, e.g.*, *United States v. UnitedHealth Group Incorporated*, 22 Civ. 00481 (D.D.C. filed Feb. 24, 2022); *U.S. Anesthesia Partners v. UnitedHealthcare Insurance Company*, 2021CV31061 (Colo. Dist. Ct. Denver Cty. filed Mar. 31, 2021); *U.S. Anesthesia Partners v. UnitedHealthcare Insurance Company*, DC-2021-04103 (Tex. Dist. Ct. Dallas Cty. filed Mar. 31, 2021); *Fremont Emergency Services*

(Mandavia) v. UnitedHealth Group, A-19-792978-B (Nev. 8th Dist. Ct. verdict Dec. 6, 2021) ($62.65 million jury award against UnitedHealthcare).

47. UHG divides its business into two main "platforms": Optum and UnitedHealthcare.

Optum Care Competes with LIA

48. Optum describes itself as purportedly serving "the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its Optum Health, Optum Insight and Optum Rx businesses. These businesses improve overall health system performance by optimizing care quality and delivery, reducing costs, and improving consumer and provider experience, leveraging distinctive capabilities in data and analytics, pharmacy care services, health care operations, population health and health care delivery."

49. One of Optum Health's businesses is OptumCare, which acquires physician and other health care practices throughout the United States, and then directly manages them.

50. In 2021, Optum Health generated approximately $54 billion in revenue.

51. In 2022, Optum Health's reported revenue was $71.1 billion.

52. In 2023, Optum Health revenue increased 33.9% from 2022.

53. Currently, OptumCare is largest employer of physicians in the United States, with more than 90,000 physicians, including anesthesiologists and anesthesia practices, at 2,200 neighborhood clinics across the country. In 2022, it provided health care services to 102 million patients.

54. In the New York area, OptumCare manages ProHealth, a large multi-specialty practice with over 300 locations throughout the metropolitan area. It employs or is affiliated with over 1,000 physicians and other health care providers.

55. Founded on Long Island, ProHealth has practitioners and clinics in virtually every Long Island community. There are six practices alone in West Islip, where LIA is located. ProHealth offers anesthesia services on Long Island, upon information and belief employing at least 22 anesthesiologists.

56. OptumCare also manages CareMount Medical, which currently serves patients throughout New York City, Westchester, Putnam, Dutchess, Columbia, and Ulster Counties.

57. CareMount owns and operates seven urgent care locations, clinical laboratories and radiology services, as well as endoscopy suites and infusion suites. It is affiliated with Massachusetts General Hospital and Northwell Health. Upon information and belief, it currently employs 31 anesthesiologists.

58. OptumCare also manages Riverside Medical Group, a large multi-specialty provider that services patients throughout New Jersey and southern Connecticut.

59. In February 2023, OptumCare purchased Middletown, New York-based Crystal Run Healthcare, a multispecialty physician group with over 400 providers across 30 locations.

60. All totaled, OptumCare has more than 2,100 providers in the New York metropolitan area, including over 50 anesthesiologists. It serves more than 1.6 million patients.

61. OptumCare also owns Sound Physicians, a large physician practice group in the Midwest and Southwest that is a substantial and growing anesthesia provider.

United's Market Presence

62. United offers a full-range of health benefits and insurance plans through four segments: (a) UnitedHealthcare Employer & Individual, which serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers; (b) UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees; (c) UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants; and (d) UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and through other diversified global health services.

63. In terms of size, United's provider networks include over 1.7 million physicians and other health care professionals, and more than 6,400 hospitals and other facilities throughout the United States.

64. As of December 31, 2022, UnitedHealthcare Employer & Individual provides access to medical services for 26.7 million people on behalf of its customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

65. In 2021, United's national accounts and large group employer commercial health insurance plans had about 23 million members and generated an estimated $31 billion in revenue.

66. UnitedHealthcare Medicare & Retirement provides health benefit services to individuals aged 50 and older in all 50 states, the District of Columbia and most U.S. territories. It served 7.1 million people through its Medicare Advantage products as of December 31, 2022. It also currently serves 4.4 million seniors nationwide through various Medicare Supplement products in association with AARP.

67. UnitedHealthcare Community & State provides services to state programs caring for the poor, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. As of December 31, 2022, UnitedHealthcare Community & State participated in programs in 32 states and the District of Columbia and served 8.2 million people: including nearly 1.5 million people through Medicaid expansion programs in 19 states under the Patient Protection and Affordable Care Act (ACA).

68. United has a significant share of the market in the New York area. For example, an analysis by the American Medical Association determined that United had the largest market share of health care insurers (all products) as of January 1, 2020, in the New York-Newark-Jersey City, NY-NJ-PA Metropolitan Statistical Area, at 26%. For point-of-service products, UnitedHealthcare's share soared to 66%.

69. As of January 1, 2022, United's market share of the New York-Newark-Jersey City, NY-NJ-PA Metropolitan Statistical Area combined (all products) market, as reported by the American Medical Association, was 26%.

70. Likewise, another study of the market share of private (non-governmental) enrollment plans in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties) as of the third quarter of 2022 reported that United's share was 33.8%. Its closest competition was Elevance at 20.2% and Cigna at 20.2%

The Empire Plan

71. In the New York market, United is not just a commercial insurer. Its United subsidiary also acts as the administrator of the Medical/Surgical Program of the Empire Plan, which is part of the New York State Health Insurance Program (NYSHIP). This Program provides health coverage for public employees in New York.

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

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

74. Based on this statutory authority, NYSHIP's Empire Plan pays for covered hospital services, physicians' bills, prescription drugs, and other covered medical expenses of eligible public employees and their dependents. The Empire Plan has contracted with United to administer its Medical/Surgical Program.

75. Many New York state residents are covered by the Empire Plan. This is because the Plan covers not only New York state employees and their residents, but also employees and

dependents of state-related entities, municipalities (county, town, city, and village), school districts, and special purpose government districts.

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

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

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

United's Involvement In Empire Plan

79. As alleged above, United is the administrator of the Empire Plan, which is self-funded by the state and local government entities in New York.

80. Although New York state and local government entities fund the Empire Plan and select the administrator, most day-to-day decisions regarding the operation of the Plan and the provision of benefits are the responsibility of United.

81. United, for example, makes coverage and benefits determinations for the Plan's written terms and uses plan assets to pay benefits for covered healthcare expenses.

82. As New York State Comptroller – the State's fiscal watchdog – has explained, as the Empire Plan administrator, United is "responsible for establishing a network of participating providers, establishing reimbursement rates, processing and paying claims from both participating and non-participating providers, and ensuring compliance with the requirements of the Empire Plan. Under the Empire Plan, [United] is reimbursed by Civil Service for the claims they process and pay. Additionally, Civil Service pays [United] an administrative fee." Thomas P. DiNapoli, *Preventing Inappropriate and Excessive Costs in the New York State Health Insurance Program* (N.Y. State Comptroller Audit 2016-D-1 (May 2018)) at 4-5.

83. The exact financial terms of the administrative services arrangement between the Empire Plan and United is a closely guarded price of competitively sensitive and proprietary information shielded even from disclosure through the New York Freedom of Information Law.

84. Nevertheless, upon information and belief, the administrative services fee that United receives for administering the Empire Plan is calculated the same way as it is for most self-funded health plans that United administers: The Plan's administrative fee is calculated as a set amount per Plan member, per month.

85. One of most crucial functions that United provides to the Empire Plan as its administrator is the determination and payment of reimbursement rates for medically necessary services that health care providers render to Plan enrollees.

86. As the State Comptroller explains, "Civil Service contracts with United to administer the medical/surgical portion of the Empire Plan. . . . United contracts with in-network health care providers who agree to accept payments at rates established by United to furnish medical services to Empire Plan members. United remits payment directly to in-network providers based on claims submitted for services provided . . . Empire Plan members may also

choose to receive services from out-of-network providers. . . . United bases its payments of out-of-network provider claims on the reasonable and customary (R&C) for the service. . . ." *Id.*

87. For out-of-network providers such as LIA, United has significant leeway under the Empire Plan to determine the appropriateness of the billed codes and charges, calculate the applicable reasonable and customary reimbursement rate using benchmarking databases and other tools, and decide whether and to what extent to negotiate discounts or seek other reductions in reimbursement from the providers.

88. Since United is in the business of administering, adjudicating, and negotiating health care benefits of a daily basis for thousands of self-funded plans throughout the United States and beyond, New York state officials – who are *not* in this business – rely on the substantial expertise United when making reimbursement determinations, particularly with respect to out-of-network providers.

89. Upon information and belief, keeping out-of-network reimbursement rates as low as possible brings substantial financial benefits to United.

90. Specifically, for many years, the fixed per member, per month administrative fees were all that United earned for its claims-administration services to self-funded plans. Recently, however United realized that it could bring in substantially more revenue by charging self-funded plans an additional "savings fee" each time it secured a "discount" on an out-of-network provider's billed charges.

91. Starting in or around 2016, United began encouraging the plans to which it provided administrative services to move to a "shared savings initiative," which featured these "savings fees." Under the "shared savings" program, United calculates the "savings fee" it

charges to plans as a percentage – often as high as 35% — of the difference between the provider's billed charge and the reimbursement rate determined by United.

92. Upon information and belief, the Empire Plan – like most self-funded plans that have administrative services arrangements with United – participates in United's "shared savings" program.

93. Even if the Empire Plan does not participate in United's "shared savings" program, United derives other benefits from lowering out-of-network reimbursement rates as much as possible.

94. Specifically, because the benchmarking databases used by United to calculate customary and reasonable reimbursement for out-of-network services rely, in large part, on the aggregated amount of historical paid claims, lowered reimbursement rates for care provided to Empire Plan members – one of the largest plans in the country with over 1.2 million members – significantly depresses the benchmark databases' reimbursement rates, thereby generating savings in connection with United's "shared saving" program and fully insured businesses.

Empire Plan Reimbursement

95. Historically, the Empire Plan reimbursed out-of-network physicians for providing covered medical services to Plan enrollees at amounts approximating the usual, customary, and reasonable (UCR) rate for the medical services in the geographic area where the services are provided.

96. The UCR rate used by the Empire Plan for out-of-network reimbursement was determined using the benchmarking databases maintained by FAIR Health, established in October 2009 as part of the settlement of an investigation by the Attorney General into conflicts

of interest involving UnitedHealthcare[1] involving the adjudication of claims. FAIR Health was formed to create an independent, trusted and transparent source of data to support claims adjudication and to meet the healthcare cost and utilization information needs of all participants in the healthcare community (https://www.fairhealth.org/mission-origin).

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

98. As a result of these provisions, LIA, as well as other anesthesia groups in the New York metropolitan area, were able to obtain reasonable reimbursement for providing high-quality, medically necessary anesthesia services to Empire Plan enrollees.

99. Given that this reimbursement was based, in large part, on UCR rates established through Fair Health, the rates at which Empire Plan reimbursed LIA, and other anesthesia groups, in the New York metropolitan area for providing medically necessary anesthesia services to Empire Plan enrollees were market rates.

100. It was vitally important that the Empire Plan reimbursed LIA and other anesthesia groups in the New York metropolitan area at these rates because, given the number of Empire

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

Plan enrollees, Empire Plan reimbursement represented a significant amount of these groups' revenues.

101. For example, in the years leading up to 2022, Empire Plan represented approximately 40% of LIA's revenues.

102. LIA's clientele is representative of the clientele that are patients at other local private anesthesia practices.

103. Specifically, Long Island Anesthesia Physicians, LLP provides anesthesia services at John T. Mather Memorial Hospital, in Port Jefferson; Long Island Community Hospital in Patchogue; Mercy Medical Center, in Rockville Centre; St. Charles Hospital and Rehabilitation Center in Port Jefferson; and St. Joseph Hospital in Bethpage. It also provides anesthesia services at Port Jefferson Surgery Center; Progressive Surgery Center of Long Island; Precision Care Surgery Center; and The Center for Advanced Spine & Joint Surgery.

104. The Chief Operating Officer of Long Island Anesthesia Physicians testified in an affidavit submitted in New York state court in 2022 that, in 2021, 44% of that practice's revenues were attributable to services performed on Empire Plan members.

105. Likewise, the President of New York Cardiovascular Anesthesiologists, which provides anesthesia services to St. Francis Hospital in Roslyn, testified in an affidavit submitted in New York state court in 2022 that, in 2021, 19% of his practice's revenues were attributable to services performed on Empire Plan members.

106. Empire Plan's reimbursement levels also significantly benefited its enrollees. They had broad access to the finest out-of-network specialty physicians in the country. They were protected against the large balance bills and surprise bills that many other patients faced when they did not have the protections that the Empire Plan enrollees had.

New York Surprise Bill Law

107. Empire Plan enrollees and anesthesia practices such as LIA were further benefitted in March 2015 when the New York Surprise Bill Law (Financial Services Law §§ 601-08) became effective. Through Civil Service Law § 162, the Surprise Bill Law also applied to the Empire Plan (Civil Service Law § 162[1][b][iv]).

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

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

110. The Empire Plan and other health plans subject to the Surprise Bill Law were required under the Law to reimburse the out-of-network physicians at a "reasonable amount" for their covered medical services (Financial Services Law §§ 607[a][3] [surprise bills], 605[a][1] [emergency services bills]).

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

112. A qualified independent dispute resolution (IDR) entity then reviewed the disputed bills code-by-code and selects either the out-of-network physician's fee or the health

plan's payment amount as the "reasonable fee for the services rendered" (Financial Services Law §§ 607[a][6] [surprise bills], 605[a][4] [emergency services bills]).

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

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

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

116. Accordingly, at least for those circumstances constituting a surprise bill or an emergency services bill, out-of-network physicians, such as LIA, had a remedy if Empire Plan failed to reimburse it near the UCR for covered medical services.

LIA Remains Out-of-Network

117. Indeed, these protections, and Empire Plan's reimbursement level, formed the basis of LIA's refusal to enter in-network participating provider agreements with United that included the Empire Plan business.

118. Accordingly, when, in or around 2012, United started pressuring Good Samaritan Hospital to require LIA to become an in-network participating provider, LIA agreed with

United to become an in-network participating provider for its commercial health plan products, but expressly excluded the Empire Plan from the participating provider agreement. This preserved the favorable Empire Plan out-of-network reimbursement rates for LIA. The in-network reimbursement rates imposed by United were significantly below these out-of-network reimbursement rates.

119. Most other similarly situated anesthesia groups in the New York metropolitan area were similarly able to avoid entering an in-network participating provider agreement that included the Empire Plan, to preserve the favorable out-of-network Empire Plan reimbursement rates for them as well.

United's Dramatic Reduction in Reimbursement

120. All this has changed since January 1, 2022, when LIA – and other out-of-network physicians – began being reimbursed by United for providing medically necessary anesthesia services to Empire Plan enrollees at amounts dramatically less than provided for in the Plan.

121. For example, LIA's reimbursement was in most cases **more than 80% less** than what they were reimbursed for the services in December 2021.

122. This dramatic decrease is verified by New York Cardiovascular Anesthesiologist's President, who testified that in April 2023 that NYCA's reimbursement decreased 73% in January 2022.

123. Likewise, Long Island Anesthesia Physicians' Chief Operating Officer also testified in April 2023 that his practice's Empire Plan reimbursement decreased more than 80% effective January 2022.

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

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

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

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

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

129. And, indeed, since January, United has responded to complaints made to the Department of Financial Services by out-of-network physician practices by contending that the Empire Plan is no longer subject to regulation by that agency. Likewise, since January, United has responded to New York IDR proceedings initiated by out-of-network physician practices by

contending that because it is no longer subject to New York insurance laws, its reimbursements are no longer reviewable in New York IDR.

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

131. United is also contending – wrongly – that all hospital-based anesthesia cases fall under the No Surprises Act and accordingly, intentionally reimbursing for ambulatory and day admission surgeries at artificially low rates.

No Surprises Act

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

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

134. The No Surprises Act provides that the federal IDR process will apply and may be used by physicians and health plans to determine the out-of-network rate for emergency services in the emergency department of a hospital or independent freestanding emergency department and non-emergency items and services furnished by non-participating providers

during a visit to a participating health care facility when a "specified state law" does not apply (42 U.S.C. § 300gg-111).

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

136. For a state law to determine the amount upon which cost-sharing is based and the out-of-network rate, the state law must apply to [a] the plan, issuer, or coverage involved; [b] the non-participating provider or non-participating emergency facility involved; and [c] the item or service involved. (42 U.S.C. § 300gg-111).

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

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

139. Accordingly, in New York, the provisions of the Surprise Billing Law constitutes a "specified state law" under the No Surprises Act, because, for health plans and circumstances governed by it, the Surprise Bill Law has a method for determining the total amount payable—

the health plan pays what it determines to be a reasonable amount, and then either the health plan or the out-of-network physician can submit the matter to IDR, which will determine the reasonable payment amount using the Financial Services Law §§ 600-08.

140. Thus, even after the No Surprises Act took effect January 2022, for health plans and circumstances covered by the Surprise Bill Law, that Law, and not the federal No Surprises Act, governs the reimbursement of out-of-network physicians.

141. Indeed, the Department of Financial Services recognized this when it issued Circular Letter No. 10, in December 2021. In this Letter, the Department of Financial Services stated: "New York has an IDR process that applies to out-of-network emergency services, including inpatient services that follow an emergency room visit, in hospital facilities, and surprise bills in participating hospitals or ambulatory surgical centers and for services referred by a participating physician. The IDR process requires issuers, physicians, hospitals and ambulatory surgical centers, and providers to whom the patient was referred by their participating physician, to ensure that the insured incurs no greater out-of-pocket costs for emergency services and surprise bills than the insured would have incurred with an in-network provider. **Since New York has a specified state law, the New York IDR process will continue to apply to out-of-network emergency services and surprise bills**"

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

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

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

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

146. United's efforts did not end with taking the position that the Empire Plan was no longer governed by New York law.

United's and MPI's Scheme to Deprive Anesthesia Providers of Reimbursement

147. After Empire Plan refused to participate in New York IDR for disputed reimbursement claims, LIA and other anesthesia groups believed they had no choice but to invoke the federal IDR process under the No Surprise Act.

148. Puzzlingly, Empire Plan's response to the invocation of the federal IDR process was to contend to the IDR entity that, somehow, it was exempt from the federal IDR process as well.

149. Accordingly, LIA and other anesthesia groups received responses from the federal IDR entities that "[t]he non-initiating party has provided reason as to why this dispute does not apply for the IDR process. CMS will take a more detailed look into this dispute to determine eligibility. I am unable to provide a time frame at the moment but will keep you updated on the status. It was communicated to us that once a dispute is on hold the timeline is also on hold and therefore there will be no penalty if any deadlines are missed."

150. There is no statute, regulation, guidance, or case that would make the Empire Plan exempt from both the NY state and federal IDR processes for the same claims during the same period.

151. Unfortunately, the correspondence from the federal IDR entities was not the end of the saga. Several days after receiving the correspondence, LIA started receiving written communications from MPI, identifying itself as working with United.

152. The communications purport to respond to LIA's "Open Negotiation Notice," and state that the claims have "been identified as a No Surprises Bill under the No Surprises Act. We are offering the Qualifying Payment Amount to resolve this for payment in response to your Open Negotiation Notice. . .. Please note the following[:] upon expiration of the 30-business-day open negotiation period required by the No Surprises Act. If you choose to submit the Federal IDR Process, you must submit a Notice of IDR Initiation through the Federal IDR Portal. . . ."

153. The first set of these notices demand a response in less than 24 hours' time. Thus, it appears from these communications, that United, through MPI, was now acknowledging that the federal IDR process applied. When LIA and other anesthesia group representatives called

MPI to negotiate the payment amounts, MPI representatives flatly refused, stating that they were only authorized to offer the QPA amount.

154. Thereafter, LIA and other anesthesia practices started receiving more notices from MPI as United's representative. These notices demanded a response within 45 minutes of receipt, and ominously warned LIA that the "No Surprises Act states you must provide justification for your offer on the Open Negotiation Notice request. Some common reasons could be patient severity and acuity, provider level of training, facility teaching status or market share. Our offer is based on the information we currently have available. Failure to provide the requested information will result in your Open Negotiation Notice request being closed without a good faith engagement."

155. Once again, contrary to MPI's representations, there is no statute, regulations, or guidance that obligates LIA to provide it with detailed information regarding its reimbursement claims within 45 minutes of demand.

156. To make such demands in connection with scores of reimbursement disputes is the height of bad faith, particularly given the threat that non-compliance will result in the closure of the Open Negotiation period and the implied loss of the right to pursue the disputes.

157. The whole position is particularly disingenuous given that MPI already has said that it has no intent to negotiate further. It is hard to conceive of a scenario other than that this entire process is a cynical attempt to prevent LIA from pursuing any type of IDR on these claims.

158. Other anesthesia groups on Long Island similarly situated to LIA received similar correspondence from United and MPI.

159. Not only does this correspondence serve to effectively deny LIA and other similarly situated anesthesia providers the ability to contest these abysmally and predatorily low reimbursement rates, but it is flooding each provider with such a large volume of correspondence demanding responses in ever shortening periods of time – as short of 15 minutes – as to make it impossible to keep up with the flood of correspondence and still keep up with the ability to routinely bill and collect for other anesthesia services.

160. Given all the circumstances, the only logical conclusion that can be drawn is that this campaign of excessive correspondence with exceedingly short deadlines is designed to force anesthesia providers from abandoning their challenges to Empire Plan's low reimbursement.

161. And this is exactly what has happened. Many practices receiving this torrent of correspondence from MPI and United have made the decision not to challenge Empire Plan's low reimbursement rates simply because they lack the bandwidth or resources to keep up with the MPI and United correspondence while at the same time performing routine billing and collection tasks.

MPI's Illegal and Improper Motives

162. Although on its face MPI appears to be nothing more than a United vendor engaging in isolated communications with out-of-network providers on its behalf, nothing can be further from the truth.

163. First, MPI is a horizontal competitor of United because both MPI and United own and operate Preferred Provider Organization (PPO) networks.

164. As the Kaiser Family Foundation explained in 2022, PPOs are the most common type of employer provided healthcare plan in the United States. They contract with health care

providers to establish agreed-upon payment rates for the providers' services. Subscribers to PPO plans can access any network healthcare provider at a reduced rate. Subscribers almost always must pay more if they choose an out-of-network provider.

165. MPI acknowledges that it operates the "oldest and largest independent [PPO] network" in the United States. Collectively, its PPO networks have over 1.3 million healthcare providers under contract, encompassing approximately "920,000 practitioners, 4,800 acute care hospitals and 87,000 ancillary facilities."

166. Private and public-sector employers, insurance companies, tribal entities, and union benefit plans are all subscribers to MPI's PPO networks. Additionally, MPI provides competing health insurance networks access to its "complementary" PPO networks in exchange for a fee. Indeed, MPI makes money from all these PPO networks, by contracting with insurers and others to permit their plan beneficiary to use the medical providers who participate in the applicable MPI PPO network.

167. All these PPO networks compete with other commercial health insurance payers to secure contracts with medical providers. Many large health payers, including United, operate their own PPO network. United, for example, offers UnitedHealthcare Options PPO plans. These PPO plans rely on PPO networks that directly compete with MPI's PPO networks to obtain provider contracts.

168. MPI's 2023 Annual Report admits that its PPO networks compete against United and other commercial health insurance networks: "We also compete with PPO networks owned by our large Payor customers[.]"

41. MPI has also recently admitted under oath that, like United, it is a health insurance payer. As Marjorie G. Wilde, Senior Counsel for MPI, explained in a declaration filed

in *Jonathan Hott, M.D. v. MPI, Inc.*, Case No. 1:21-cv-02421-LLS (S.D.N.Y. Aug. 15, 2022) (Dkt. 38-2):

> MPI provides healthcare cost management services and operates a network-only preferred provider organization ("PPO") that does business nationwide by contracting, on the one hand, with healthcare providers, such as hospitals, physicians, physician groups and ancillary providers ("Network Agreements"). These contracted providers agree to give discount off of medical services rendered to the beneficiaries of clients of MPI. . . . On the other hand, MPI also contracts with its clients, which include health insurance carriers, health maintenance organizations, self-funded health plans, third party administrators, and other third-party payors that have members and beneficiaries who receive medical services from the provider network assembled by MPI.

Id. ¶¶ 3–4.

169. United itself has recognized that MPI is a competing network. At a trial, John Haben, United's former Vice President of Networks testified that "MPI has the largest network in the country. . . . They have a broad network. Broader than United."

170. MPI, however, is more than just a horizontal competitor. Rather, starting around 2006, it embarked on a strategy – self-described as "MultiPlan 2.0" – to sell "analytics" services to its health insurance competitors. MPI described these services as a "[d]ata-driven, customized healthcare cost management solution." As we allege below, these "analytics" are nothing more than an agreed-upon methodology for health insurance payers to suppress payments to health care providers using the artifice of a "fair" and "reasonable" repricing scheme.

171. Specifically, uses analytics tools it created or acquired, such as Pro Pricer, Viant, MARS, and Data iSight to "re-price" out-of-network health plan claims. In a typical example, after an out-of-network provider renders a covered health care service to a plan enrollee, the plan receives the provider's reimbursement claim and turns it over to MPI. Multi-Plan then uses its analytic tools to "reprice" the claim pursuant to MPI's agreement with the health plan. This

repricing process almost invariably leads to a reimbursement amount below the customary and reasonable amount. MPI then either directly or through the plan repriced claim on a take-it-or-leave-it basis.

172. MPI makes money on claims repricing by charging its health care payer customers a fee based on the difference between a healthcare providers' original claim and the amount the provider accepts following MPI's repricing of the claim. This fee is usually equal to 5-7% of the "savings," but can be as high as 9.75%. As a result, MPI is motivated to recommend the lowest reimbursement price possible, since it increases the fee that MPI charges to its competing insurance companies.

173. Importantly, in most cases, MPI's repriced amount is not just a payment recommendation to the health care payer; it is a determine of the payment amount. Typically, MPI's recommendation is accepted by the payer anywhere from 93% to 99.4% of the time.

174. These high acceptance rates are not because MPI's repriced amounts are fair or reasonable, but rather because almost all major health payers use MPI to reprice their out-of-network claim using the exact same analytic tools, thereby yielding virtually identical repricing amount, leaving the providers little alternative but to accept them.

175. Without the uniformity that the MPI repricing scheme provides, health payers would determine reimbursement rates independently based on their own individual analyses.

176. In such an environment, an individual payer would be constrained in its ability to impose dramatically decreased reimbursement rates upon out-of-network providers, for fear that providers and enrollees, when confronted by these reduced rates and the damage they do to the delivery of high quality care, would seek to avoid dealing with the low reimbursement payer.

177. This, however, does not occur with the MPI repricing scheme. Because payers know that their competitors are using the same repricing tools that generate virtually identical amounts, they are free to dramatically reduce reimbursement knowing that their competitors will be doing the same.

178. Indeed, MPI leaves little room for doubt that its motives are not fairness or reasonableness. Its marketing materials are clear that its products were "built to help [insurers and other] payers reduce the cost of . . . out-of-network" reimbursements to physician practices such as LIA.

179. MPI further advertises that it generates over $15 billion in reimbursement rate reductions. It has variously alleged that it has reduced out-of-network reimbursement payments throughout the country by anywhere from 18% to 81%.

180. MPI's clients for these services include not only United, but also Cigna, Elevance, Centene, and Humana. These are some of the largest health care companies in the world. As of 2022, United was 5 on the Forbes' list. Aetna (part of CVS Health) was 4, Cigna is 12, Anthem (now Elevance Health) was 20, Centene was 26, and Humana was 40 on the Forbes' list.

181. In 2021, Sean Crandell, the Senior Vice President of Healthcare Economics at MPI, testified that "all of the top 10 insurers in the U.S." are MPI customers. By 2023, MPI acknowledged that "all of the top 15 insurers" in the nation have agreed to use MPI as their out-of-network claim repricer.

182. All totaled over 700 managed care companies and 100,000 health plans/sponsors use MPI's services; these cover over 60 million beneficiaries throughout the United States.

183. The relationship between MPI and the plans is quite deep and longstanding. According to MPI's Annual Report, it "continue[s] to experience high renewal rates and our top

ten customers based on full year 2021 revenues have been customers for an average of 25 years. Our customer relationships are further strengthened by high switching costs as MPI is electronically linked to customers in their time-sensitive claims processing functions, and we support highly flexible benefits offerings to an extensive group of customers who often feature a MPI logo on membership cards when networks are used." *Id.*

184. The relationship between MPI and United is particularly close and deep. United is MPI largest customer, representing 30% of its revenue. As MPI stated in 2021, "Over the past three years, MPI's revenues from UHC have grown more than 30% to an all-time high. MPI and UHC have partnered on a series of strategic initiatives that we expect will further grow this business in 2022 and beyond. UHC is an extraordinary customer and partner of MPI. . . . We are excited to continue that partnership in the years to come. . . ."

185. United's motives for using MPI become clear from their correspondence. In 2016, MPI's then Chief Revenue Officer, Dale White, authored an email to United executives informing them that 7 of United's top 10 competitors were using MPI's repricing services. White specifically stated "[i]mplementing these initiatives will go a long way to bring UnitedHealth back into alignment with its primary competitor group [Blues, Cigna, Aetna] on managing out-of-network costs."

186. Dale White is currently MPI's Chief Executive Officer, although he will be transitioning into the role of Executive Chair effective March 1, 2024.

187. Rebecca Paradise, United's Vice President of Out-of-Network Payment Strategy, after receiving White's email explained that a key factor in United's decision to use MPI's repricing services was that it was "widely used by our competitors."

188. John Haben, another United executed, recommended to senior United management in 2017 that [t]oday, our major competitors have some sort of outlier cost management; they use Data iSight. United will be implementing July 1, 2017."

189. Haben testified under oath that United moved from paying out-of-network claims at reasonable and customary rates, or rates determined by benchmarking databases, to using MPI's tools because reasonable and customary rates led to "uncontrolled" costs. Rather, United, like its competitors, shifted to a "shared saving" model using MPI's repricing tools.

190. United made approximately $1.3 billion from its shared savings agreements to suppress out-of-network claims in 020. United has also stated in an internal presentation that it intended to cut its out-of-network reimbursements by $3 billion through 2023.

191. So successful was MPI's repricing arrangement with United and the other health care payers, that MPI sought to extend its features to the No Surprises Act process when it became operational in January 2022.

192. Accordingly, MPI's marketing materials announced a coordinated strategy to partner with United and other health plan clients to manage the entire No Surprises Act compliance process with the goal of significantly reducing the plans' reimbursement rates. https://www.MPI.us/no-surprises-act/ (accessed Nov. 11, 2022). Like the overall repricing product, MPI would share in the savings generated by United and the other health plans resulting from its negotiation efforts.

193. As MPI explained in its 2021 Annual Report:

> The [NSA] require[s] extensive data collection and analysis to identify claims as surprise bills under the law's definition; calculate the new QPA benchmark introduced by the law and append it to the claim; create an initial payment amount for the claim, typically by using the QPA as the reference point; negotiate a settlement as needed; and take claims through an independent

> dispute resolution process as needed. We leverage existing technology and expertise in data science, claim pricing and negotiation in offering these new services. They are used by all types of Payors that must comply with the NSA, and are priced either at a percentage of savings for the end-to-end service, or on a per-claim basis for individual components.

MPI Annual Report (SEC Form 10-K) at 13 (Feb. 25, 2022).

194. Accordingly, MPI developed an "End to End Surprise Billing Service," stating that "[w]ith expertise in every step of the process, we can administer the entire NSA process on your behalf. Our easy-to-implement services can help you organization achieve compliance quickly."

195. This Service has five key features, as explained by MPI:

- **Identify Surprise Bill**: "We examine billing codes, facility network status and episodes of care for your primary network(s) and ours."
- **Calculate and Append QPA**: "We calculate the Qualifying Payment Amount (QPA) and include it on the processed claim so that you can complete the adjudication."
- **Price Claim**: "We can reprice claims at QPA or an amount just below or above it. Alternatively, we can use another of our Analytics-Based services to determine a fair amount that providers are likely to accept."
- **Negotiate Settlement**: "Providers that reject the initial payment contact us to start the process. We leverage technology, data, and experienced staff to negotiate a settlement to accept.
- **Arbitrate**: "When settlement isn't reached, we'll own the IDR process from start to finish. In calculating a payment offer, we analyze data from millions of claims, actual facility costs, and more."

196. MPI's 2022 Annual Report describes the Services as follows:

Surprise Billing Services. Introduced in 2021, our surprise billing services help Payors comply, or help their employer/plan sponsor customers comply, with the federal No Surprises Act ("NSA"), which became effective on January 1, 2022. Interim final regulations issued on July 13, 2021 and October 7, 2021 ("IFRs") and then final regulations issued on August 26, 2022 (the "Final Rules"), have provided additional detail on how payors and providers must operate under the NSA. These IFRs and Final Rules implemented portions of the NSA and introduced changes to the reimbursement process of certain types of medical claims, increasing what was typically a one- to two-step reimbursement process to five steps. MultiPlan performs all five steps in an end-to-end service, or makes each step available as components to meet the specific needs of each Payor. The steps require extensive data collection and analysis to identify claims as surprise bills under the law's definition; calculate the new QPA introduced by the law and append it to the claim; create an initial payment amount for the claim, typically by using the QPA as the reference point; negotiate a settlement as needed; and take claims through an independent dispute resolution process as needed. In offering these new services, we leverage existing technology and expertise in data science, claim pricing, and negotiation. The services are used by all types of Payors that must comply with the NSA, and are priced either as a percentage of savings for the end-to-end service, or on a per-claim basis for individual components.

197. It is the Price Claim, Negotiate Settlement, and Arbitrate features of the Service that incorporate significant aspects of MPI's pre-existing repricing services and are thereby used to extend and replicate the reimbursement reducing benefits of the repricing services to the NSA environment.

198. MPI's efforts in connection with No Surprises Act compliance are part of its overall, decade-long strategy to work with "substantially all of the largest health plans," to reduce out-of-network reimbursement rates, "using data-driven negotiation and/or reference-based pricing methodologies."

199. It is this extension of the MPI repricing strategy to the NSA environment that is at work in the events underlying this lawsuit.

Anti-Competitive Harm Caused Anesthesia Providers

200. As a result of the actions of United and MPI, which continue to date, LIA and other anesthesia groups are in the untenable and unenviable position where their reimbursement for providing medically necessary anesthesia services have been dramatically cut – more than 80% –by United, with the assistance of MPI, and they have no viable avenue to redress these cuts.

201. These actions of United and MPI have caused significant harm.

202. The sudden, precipitous decrease in reimbursement – to less than 20% of what it was in December 2021 – is devastating to LIA.

203. LIA is a hospital-based anesthesia provider and cannot simply choose not to accept certain patients referred to it. Accordingly, it cannot turn away patients with the Empire Plan.

204. Given these circumstances and the fact that LIA is already out-of-network for the Empire Plan, LIA has little recourse in the facte of the lowered reimbursement rates.

205. If LIA were to choose to go in-network—its only option—its reimbursement rate would likely be the same or less than it is now, according to testimony from Daniel Yanulavich, the Director of the Employee Benefits Division of the New York State Department of Civil Service (responsible for administration of the Empire Plan). *See* ECF Dkt. 41-3.

206. LIA's practice is representative of other private practices in the market, and, upon information and belief, each are situated similarly.

207. For example, Long Island Anesthesia Partner's Chief Operating Officer testified in late 2022 that the sudden, precipitous decrease in Empire Plan reimbursement — to less than 20% of what it was in December 2021 — constituted unabsorbable loss to the practice, especially given a severe shortage of quality anesthesia providers in the Long Island area, skyrocketing expenses due to inflation and the uncertain economic climate.

208. The testimony went on to explain that, if low Empire Plan reimbursement levels continue unabated, the practice would, at the very least, be forced to significantly curtail its services and not allow its hospital clients to open all required operating rooms on any given day. It would be severely hampered in its ability to recruit and retain high quality recently trained physicians or acquire new technology and information systems. This is exacerbated by

demographic and societal factors such as the "Great Resignation," causing an already significant shortage of well-qualified clinicians.

209. In 2021, 44% of LIAP's revenues were attributable to services performed on Empire Plan's members. Consequently, following the Empire Plan's actions, as of June 2022, only 11% of LIAP's revenues are attributable to services performed on Empire Plan's members resulting in a reduction of revenues of more than $20 million and reduction of practice profits by more than 80%.

210. As of June 2022, LIAP has seen its average reimbursement per case decline from $6,083.00 to $873.00 in a matter of days for the same services provided to members of the Empire Plan.

211. LIAP's Chief Operating officer explains that, shortly and assuredly, the low Empire Plan' reimbursement rates would disrupt longstanding relationships that its participating facilities and providers have with the practice. Its clinicians intimately know the participating facilities' and providers' requirements to deal with unique medical conditions and how best to treat them. This will be hampered, if not lost, negatively impacting the health and wellbeing of New York's public employees and their dependents during these stressful times.

212. The COO further testified that, due to the low Empire Plan rates, LIAP has lost more than 10% of its physician staff due to financial distress, resigned from a new ambulatory surgery center due to an inability to continue to make the investment required to insure the facility's success after its initial first few years of start-up losses, terminated both of its general surgeons, commenced the divestiture of its interventional pain management operation impacting 70 employees and approached its clients for stipends which will now place even greater financial stress on not-for-profit hospitals which could lead to further reduction in much needed

hospital services. These dramatic changes were fundamentally, severely and permanently damaging to LIAP, its hospital clients, patients and employees and such damage will be irreversible.

213. In addition, LIAP is the exclusive anesthesia provider to five hospitals located on Long Island. There are no alternative in-network providers at the hospitals nor the availability of alternative anesthesia resources by others to staff these hospitals. Due to the Empire Plan's actions, LIAP's ability to service these hospitals has been severely hampered, causing a shortage of anesthesia providers to take call at these hospitals. As a result, these hospitals have been forced to shutter operating or procedure rooms, or lengthen schedules or wait times, to account for these shortages. This directly and irreparably impacts patient care at hospitals.

214. This consistent and continued lowered reimbursement led LIAP to announce that, as of February 1, 2024, it ended its 50+-year history of being an independent medical practice and joined NYU-Langone Health. This difficult decision was largely precipitated by the No Surprises Act impacting out-of-network reimbursement from NYSHIP making it nearly impossible to continue to practice independently.

215. Likewise, New York Cardiovascular Anesthesiologist's President has testified that NYCA relies on fair reimbursement to continue its mission to provide high quality, innovative care to its patients. The sudden, precipitous decrease in Empire Plan reimbursement — a 73% decrease compared to December 2021 — also constituted unabsorbable loss to its practice.

216. He further explained that, if the low Empire Plan reimbursement rates continue, the practice will, at the very least, be forced to significantly curtail its services, preventing it from opening all required operating rooms. Since January 2022, the practice also has been

severely hampered in our ability to recruit and retain high quality recently trained physicians or acquire new technology and information systems.

217. The President concludes that, unless Empire Plan reimbursement rates are restored, there will be a loss of continuity of medical care, significant delays in the provision of care due to the lack of or restricted access to out-of-network physicians, potential exposures to surprise and balance bills, and significant increases in adverse health outcomes, including serious illness and the potential loss of life.

218. In 2021, 19% of NYCA's revenues were attributable to services performed on Empire Plan's members. Consequently, following the Empire Plan's unlawful actions, as of July 2022, 10% of .NYCA's revenues are attributable to services performed on Empire Plan's members. Essentially overnight NYCA has lost over 12% of overall revenue. Due to this situation, NYCA has been forced to suspend all new hires, lay off staff and eliminate sites of service.

219. In addition, NYCA is a contractual anesthesia provider to hospitals located on Long Island. There are no alternative in-network providers at the hospitals it services. The low Empire Plan reimbursement rates have hampered NYCA's ability to service these hospitals, which has caused a shortage of anesthesia providers to take call at these hospitals. As a result, these hospitals too have been forced to delay operating and procedure rooms, lengthen schedules and patient wait times to account for these shortages. This directly and irreparably impacts patient care at hospitals.

220. LIA, NYCA, and LIAP collectively service seven large Long Island hospitals, and a significant number of ambulatory surgery centers and other facilities. Their demonstrated

difficulties at the hands of United and the lowered Empire Plan reimbursement rates demonstrate a large, market-wide impact.

221. Further, these practices' experiences are corroborated by other market participants, including John F. DiCapua, M.D., the Chief Executive Officer of Long Island-headquartered North American Partners In Anesthesia stated in *MDnewslongisland.com* regarding the post-NSA reimbursement reductions: "In a profession already facing a shortage of clinicians, long work hours and burnout, reducing reimbursement perpetuates this shortage by encouraging even more early retirements. This attrition only increases healthcare labor costs, as medical centers facing heavy competition often feel the need to offer higher salaries to attract and retain the remaining pool of anesthesia providers. Higher labor costs have also resulted in a record number of practice closures in this specialty, Dr. Di Capua explains, affecting access to care in many regions, including lower income and rural communities. 'We are at a point that I thought I would never see in my career,' Dr. Di Capua says. 'Hospitals may not have enough anesthesia providers to support their patient population.'"

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

Defendants' Anti-Competitive Motives

223. Defendants' conduct is particularly egregious given that its intent in undertaking this conduct is simply anticompetitive harm and restraint of trade.

224. Put simply, United, aided by MPI, is using its significant market power to drive down out-of-network anesthesia reimbursement rates in the New York metropolitan area knowing full well that the impact of lower reimbursement rates will be to drive out anesthesia providers such as LIA.

225. Driving anesthesia providers such as LIA from the market will significantly benefit United because, as alleged above, United, through its OptumCare subsidiary, provides anesthesia services in market and is looking to expend its delivery of all healthcare services, including anesthesia services, in the New York metropolitan area.

226. Thus, the elimination of independent anesthesia providers, such as LIA, from the market, will significantly benefit United at the expense of LIA and other similarly situated anesthesia providers.

227. Given United's size and market share, the dramatic lowering of its reimbursement rate for anesthesia services is causing, and will continue to cause, a sizable number of anesthesia practices to leave the relevant market by either going out of business entirely or being forced to sell their practices to hospitals or multispecialty groups. Those that survive have will be seriously hampered in their ability to compete.

228. This will result in decreased output and quality of anesthesia services.

229. The dramatic lowering of reimbursement rates will also have a direct negative economic effect on patients, because those patients with high deductible plans or plans with large cost-sharing requirements for out-of-network services may have to pay significantly more out-of-pocket to receive medically necessary services.

230. Because of all the foregoing, Defendants' actions have greatly and irreparably harmed competition in general and LIA in particular.

231. There is no reasonable, pro-competitive justification for Defendants' actions, much less one that outweighs these anti-competitive effects.

232. Indeed, while United is decreasing the amount it pays for anesthesia services in the relevant market, it is not passing on these savings to patients or the purchasers of health care coverage.

233. Not only will Defendants' actions harm LIA, but they will also harm other anesthesia providers and, indeed, the whole market.

234. Indeed, premiums have increased. For 2022, United sought an increase in premiums for the small group market in the amount of 17.5%; it obtained an increase of 6.3%. For 2023, United seeks an increase of 19.1%. It received a 6.0% increase.

Defendants Under Antitrust and Other Investigative Scrutiny

235. United's conduct recently has led to the opening of an antitrust inquiry by the Department of Justice into its operations.

236. Specifically, the *Wall Street Journal* reported on February 27, 2024 that the "Justice Department has launched an antitrust investigation into UnitedHealth, owner of the biggest U.S. health insurer, a leading manager of drug benefits and a sprawling network of doctor groups. The investigators have in recent weeks been interviewing healthcare-industry representatives in sectors where UnitedHealth competes, including doctor groups, according to people with knowledge of the meetings."[2]

237. The article goes on to explain that "[d]uring their interviews, investigators have asked about issues including certain relationships between the company's UnitedHealthcare insurance unit and its Optum health-services arm, which owns physician groups, among other

[2] https://www.wsj.com/health/healthcare/u-s-launches-antitrust-investigation-of-healthcare-giant-unitedhealth-ff5a00d2?st=o9j2rb3xua0897y&reflink=article_email_share (accessed May 28, 2024).

assets. Investigators have asked about the possible effects of the company's doctor-group acquisitions on rivals and consumers, the people said."

238. Explaining United's vast size, the *Wall Street Journal* wrote "UnitedHealth, based in Minnetonka, Minn., had $372 billion in revenue last year. Its insurance unit covers about 53 million people, across a range of plans including employer, Medicaid and Medicare coverage. After years of acquisitions, Optum includes about 90,000 physicians, as well as surgery centers, an array of health data and technology units, and one of the largest pharmacy-benefit managers."

239. At least part of the investigation is focused on New York. The *Journal* article explains that the "new Justice Department inquiry, reported earlier by the Examiner News, a news organization based in New York's Hudson Valley, is partly examining Optum's acquisitions of doctor groups and how the ownership of physician and health-plan units affects competition, according to the people with knowledge of the matter. Investigators have asked whether UnitedHealthcare favored Optum-owned groups in its contracting practices, potentially squeezing rival physicians out of certain types of attractive payment arrangements. Investigators have also explored whether Optum's ownership of healthcare providers could present challenges to health insurers that are rivals to UnitedHealthcare."

240. This is not the only investigative scrutiny that Defendants have been subjected to in the recent past.

241. Specifically, the *New York Times* published a series of investigative articles on April 7, 2024, about MPI and its relationships with the major managed care plans, including United.[3]

[3] https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html (accessed May 28, 2024).

242. The *Times* reported that "[l]arge health insurers are working with a little-known data company to boost their profits, often at the expense of patients and doctors." This data company, MPI, "has helped drive down payments to medical providers and drive up patients' bills, while earning billions of dollars in fees for itself and insurers."

243. The *Times* went on to explain that, when patients receive care from providers outside their insurance plans' networks, large commercial insurers (including United) send the bills MPI to recommend a payment amount. But MPI and the insurers are strongly incentivized to keep the payments low because their fees increase when the reimbursements decrease. Specifically, their revenues are based on the difference between the original bill and the amount the insurer actually pays, so these giant corporate entities have every reason to pay far less than they should. Remarkably, the fees paid to commercial insurers and MPI are often far higher than the reimbursement for the health care itself. Given these perverse incentives, it is not surprising that these returns help pad the sky-high profits of large corporate conglomerates like United. Tellingly, United alone reportedly reaps $1 billion in annual fees from employers for its work with MPI.

SUMMARY OF ANTITRUST ALLEGATIONS

Relevant Product Market

244. The relevant product market at issue here is the provision of medically necessary anesthesia services to patients.

245. Anesthesia services comprises the use of various injected and inhaled medications to produce a loss of sensation in patients, making it possible to carry out procedures that would otherwise cause intolerable pain or be technically unfeasible.

246. Safe anesthesia requires in-depth knowledge of various invasive and non-invasive organ support techniques that are used to control patients' vital functions while under the effects of anesthetic drugs; these include advanced airway management, invasive and non-invasive hemodynamic monitors, and diagnostic techniques like ultrasonography and echocardiography. Anesthesiologists are expected to have expert knowledge of human physiology, medical physics, and pharmacology, as well as a broad general knowledge of all areas of medicine and surgery in all ages of patients, with a particular focus on those aspects which may impact on a surgical procedure.

247. In recent decades, the role of anesthesiologists has broadened to focus not just on administering anesthetics during the surgical procedure itself, but also beforehand to identify high-risk patients and optimize their fitness, during the procedure to maintain situational awareness of the surgery itself to improve safety, as well as afterwards to promote and enhance recovery.

248. Anesthesiologists are also responsible for ensuring adequate pain relief for patients in the immediate postoperative period. The field comprises individualized strategies for all forms of analgesia, including pain management during childbirth, neuro-modulatory technological methods such as transcutaneous electrical nerve stimulation or implanted spinal cord stimulators, regional anesthesia and nerve blocks, and specialized pharmacological regimens.

249. Only appropriately educated, trained, and experienced anesthesiologists have the necessary skills and training to provide these services.

250. Other physicians or clinicians do not have the expertise to competently provide these services and therefore cannot be considered reasonable substitutes.

251. The relevant product market at issue here is the New York metropolitan area.

Relevant Geographic Market

252. Given the chronic and urgent nature of most medical problems requiring procedures performed under anesthesia, patients need to seek this treatment close to where they live and work.

253. Generally, most patients are willing to travel, under the best of circumstances, only about 30 minutes for health care services.[4]

254. Accordingly, the relevant geographic market for anesthesia services in this lawsuit is no larger than the New York metropolitan area, including New York City, Nassau, Suffolk, and Westchester Counties.

United's Market Power

255. LIA participates in this market as a "seller" of anesthesia services. Other anesthesia providers – including OptumCare practices – also participate in this market as sellers.

256. Accordingly, LIA and other similarly situated anesthesia providers are horizontal competitors of United in this market.

257. The patients of LIA, as well as the patients of the other anesthesia providers in the relevant market participate in the relevant market as consumers of anesthesia services.

258. In addition to competing in the market as a seller of anesthesia service, United -- through administering the Empire Plan and other health plans as well as directly providing health plans itself – also participates in the relevant market as a payer or "purchaser" of anesthesia services to the extent plan enrollees seek anesthesia services in the relevant market.

[4] https://altarum.org/sites/default/files/uploaded-publication-files/Altarum_Travel-and-Wait-Times-for-Health-Care-Services_Feb-22.pdf.

259. MPI, to the extent that it assists plans in terms of calculating reimbursement levels and facilitating reimbursement, also constitutes a market participant as a payer or purchaser of anesthesia services.

260. For these reasons, the provision of anesthesia services in the New York metropolitan area is the proper antitrust market in connection with this lawsuit.

261. United has market power in this market. As alleged above, Defendants' actions have had, and will continue to have, an actual adverse effect on competition in terms of decreased output and quality in the market for anesthesia services in the New York metropolitan area.

262. Additionally, as alleged above, United has a significant share of the market in the New York area. Depending on the health plan product involved, United's market share is as high as 66%. Its share of commercial insurers in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties) as of the third quarter of 2019 was 50%.

263. And, in the New York market, United also acts as the administrator of the Empire Plan, which is part of the New York State Health Insurance Program (NYSHIP). This Program provides health coverage for over 1.2 million public employees in New York.

264. In the New York metropolitan area, the Empire Plan represents a significant, if not dominant, payer of reimbursement for anesthesia services.

265. As alleged above, for LIA and, upon information and belief, for similarly situated anesthesia practices, approximately 40% of revenues is received from the Empire Plan.

Defendants' Anti-Competitive Scheme

266. As alleged above, Defendants' anti-competitive conduct here has included significantly reducing reimbursement to out-of-network anesthesia providers such as LIA to more than 80% below previous market levels.

267. Logically, its efforts have a far greater chance to succeed if pressure is applied out out-of-network anesthesia providers to accept these rates without challenge or complaint.

268. United uses MPI to apply this pressure.

269. Under the No Surprises Act, there is a 30-day negotiation period between the health plan and the provider for every out-of-network claim.

270. United takes advantage of this negotiation period by having MPI make extremely low, and entirely unsupported, opening offers in every out-of-network claim, and then demanding that the practice respond, with data supporting its position, in periods as short as 45 minutes after receiving the offer.

271. MPI thereafter threatens the practice that failure to timely respond will be treated as bad faith refusal to negotiation, causing the practice to lose its ability to challenge the reimbursement rate.

272. Practices such as LIA must scramble to provide meaningful responses in virtually impossible timeframes.

273. These steering efforts, including bogus negotiations, applying unrealistic deadlines, and burying practices in mountains of correspondence, are intended to force anesthesia practices to accept these low rates.

274. These actions have been undertaken as part of a contract, combination, or conspiracy between United and MPI so that LIA will accept low Empire Plan rates without challenge or complaint.

275. Indeed, MPI's actions are not simply isolated communications or recommendations. Rather, they grow out of longstanding arrangements between MPI and large health plan payers, including United, to use MPI repricing tools as an agreed-upon methodology to suppress out of network reimbursement.

276. As alleged above, starting around 2006, MPI embarked on a strategy to sell analytic tools designed to reprice out-of-network claims for health plan payers. This repricing process almost invariably leads to a reimbursement amount below the customary and reasonable amount. MPI then either directly or through the plan repriced claim on a take-it-or-leave-it basis. (MPI charges its health care payer customers a fee based on the difference between the original and repriced claim amounts. As a result, MPI is motivated to recommend the lowest reimbursement price possible, since it increases the fee that MPI charges to payers.

277. MPI's repricing customers include, as of 2023, all the top 15 health insurers, including not only United, but also Cigna, Elevance, Centene, and Humana. Over 700 managed care companies and 100,000 health plan/sponsors use MPI's repricing services; these cover over 60 million beneficiaries In most cases, MPI's repriced amount is not just a recommendation, it is a determination accepted by the payer more than 90% of the time. This is not because MPI's repriced amounts are fair or reasonable, but rather because almost all major health payers use MPI to reprice their out-of-network claim using the exact same analytic tools, thereby yielding virtually identical repricing amount, leaving the providers little alternative but to accept them.(PAC)

278. Without the uniformity that the MPI repricing scheme provides, health payers would determine reimbursement rates independently based on their own individual analyses. In such an environment, am individual payer would be constrained in its ability to impose dramatically decreased reimbursement rates upon out-of-network providers, for fear that providers and enrollees, when confronted by these reduced rates and the damage they do to the delivery of high quality care, would seek to avoid dealing with the low reimbursement payer. This, however, does not occur with the MPI repricing scheme. Because payers know that their competitors are using the same repricing tools that generate virtually identical amounts, they are free to dramatically reduce reimbursement knowing that their competitors will be doing the same.

279. Regarding United, MPI approached it in 2017 and opined that United's out-of-network reimbursements were too high and needed to be brought "back into alignment." MPI affirmed United that it had already agreed with other competing health payers to manage out-of-network costs and offered to enter into a similar agreement with United. When considering whether to enter into the MPI agreement, a key factor for United was that its competitors also used MPI's pricing methodology to suppress out-of-network rates. United and MPI thereafter discussed and agreed upon how little United would pay for out-of-network claims using the MPI repricing tools.

280. Thereafter, MPI extended its repricing arrangement's features to the No Surprises Act processes when it became operational in January 2022. It incorporated noteworthy features of its pre-existing repricing services to extend and replicate the reimbursement reducing benefits of the repricing services to the No Surprises Act environment. It is through United's use of this

service that MPI engaged in negotiating pressure tactics upon market anesthesia providers to aid United in significantly reducing Empire Plan out-of-network reimbursement rates.

281. Taken as a whole, these factual allegations establish an antitrust conspiracy. United entered into the arrangement not just because MPI would assist it in repricing claims and thereby potentially lower out-of-network reimbursement. It entered the arrangement because *it knew* that MPI was entering into similar arrangements with its major competitors. Therefore, its ability to dramatically reduce out-of-network reimbursement rates would be assured because providers would have no choice but to accept these lower rates. And, since its competitors were using the same repricing methodology, it would be insulated from losing business to them when it dramatically lowered reimbursement rates.

282. Likewise, MPI, when entering into the arrangement with United, knew that it was facilitating a price coordination scheme among competitors. Indeed, MPI's entire marketing program was how its repricing methodology was sued by all the major health payers. MPI also knew that its uniform repricing methodology was accepted more than 93% of the time by providers.

283. Because of the extensive reimbursement data from all major market competitors, it is also plausible that MPI was fully aware that United was dramatically reducing reimbursement levels to market anesthesia providers below competitive levels and would thereby reduce output and quality.

284. Finally, United, far from simply recommending action to the Empire Plan, has substantial control over the Empire Plan by setting and determining reimbursement rates, selecting in-network providers, processing and adjudicating claims, paying claims, and negotiating dispute resolutions. It earns more money the more savings it generates.) Given this

level of authority, coupled with the significant competitive interest that United has in lowering the reimbursement rates for hospital anesthesia providers to below competitive levels, renders United's actionable involvement in this conspiracy plausible.

Antitrust Injury to Patients in the Relevant Market

285. The harm to competition required for antitrust injury is established by demonstrating that a defendant's anticompetitive behavior had adverse effects on the price, *quality, or output* of the relevant good or service.

286. Here, there are ample facts alleged to render plausible market-wide adverse effects of the quality or output of the anesthesia services.

287. Indeed, from the perspective of the consumer-patient, the actions of United and MPI has required the closure of operating and procedure rooms for lack of available anesthesiologists, the lengthening of OR schedules and wait times, the curtailment anesthesia-related services, the layoff of highly trained and qualified anesthesia staff, the suspension of efforts to recruit, hire, and retain highly trained and high quality anesthesiologists, and the halting of new equipment and technology acquisitions.

288. If left unabated, the current severe financial crises caused by the actions of United and MPI will cause many of the anesthesia practices in the market to close their doors, further exacerbating output and quality reductions.

289. For these reasons, the facts indicated plausible harm to competition in the relevant anesthesia market here caused by reduced output and quality.

290. Additionally, the actions of United and MPI will also lead to market-wide price increases.

291. United, aided by MPI, is using its significant market power to drive down out-of-network anesthesia reimbursement rates in the New York metropolitan area knowing full well that the impact of lower reimbursement rates will be to drive out anesthesia providers.

292. Eventually, this will significantly benefit United because United, through its OptumCare subsidiary, provides anesthesia services in market and is looking to expend its delivery of all healthcare services, including anesthesia services, in the New York metropolitan area.

293. Once United and MPI succeed in driving competing anesthesia practices from the market, OptumCare will be the proverbial "only game in town," able thereby to demand supra-competitive prices from United's health plan competitors and other third-party health care payers. This will, in turn, enable United to maintain supra-competitive premium pricing in local health plan and insurer markets.

294. It will finally give United a supra-competitive advantage when negotiating with customers and hospital advisers because of its ability, through OptumCare, to control access to and the supply of anesthesia services in the market.

295. Thus, Defendants' actions are causing adverse economic effects, such as decreased quality or output, in the market for the delivery of anesthesia services in the New York metropolitan area.

296. Moreover, there is no reasonable, pro-competitive justification for Defendants' actions, much less one that outweighs these anti-competitive effects. Indeed, while United is decreasing the amount it pays for anesthesia services in the relevant market, it is not passing on these savings to patients or the purchasers of health care coverage.

297. For these reasons, judicial intervention is vitally needed.

FIRST CAUSE OF ACTION

298. LIA repeats and re-alleges each of the above paragraphs as though fully set forth herein.

299. At all times relevant to this Complaint, under the circumstances listed above, Defendants have entered contracts, combinations, or conspiracies in unreasonable restraint of trade in violation of Section 1 of the Sherman Act (15 U.S.C. § 1).

300. These contracts, combinations, or conspiracies have caused substantial anticompetitive effects, including the exclusion of competition by LIA and other anesthesia providers, ultimately leading to lower quality and output of anesthesia services available to patients.

301. These contracts, combinations, or conspiracies have no legitimate business justification or offsetting procompetitive benefit. They achieve no legitimate efficiency benefit to counterbalance the anticompetitive effects that they cause.

302. Because of the foregoing, LIA has been damaged in an amount to be determined at trial.

SECOND CAUSE OF ACTION

303. LIA repeats and re-alleges each of the above paragraphs as though fully set forth herein.

304. United possesses monopsony power in the market for the reimbursement of anesthesia services in the New York metropolitan area.

305. United is willfully maintaining that monopsony power through anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for

anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market.

306. United is leveraging that monopsony power to gain an anticompetitive advantage in the market for the provision of anesthesia services in the New York metropolitan area.

307. Because of the foregoing, LIA has been damaged in an amount to be determined at trial.

THIRD CAUSE OF ACTION

308. LIA repeats and re-alleges each of the above paragraphs as though fully set forth herein.

309. United has engaged in predatory or anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market.

310. United undertook this conduct with the specific intent to monopsonize.

311. United has a dangerous probability of achieving monopsony power.

312. Because of the foregoing, LIA has been damaged in an amount to be determined at trial.

FOURTH CAUSE OF ACTION

313. LIA repeats and re-alleges each of the above paragraphs as though fully set forth herein.

314. Defendants possess and exercise market power in the relevant product and geographic markets identified in this Complaint.

315. At all times relevant to this Complaint, Defendants, have entered contracts, combinations, or conspiracies in unreasonable restraint of trade in violation of the Donnelly Act, General Business Law §§ 340, *et seq*.

316. These contracts, combinations, or conspiracies have caused substantial anticompetitive effects, including the exclusion of competition by LIA and other providers of anesthesia services, ultimately leading to lower quality anesthesia services available to patients.

317. These contracts, combinations, or conspiracies have no legitimate business justification or offsetting procompetitive benefit. They achieve no legitimate efficiency benefit to counterbalance the anticompetitive effects that they cause.

318. Because of the foregoing, LIA has been damaged in an amount to be determined at trial.

FIFTH CAUSE OF ACTION

319. LIA repeats and re-alleges each of the above paragraphs as though fully set forth herein.

320. LIA was entitled to be paid at a reasonable rate by United for the medically necessary, covered health care services listed above to the United health plan enrollees at issue.

321. United improperly and without justification failed to timely and properly pay LIA for the medically necessary and covered services it provided, as enumerated above.

322. United benefitted from the services rendered by LIA because LIA discharged the obligations that Empire owed the health plan enrollees. But for the services rendered by LIA, United would have a duty under the relevant health plans to provide benefits to their members for the medically necessary anesthesia services they require.

323. As a result of the non-payment of the medically necessary services s performed by the Practice, United also retained funds designated and reserved for the payment of claims pursuant to the health plan documents. Indeed, all health and other benefit plans conduct an actuarial analysis to determine the proper funding of the plan based upon the members and the anticipated claims. In other words, health plans determine the cost of paying valid claims and set aside the funds necessary for such payment.

324. Pursuant to the relevant health plan documents, United had an obligation to pay for medically necessary services, such as those provided to the enrollees at issue here. By not paying for medically necessary claims, Empire retained an improper benefit.

325. This is so even though United may have been acting as an administrator for a self-funded health plan. In that role, United is responsible for processing claims at the level of benefits determined by the plan and for performing other administrative functions. Empire provides these administrative services pursuant to a contract with the plan sponsors in exchange for which it receives a fee.

326. United's customary administrative services agreements for self-funded insurance plans provide for administrative fees, *inter alia*, based upon a percentage of the payment reductions obtained by United.

327. For all these reasons, United was unjustly enriched by not paying LIA at a reasonable rate, or in some cases at all.

328. This enrichment was at LIA's expense.

329. Given the facts and circumstances, United must return this unjust benefit to LIA.

330. By reason of the foregoing, LIA has been damaged in an amount to be determined at trial.

331. By reason of the foregoing, Defendants have engaged in reckless and morally reprehensible conduct, therefore entitling LIA to recover punitive damages.

DEMAND FOR RELIEF

WHEREFORE, the Plaintiff, Long Island Anesthesiologists, PLLC, respectfully requests the following relief:

(a) On the first cause of action, a declaration that Defendants' conduct constitutes violations of Sherman Act § 1, 15 U.S.C. § 1; a permanent injunction preventing Defendants and their agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages in an amount to be determined at trial, to be trebled according to law, to compensate LIA for the damages it incurred from Defendants' violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(b) On the second cause of action, a declaration that United's conduct constitutes violations of Sherman Act § 2, 15 U.S.C. § 2; a permanent injunction preventing United and its agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages, in an amount to be determined at trial, to be trebled according to law, to compensate LIA for the damages it incurred from United's violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(c) On the third cause of action, a declaration that United's conduct constitutes violations of Sherman Act § 2, 15 U.S.C. § 2; a permanent injunction preventing United and its agents and employees from continuing their unlawful actions set forth herein, including engaging in retaliatory and punitive negotiations with Plaintiff; an award of damages, in an amount to be determined at trial, to be trebled according to law, to compensate LIA for the damages it incurred from United's violations of law; an award of prejudgment interest; and an award of reasonable attorneys' fees and the costs of suit incurred.

(d) On the fourth cause of action, an award of damages in an amount to be determined at trial.

(e) On the fifth cause of action, an award of compensatory and punitive damages in an amount to be determined at trial.

(f) Such other and further relief this Court deems just and proper including the costs, disbursements, attorney's fees, and other allowances of this action.

Dated: May 28, 2024
Uniondale, New York

HARRIS BEACH, PLLC.
Attorneys for Plaintiff

By _____
Roy W. Breitenbach

333 Earle Ovington Boulevard
Uniondale, New York 11553
(516) 880-8378

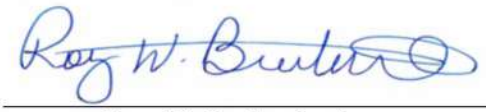
TO: ALL COUNSEL OF RECORD

JURY TRIAL DEMAND

Plaintiff, Long Island Anesthesiologists, P.C. by its attorneys, Harris Beach PLLC, hereby demands a jury trial under Fed. R. Civ. P. 38(b) on all claims so triable.

Dated: Uniondale, New York
May 28, 2024

HARRIS BEACH, PLLC
Attorneys for Plaintiff

By: 

Roy W. Breitenbach

The Omni
333 Earle Ovington Boulevard
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Uniondale, New York 11553
(516) 880-8484

TO: ALL COUNSEL OF RECORD

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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

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

PLEASE TAKE NOTICE that Defendant UnitedHealthcare Insurance Company of New York (United), by and through its undersigned counsel, will move the Honorable Hector Gonzalez of the United States District Court of the Eastern District of New York, located at 225 Cadman Plaza East, Brooklyn, NY 11201, at a time and date to be set by the Court, for an Order dismissing with prejudice the Amended Complaint filed by Plaintiff Long Island Anesthesiologists PLLC (LIA) under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim.

PLEASE TAKE FURTHER NOTICE, that in support of its motion, United relies on its accompanying Memorandum Supporting its Motion to Dismiss the Amended Complaint, dated July 18, 2024.

PLEASE TAKE FURTHER NOTICE, that pursuant to the Court's June 21, 2024 Order, Plaintiff's response, if any, is due on August 19, 2024, and United's reply, if any, is due on September 4, 2024.

United requests oral argument on its motion.

Dated: July 18, 2024

ALSTON & BIRD LLP

/s/Karl Geercken
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Attorneys for Defendant UnitedHealthcare Insurance Company of New York

CERTIFICATE OF SERVICE

I certify that on July 18, 2024, I electronically filed the foregoing Notice of Motion and Memorandum of Law in Support of the Motion to Dismiss the Amended Complaint with the Clerk of Court using the CM/ECF system.

/s/ Karl Geercken

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

Attorney for Defendant UnitedHealthcare Insurance Company of New York

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Case No.: 2:22-cv-04040-HG

Plaintiff,

v.

UNITEDHEATLHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC.,

Defendants.

MULTIPLAN, INC.'S MOTION TO DISMISS PLAINTIFF'S AMENDED COMPLAINT

PLEASE TAKE NOTICE THAT Defendant MultiPlan, Inc. ("MultiPlan"), by and through its undersigned counsel, will move the Honorable Hector Gonzalez of the United States District Court of the Eastern District of New York, located at 225 Cadman Plaza East, Brooklyn, NY 11201, at a time and date to be set by the Court, for an Order dismissing with prejudice the Amended Complaint filed by Plaintiff Long Island Anesthesiologists PLLC ("LIA" or "Plaintiff") under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim.

MultiPlan requests that the Court dismiss the Amended Complaint in its entirety with prejudice. This Motion is based on the Memorandum of Law filed concurrently herewith, all pleadings on file with this Court, and on such oral argument as may be presented at the hearing on this matter.

July 18, 2024

Respectfully Submitted,

/s/ Errol J. King, Jr.
Errol J. King *(pro hac vice)*
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Attorneys for Defendant MultiPlan, Inc.

CERTIFICATE OF SERVICE

I, Errol J. King, Jr., certify that on July 18, 2024, I caused the foregoing Motion to Dismiss and Memorandum of Law in Support of the Motion to Dismiss to be filed with Clerk of the Court and served upon all counsel of record via the Court's CM/ECF system.

Dated: July 18, 2024

/s/ Errol J. King, Jr.
Errol J. King, Jr.

ALSTON & BIRD

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October 29, 2024

The Honorable Hector Gonzalez, U.S.D.J.
United States District Court for the Eastern District of New York
225 Cadman Plaza East
Brooklyn, NY 11201

Re: *Long Island Anesthesiologists PLLC v. UnitedHealthcare Insurance Company of New York et al.*, No. 2:22-cv-04040, Notice of Supplemental Authority

Dear Judge Gonzalez:

I represent UnitedHealthcare Insurance Company of New York in this litigation and write to notify the Court of a decision (attached as Exhibit 1) in *Joseph v. Corso*, 2024 NY Slip Op 05170 (App. Div. 3rd Dept.), an appeal to which Plaintiff Long Island Anesthesiologists PLLC (LIA) is also a party. As relevant to UnitedHealthcare's motion to dismiss the Amended Complaint (*see* Dkt. 61-1 at 7–9; Dkt. 67 at 1–2), the Appellate Division affirmed the trial court's ruling in *Joseph* that the New York Surprise Bill Law does not apply to the Empire Plan.

In this litigation, LIA alleges that the New York Department of Civil Services, at United's behest, incorrectly followed the federal No Surprises Act instead of New York's Surprise Bill Law—resulting in lower reimbursements for LIA and other anesthesiology practices that serve the Empire Plan as out-of-network providers. *See generally* Dkt. 58, Am. Compl.

The Appellate Division affirmed the New York Supreme Court's decision rejecting LIA's allegations. It held that "the Empire Plan is not required to use the IDR process of the [New York state] Surprise Bill Law." Ex. 1, *Joseph v. Corso*, 2024 NY Slip Op 05170 (App. Div. 3rd Dept.) at 7. That holding, along with the state trial court's other unchallenged holding that the New York Department of Civil Services, not United, made the decision to follow the federal No Surprises Act, forecloses LIA's claims. The Court should dismiss LIA's Amended Complaint.

Respectfully,

/s/ Brian D. Boone
Brian D. Boone

Attorney for UnitedHealthcare Insurance Company of New York

EXHIBIT 1

FILED: APPELLATE DIVISION - 3RD DEPT 10/17/2024 10:16 AM CV-23-1477
NYSCEF DOC. NO. 18 RECEIVED NYSCEF: 10/17/2024

State of New York
Supreme Court, Appellate Division
Third Judicial Department

Decided and Entered: October 17, 2024 CV-23-1477

WAYNE JOSEPH et al.,
Appellants,
v
OPINION AND ORDER
REBECCA CORSO et al.,
Respondents,
et al.,
Defendant.

Calendar Date: September 11, 2024

Before: Aarons, J.P., Lynch, Ceresia, McShan and Mackey, JJ.

Harris Beach PLLC, Uniondale (*Roy W. Breitenbach* of counsel), for appellants.

Letitia James, *Attorney General*, Albany (*Frederick A. Brodie* of counsel), for respondents.

Lynch, J.

Appeal from an order of the Supreme Court (Roger D. McDonough, J.), entered July 14, 2023 in Albany County, which, among other things, denied plaintiffs' cross-motion for summary judgment.

In 2014, the Legislature passed the "Surprise Bill Law" (L 2014, ch 60, part H, § 26) which, among other things, protects insureds from being billed directly for healthcare services they did not know were being performed by an out-of-network provider (*see* Financial Services Law §§ 603 [h]; 606 [a]). Under the law, the "health care plan" of an insured who receives a surprise bill is liable for the costs of the out-of-network services

and may attempt to negotiate a reimbursement amount that is less than the amount billed (Financial Services Law § 607 [a] [1], [2]). "If the health care plan's attempts to negotiate . . . do[ ] not result in a resolution of the payment dispute . . . , the health care plan shall pay the non-participating provider an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's co-payment, coinsurance or deductible" (Financial Services Law § 607 [a] [3]). The law also contains an independent dispute resolution (hereinafter IDR) process to address payment disputes, which may be invoked by "[e]ither the health care plan or the non-participating provider" if certain conditions are met (Financial Services Law 607 [a] [4]). When invoked, the IDR process assigns the dispute to an independent arbitrator to determine the reasonable fees for services rendered by an out-of-network provider utilizing the factors outlined in Financial Services Law § 604 and the FAIR Health benchmarking database (*see* Financial Services Law § 607 [a] [4], [6]).

Beginning in 2015, the Empire Plan – a self-funded government health insurance program established in 1986 by the New York State Health Insurance Program (hereinafter NYSHIP) for the state's public employees (*see Matter of Martin H. Handler, M.D., P.C. v DiNapoli*, 23 NY3d 239, 243 [2014]) – utilized the IDR process set forth in the Surprise Bill Law to resolve payment disputes with out-of-network providers for surprise bills. However, after the US Congress passed the federal No Surprises Act in 2020 (*see* 42 USC § 300gg-111 *et seq.*) – a statute substantively similar to the state's Surprise Bill Law – the Empire Plan began using the IDR process set forth in the federal law,[1] which uses different benchmarks to determine the reasonable fees to be paid to an out-of-network provider by an insured's health care plan (*see* 42 USC §§ 300gg-111 [c]).[2]

Plaintiffs – out-of-network healthcare practices and individual members of the Empire Plan – commenced this action challenging the Empire Plan's use of the federal IDR process set forth in the No Surprises Act, contending that, under Civil Service Law § 162, the Empire Plan is subject to the Surprise Bill Law and the associated state IDR process. They seek a declaration to that effect and an injunction prohibiting the Empire Plan's use of the federal IDR process when resolving payment disputes for surprise bills. Following joinder of issue and motion practice, Supreme Court, among other things,

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[1] The effective date of the federal No Surprises Act was January 1, 2022. The Empire Plan began using the federal IDR process that year.

[2] Plaintiffs maintain that use of the federal IDR process set forth in the No Surprises Act has decreased their reimbursement amounts by more than 80%.

denied plaintiffs' request for injunctive relief and declared that "Civil Service Law § 162 and the Surprise Bill Law do not require that New York's IDR process be available to resolve out-of-network disputes involving the Empire Plan." Plaintiffs appeal.[3]

This dispute turns on a straightforward application of the state Surprise Bill Law and the associated federal No Surprises Act. Like the state Surprise Bill Law, the federal No Surprises Act "was passed in 2020 to end surprise medical billing" (*Association of Air Med. Servs. v United States Dept. of Health & Human Servs.*, ___ F Supp 3d ___, 2023 WL 5094881, *1 [Dist DC 2023]) and "addresses the payment of . . . out-of-network providers by group health plans or health insurers" with respect to surprise bills (*Texas Med. Assn. v United States Dept. of Health & Human Servs.*, 587 F Supp 3d 528, 533 [ED Tex 2022], *appeal dismissed* 2022 WL 15174345 [5th Cir 2022]). Pertinent here, the No Surprises Act "requires insurers to reimburse out-of-network providers at a statutorily calculated out-of-network rate," which is "either the amount agreed to by the insurer and the out-of-network provider or an amount determined through" the federal IDR process (*id.* at 533-534 [internal quotation marks omitted]). However, the federal IDR process is inapplicable in states "with an All-Payer Model Agreement" (*id.* at 534) or a "specified state law that meets certain criteria regarding the provision of an alternative IDR process" (*Neurological Surgery Practice of Long Isl., PLLC v United States Dept. of Health and Human Servs.*, 682 F Supp 3d 249, 262 [ED NY 2023]; *see* 42 USC § 300gg-111 [a] [3] [k] [i]). Under the Act, specified state law means "a State law that provides for a method for determining the total amount payable" under a "group health plan or group or individual health insurance coverage offered by a health insurance issuer . . . (*to the extent such State law applies to such plan*, coverage, or issuer)" for "an item or service furnished by a nonparticipating provider or nonparticipating emergency facility" (42 USC § 300gg-111 [a] [3] [I] [emphasis added]). Since the state Surprise Bill Law sets forth a method for determining the total amount payable by a health care plan for a surprise bill, the issue distills to whether the Empire Plan constitutes a health care plan within the embrace of that law (*see Neurological Surgery Practice of Long Island, PLLC v United States Dept. of Health and Human Servs.*, 682 F Supp 3d at 262).

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[3] In its decision on appeal, Supreme Court also granted a motion by defendant UnitedHealthCare Insurance Company of New York, Inc. (hereinafter United) – the program administrator of the Empire Plan Medical/Surgical Program – to dismiss the complaint against it. Plaintiffs do not challenge this ruling on appeal, abandoning any such issue (*see Currie v Oneida Health Sys., Inc.*, 222 AD3d 1284, 1291 [3d Dept 2023]).

Under the state Surprise Bill Law, the term "[h]ealth care plan" is defined narrowly to include only "an insurer licensed to write accident and health insurance pursuant to [Insurance Law article 32]; a corporation organized pursuant to [Insurance Law article 43]; a municipal cooperative health benefit plan certified pursuant to [Insurance Law article 47]; a health care maintenance organization certified pursuant to [Public Health Law article 44]; or a student health plan established or maintained pursuant to [Insurance Law § 1124]" (Financial Services Law § 603 [c]). Unlike the Empire Plan, each of these five entities is either authorized to conduct insurance business in New York, provides insurance through a purchased policy or HMO, or provides health benefits to municipal employees or students (*see* Civil Service Law § 162 [1] [b] [iv]; Insurance Law §§ 1101 [b] [6]; 3201; 4301; 4702; Public Health Law § 4400). Defendants argue that, because the Empire Plan is not one of the entities listed in Financial Services Law § 603 (c), the state IDR process is inapplicable and the federal IDR process controls. Notably, plaintiffs do not dispute that the Empire Plan is not one of the health care plans listed in Financial Services Law § 603 (c). Rather, they argue that Civil Service Law § 162 subjects the Empire Plan to state insurance laws and regulation by the Department of Financial Services (hereinafter DFS), rendering use of the state IDR process appropriate. We are constrained by the plain language of Financial Services Law § 603 (c) to reject plaintiffs' argument.

The Empire Plan is a self-funded government health plan established under Civil Service Law § 162. It is neither an insurer nor contracts with an insurer to provide health benefits to its members (*see* Civil Service Law § 162 [1] [b] [iv]; Insurance Law § 1101 [b] [6]).[4] That said, unlike other self-funded plans, the Empire Plan is subject to certain provisions of the Insurance Law, including providing "coverage mandated pursuant to [Insurance Law article 43] . . . assuring uninterrupted continuance of coverage for all covered persons" (Civil Service Law § 162 [1] [b] [i]). The required coverage "shall include but shall not be limited to all benefits, services, rights, privileges and guarantees allowed by law" (Civil Service Law § 162 [1] [b] [i]). Empire Plan participants are also guaranteed the "internal and external review and appeal rights as described in [Insurance Law article 49]" pertaining to, among other things, final adverse determinations of the medical necessity of a requested service (Civil Service Law § 162 [1] [b] [ii]; s*ee* Insurance Law §§ 4900 [a]; 4910 [a]). Moreover, the Empire Plan's provision of direct

[4] The Empire Plan does contract with United for the purpose of processing and paying claims, but the "State covers its full cost [of the health services] and . . . United merely passes state money to the proper payees" (*Matter of Martin H. Handler, M.D., P.C. v DiNapoli*, 23 NY3d at 243).

benefits is "subject to review by the superintendent of financial services for the purposes of ensuring compliance with applicable insurance law and any and all associated insurance rules and regulations noted in this subdivision" (Civil Service Law § 162 [1] [b] [iv]).

Highlighting the aforementioned provisions, plaintiffs emphasize that, unlike other self-funded plans, the Empire Plan is beholden to certain state insurance laws and DFS regulation. However, the state insurance laws and regulations to which the Empire Plan are subjected do not require use of the state IDR process when arbitrating disputes about its liability for surprise bills. Nor does the Empire Plan's use of the IDR process set forth in the federal No Surprises Act bear upon or in any way conflict with the state law requirements to which it is subjected under Civil Service Law § 162, including the provision of coverage in accordance with Insurance Law article 43. Although it is difficult to discern why the Legislature excluded the Empire Plan from the reach of the state Surprise Bill Law, the fact remains that, in its current form, the plain language of Financial Services Law § 603 (c) subjects only five specified types of "health care plans" to the state IDR process and the Empire Plan is not one of them (*see Pultz v Economakis*, 10 NY3d 542, 547 [2008] ["where the language of a statute is clear and unambiguous, courts must give effect to its plain meaning" (internal quotation marks and citations omitted)]). At the same time, the No Surprises Act recognizes that state IDR processes available to address surprise billing disputes may be inapplicable to certain health plans, providing a gap-filling measure to ensure that insureds of excluded plans will also be protected from being billed directly for out-of-network services of which they were unaware.

In support of their argument to the contrary, plaintiffs note that a bill is pending in the Legislature to amend the definition of "health care plan" as set forth in Financial Services Law § 603 (c) to include "any provision of health benefits under" Civil Service Law § 162 (*see* 2023 NY Senate-Assembly Bill S5638, A7120). Although still in committee, plaintiffs tout this bill as evidence that "the Legislature intended for the New York Surprise Bill Law to apply to the Empire Plan," noting that the justification for the bill is to "clarify[ ] that the term 'Health Plan' in the Financial Service Law . . . include[s] the [NYSHIP/Empire] Plan" (2023 NY Senate-Assembly Bill S5638, A7120 [Statement of Justification]). However, proposed legislation that has not made it out of committee cannot supplant the unambiguous language of Financial Services Law § 603 (c) and does not demonstrate legislative intent at the time that provision was enacted (*see generally Aybar v Aybar*, 37 NY3d 274, 291 n 9 [2021]; *Matter of LeadingAge New York v Shah*,

32 NY3d 249, 265 [2018]). In fact, the legislative history surrounding the state Surprise Bill Law tends to support the opposite conclusion than the one advanced by plaintiffs.

In that regard, we note that part H of the Laws of 2014, chapter 60 – which enacted the state Surprise Bill Law – also added a new section 24 to the Public Health Law governing certain disclosures health care practices are required to make to patients. The term "[h]ealth care plan," as used in the new section of the Public Health Law, was defined to include all the entities listed in Financial Services Law § 603 (c) *as well as* "self-funded employee welfare benefit plans" (L 2014, ch 60, part H, § 17). By contrast, the term "health care plan" within the meaning of Financial Services Law article 6 – i.e., the Surprise Bill Law – was more narrowly defined (*see* L 2014, ch 60, part H, § 26). That the Legislature defined the term "health care plan" differently within the same subsection of legislation that simultaneously enacted both the Surprise Bill Law and Public Health Law § 24 indicates a deliberate choice to narrow the scope of the former (*see generally Matter of Orens v Novello*, 99 NY2d 180, 187 [2002]). We also note that, in 2022, the Legislature amended certain provisions of the Surprise Bill Law to "enact[ ] . . . major components of legislation relating to the federal [N]o [S]urprises [A]ct" (L 2022, ch 57, part AA, subpart A § 4). The amendments made certain provisions of the state IDR process more in line with the federal IDR process but, tellingly, did not expand the categories of health care plans to which the state Surprise Bill Law applies.

Plaintiffs also suggest that the Empire Plan is estopped from using the federal IDR process due to its prior use of the state IDR process and its statements in various plan documents representing that it was subjected to the Surprise Bill Law. We are unpersuaded. The doctrine of estoppel is generally unavailable against the State acting in its governmental capacity (*see Matter of Daleview Nursing Home v Axelrod*, 62 NY2d 30, 33 [1984]; *Matter of Hamptons Hosp. & Med. Ctr. v Moore*, 52 NY2d 88, 93 [1981]). While the doctrine may be applied against the State when it is acting in its proprietary capacity, such an estoppel is limited to cases where "a manifest injustice has resulted from actions taken [by the state] in its proprietary or contractual capacity" and the State's "misconduct has induced justifiable reliance by a party who then changed [their position] to [their] detriment" (*Allen v Board of Educ. of Union Free School Dist. No. 20*, 168 AD2d 403, 404 [2d Dept 1990], *lv dismissed* 77 NY2d 939 [1991]; *see Shawangunk Reserve Inc., v County of Ulster*, 284 AD2d 771, 773 [3d Dept 2001]; *see also Branca v Board of Educ., Sachem Cent. School Dist. at Holbrook*, 239 AD2d 494, 495-496 [2d Dept 1997]; *Carney v Newburgh Park Motors*, 84 AD2d 599, 600 [3d Dept 1981]). Such is not the case here.

Although plaintiffs note that the Empire Plan's 2020 network disclosures to enrollees stated that the "surprise bills law *requires* [t]he Empire Plan to provide information regarding your out-of-network reimbursement" (emphasis added), the No Surprises Act had not taken effect by 2020 and this does not constitute a representation that the Empire Plan would continue using the state Surprise Bill Law even upon the effective date of the comparable federal law. Plaintiffs also highlight a 2021 circular promulgated by DFS – which oversees implementation of the state Surprise Bill Law – advising that, notwithstanding the impending effective date of the recently-enacted federal No Surprises Act, "the New York IDR process will continue to apply to out-of-network emergency services and surprise bills" since New York has a specified state law on point. Notably, this circular was addressed only to the entities listed in Financial Services Law § 603 (c) and not to plans established pursuant to Civil Service Law § 162.[5] In a sworn affidavit contained in the record, Daniel Yanulavich – Director of the Employee Benefits Division of the Department of Civil Service, which administers NYSHIP – explained that "the Empire Plan previously submitted out-of-network billing disputes to the [s]tate IDR process . . . in recognition of the need to provide consumer protections in the absence of any alternate means of providing those protections" and not as a "consequence of a specified legal obligation" to do so. From our perspective, the Empire Plan's prior use of the state IDR process did not preclude it from using the federal IDR process upon the enactment of the No Surprises Act. The subsequent enactment of that law, which still shifts the burden for surprise bills from the patient to the health care plan and recognizes that available state IDR processes may be inapplicable to specific plans, serves as a reasoned explanation for the Empire Plan's change in course (*see generally Matter of Richardson v Commissioner of N.Y. City of Dept. of Social Servs.*, 88 NY2d 35, 39 [1996]; *compare Matter of United University Professions v State*, 36 AD3d 297, 299 [3d Dept 2006]). In light of our determination that the Empire Plan is not required to use the IDR process of the Surprise Bill Law, plaintiffs' argument that it is entitled to a permanent injunction is academic.

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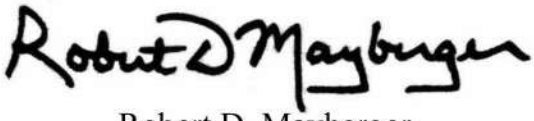
[5] We further note that DFS' website – of which we may take judicial notice (*see Matter of Executive Cleaning Servs. Corp. v New York State Dept. of Labor*, 193 AD3d 13, 18 n 4 [3d Dept 2021]) – expressly states that "[t]he [f]ederal protections from surprise medical bills apply if your employer self-funds your coverage," making clear that state protections do not apply in that circumstance (Department of Financial Services, *Consumer Protection Under the Federal No Surprises Act*, available at https://www.dfs.ny.gov/consumers/health_insurance/protections_federal_no_surprises_act#:~:text=The%20Federal%20protections%20from%20surprise,coverage%20is%20probably%20self%2Dfunded [last accessed Oct. 10, 2024]).

Aarons, J.P., Ceresia, McShan and Mackey, JJ., concur.

ORDERED that the order is affirmed, without costs.

ENTER:



Robert D. Mayberger
Clerk of the Court

EXHIBIT 1

FILED: APPELLATE DIVISION - 3RD DEPT 10/17/2024 10:16 AM CV-23-1477
NYSCEF DOC. NO. 18 RECEIVED NYSCEF: 10/17/2024

State of New York
Supreme Court, Appellate Division
Third Judicial Department

Decided and Entered: October 17, 2024 CV-23-1477

WAYNE JOSEPH et al.,
Appellants,
v
REBECCA CORSO et al.,
Respondents,
et al.,
Defendant.

OPINION AND ORDER

Calendar Date: September 11, 2024

Before: Aarons, J.P., Lynch, Ceresia, McShan and Mackey, JJ.

Harris Beach PLLC, Uniondale (*Roy W. Breitenbach* of counsel), for appellants.

Letitia James, *Attorney General*, Albany (*Frederick A. Brodie* of counsel), for respondents.

Lynch, J.

Appeal from an order of the Supreme Court (Roger D. McDonough, J.), entered July 14, 2023 in Albany County, which, among other things, denied plaintiffs' cross-motion for summary judgment.

In 2014, the Legislature passed the "Surprise Bill Law" (L 2014, ch 60, part H, § 26) which, among other things, protects insureds from being billed directly for healthcare services they did not know were being performed by an out-of-network provider (*see* Financial Services Law §§ 603 [h]; 606 [a]). Under the law, the "health care plan" of an insured who receives a surprise bill is liable for the costs of the out-of-network services

and may attempt to negotiate a reimbursement amount that is less than the amount billed (Financial Services Law § 607 [a] [1], [2]). "If the health care plan's attempts to negotiate . . . do[ ] not result in a resolution of the payment dispute . . . , the health care plan shall pay the non-participating provider an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's co-payment, coinsurance or deductible" (Financial Services Law § 607 [a] [3]). The law also contains an independent dispute resolution (hereinafter IDR) process to address payment disputes, which may be invoked by "[e]ither the health care plan or the non-participating provider" if certain conditions are met (Financial Services Law 607 [a] [4]). When invoked, the IDR process assigns the dispute to an independent arbitrator to determine the reasonable fees for services rendered by an out-of-network provider utilizing the factors outlined in Financial Services Law § 604 and the FAIR Health benchmarking database (*see* Financial Services Law § 607 [a] [4], [6]).

Beginning in 2015, the Empire Plan – a self-funded government health insurance program established in 1986 by the New York State Health Insurance Program (hereinafter NYSHIP) for the state's public employees (*see Matter of Martin H. Handler, M.D., P.C. v DiNapoli*, 23 NY3d 239, 243 [2014]) – utilized the IDR process set forth in the Surprise Bill Law to resolve payment disputes with out-of-network providers for surprise bills. However, after the US Congress passed the federal No Surprises Act in 2020 (*see* 42 USC § 300gg-111 *et seq.*) – a statute substantively similar to the state's Surprise Bill Law – the Empire Plan began using the IDR process set forth in the federal law,[1] which uses different benchmarks to determine the reasonable fees to be paid to an out-of-network provider by an insured's health care plan (*see* 42 USC §§ 300gg-111 [c]).[2]

Plaintiffs – out-of-network healthcare practices and individual members of the Empire Plan – commenced this action challenging the Empire Plan's use of the federal IDR process set forth in the No Surprises Act, contending that, under Civil Service Law § 162, the Empire Plan is subject to the Surprise Bill Law and the associated state IDR process. They seek a declaration to that effect and an injunction prohibiting the Empire Plan's use of the federal IDR process when resolving payment disputes for surprise bills. Following joinder of issue and motion practice, Supreme Court, among other things,

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[1] The effective date of the federal No Surprises Act was January 1, 2022. The Empire Plan began using the federal IDR process that year.

[2] Plaintiffs maintain that use of the federal IDR process set forth in the No Surprises Act has decreased their reimbursement amounts by more than 80%.

denied plaintiffs' request for injunctive relief and declared that "Civil Service Law § 162 and the Surprise Bill Law do not require that New York's IDR process be available to resolve out-of-network disputes involving the Empire Plan." Plaintiffs appeal.[3]

This dispute turns on a straightforward application of the state Surprise Bill Law and the associated federal No Surprises Act. Like the state Surprise Bill Law, the federal No Surprises Act "was passed in 2020 to end surprise medical billing" (*Association of Air Med. Servs. v United States Dept. of Health & Human Servs.*, ___ F Supp 3d ___, 2023 WL 5094881, *1 [Dist DC 2023]) and "addresses the payment of . . . out-of-network providers by group health plans or health insurers" with respect to surprise bills (*Texas Med. Assn. v United States Dept. of Health & Human Servs.*, 587 F Supp 3d 528, 533 [ED Tex 2022], *appeal dismissed* 2022 WL 15174345 [5th Cir 2022]). Pertinent here, the No Surprises Act "requires insurers to reimburse out-of-network providers at a statutorily calculated out-of-network rate," which is "either the amount agreed to by the insurer and the out-of-network provider or an amount determined through" the federal IDR process (*id.* at 533-534 [internal quotation marks omitted]). However, the federal IDR process is inapplicable in states "with an All-Payer Model Agreement" (*id.* at 534) or a "specified state law that meets certain criteria regarding the provision of an alternative IDR process" (*Neurological Surgery Practice of Long Isl., PLLC v United States Dept. of Health and Human Servs.*, 682 F Supp 3d 249, 262 [ED NY 2023]; *see* 42 USC § 300gg-111 [a] [3] [k] [i]). Under the Act, specified state law means "a State law that provides for a method for determining the total amount payable" under a "group health plan or group or individual health insurance coverage offered by a health insurance issuer . . . (*to the extent such State law applies to such plan*, coverage, or issuer)" for "an item or service furnished by a nonparticipating provider or nonparticipating emergency facility" (42 USC § 300gg-111 [a] [3] [I] [emphasis added]). Since the state Surprise Bill Law sets forth a method for determining the total amount payable by a health care plan for a surprise bill, the issue distills to whether the Empire Plan constitutes a health care plan within the embrace of that law (*see Neurological Surgery Practice of Long Island, PLLC v United States Dept. of Health and Human Servs.*, 682 F Supp 3d at 262).

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[3] In its decision on appeal, Supreme Court also granted a motion by defendant UnitedHealthCare Insurance Company of New York, Inc. (hereinafter United) – the program administrator of the Empire Plan Medical/Surgical Program – to dismiss the complaint against it. Plaintiffs do not challenge this ruling on appeal, abandoning any such issue (*see Currie v Oneida Health Sys., Inc.*, 222 AD3d 1284, 1291 [3d Dept 2023]).

Under the state Surprise Bill Law, the term "[h]ealth care plan" is defined narrowly to include only "an insurer licensed to write accident and health insurance pursuant to [Insurance Law article 32]; a corporation organized pursuant to [Insurance Law article 43]; a municipal cooperative health benefit plan certified pursuant to [Insurance Law article 47]; a health care maintenance organization certified pursuant to [Public Health Law article 44]; or a student health plan established or maintained pursuant to [Insurance Law § 1124]" (Financial Services Law § 603 [c]). Unlike the Empire Plan, each of these five entities is either authorized to conduct insurance business in New York, provides insurance through a purchased policy or HMO, or provides health benefits to municipal employees or students (*see* Civil Service Law § 162 [1] [b] [iv]; Insurance Law §§ 1101 [b] [6]; 3201; 4301; 4702; Public Health Law § 4400). Defendants argue that, because the Empire Plan is not one of the entities listed in Financial Services Law § 603 (c), the state IDR process is inapplicable and the federal IDR process controls. Notably, plaintiffs do not dispute that the Empire Plan is not one of the health care plans listed in Financial Services Law § 603 (c). Rather, they argue that Civil Service Law § 162 subjects the Empire Plan to state insurance laws and regulation by the Department of Financial Services (hereinafter DFS), rendering use of the state IDR process appropriate. We are constrained by the plain language of Financial Services Law § 603 (c) to reject plaintiffs' argument.

The Empire Plan is a self-funded government health plan established under Civil Service Law § 162. It is neither an insurer nor contracts with an insurer to provide health benefits to its members (*see* Civil Service Law § 162 [1] [b] [iv]; Insurance Law § 1101 [b] [6]).[4] That said, unlike other self-funded plans, the Empire Plan is subject to certain provisions of the Insurance Law, including providing "coverage mandated pursuant to [Insurance Law article 43] . . . assuring uninterrupted continuance of coverage for all covered persons" (Civil Service Law § 162 [1] [b] [i]). The required coverage "shall include but shall not be limited to all benefits, services, rights, privileges and guarantees allowed by law" (Civil Service Law § 162 [1] [b] [i]). Empire Plan participants are also guaranteed the "internal and external review and appeal rights as described in [Insurance Law article 49]" pertaining to, among other things, final adverse determinations of the medical necessity of a requested service (Civil Service Law § 162 [1] [b] [ii]; s*ee* Insurance Law §§ 4900 [a]; 4910 [a]). Moreover, the Empire Plan's provision of direct

[4] The Empire Plan does contract with United for the purpose of processing and paying claims, but the "State covers its full cost [of the health services] and . . . United merely passes state money to the proper payees" (*Matter of Martin H. Handler, M.D., P.C. v DiNapoli*, 23 NY3d at 243).

benefits is "subject to review by the superintendent of financial services for the purposes of ensuring compliance with applicable insurance law and any and all associated insurance rules and regulations noted in this subdivision" (Civil Service Law § 162 [1] [b] [iv]).

Highlighting the aforementioned provisions, plaintiffs emphasize that, unlike other self-funded plans, the Empire Plan is beholden to certain state insurance laws and DFS regulation. However, the state insurance laws and regulations to which the Empire Plan are subjected do not require use of the state IDR process when arbitrating disputes about its liability for surprise bills. Nor does the Empire Plan's use of the IDR process set forth in the federal No Surprises Act bear upon or in any way conflict with the state law requirements to which it is subjected under Civil Service Law § 162, including the provision of coverage in accordance with Insurance Law article 43. Although it is difficult to discern why the Legislature excluded the Empire Plan from the reach of the state Surprise Bill Law, the fact remains that, in its current form, the plain language of Financial Services Law § 603 (c) subjects only five specified types of "health care plans" to the state IDR process and the Empire Plan is not one of them (*see Pultz v Economakis*, 10 NY3d 542, 547 [2008] ["where the language of a statute is clear and unambiguous, courts must give effect to its plain meaning" (internal quotation marks and citations omitted)]). At the same time, the No Surprises Act recognizes that state IDR processes available to address surprise billing disputes may be inapplicable to certain health plans, providing a gap-filling measure to ensure that insureds of excluded plans will also be protected from being billed directly for out-of-network services of which they were unaware.

In support of their argument to the contrary, plaintiffs note that a bill is pending in the Legislature to amend the definition of "health care plan" as set forth in Financial Services Law § 603 (c) to include "any provision of health benefits under" Civil Service Law § 162 (*see* 2023 NY Senate-Assembly Bill S5638, A7120). Although still in committee, plaintiffs tout this bill as evidence that "the Legislature intended for the New York Surprise Bill Law to apply to the Empire Plan," noting that the justification for the bill is to "clarify[ ] that the term 'Health Plan' in the Financial Service Law . . . include[s] the [NYSHIP/Empire] Plan" (2023 NY Senate-Assembly Bill S5638, A7120 [Statement of Justification]). However, proposed legislation that has not made it out of committee cannot supplant the unambiguous language of Financial Services Law § 603 (c) and does not demonstrate legislative intent at the time that provision was enacted (*see generally Aybar v Aybar*, 37 NY3d 274, 291 n 9 [2021]; *Matter of LeadingAge New York v Shah*,

32 NY3d 249, 265 [2018]). In fact, the legislative history surrounding the state Surprise Bill Law tends to support the opposite conclusion than the one advanced by plaintiffs.

In that regard, we note that part H of the Laws of 2014, chapter 60 – which enacted the state Surprise Bill Law – also added a new section 24 to the Public Health Law governing certain disclosures health care practices are required to make to patients. The term "[h]ealth care plan," as used in the new section of the Public Health Law, was defined to include all the entities listed in Financial Services Law § 603 (c) *as well as* "self-funded employee welfare benefit plans" (L 2014, ch 60, part H, § 17). By contrast, the term "health care plan" within the meaning of Financial Services Law article 6 – i.e., the Surprise Bill Law – was more narrowly defined (*see* L 2014, ch 60, part H, § 26). That the Legislature defined the term "health care plan" differently within the same subsection of legislation that simultaneously enacted both the Surprise Bill Law and Public Health Law § 24 indicates a deliberate choice to narrow the scope of the former (*see generally Matter of Orens v Novello*, 99 NY2d 180, 187 [2002]). We also note that, in 2022, the Legislature amended certain provisions of the Surprise Bill Law to "enact[ ] . . . major components of legislation relating to the federal [N]o [S]urprises [A]ct" (L 2022, ch 57, part AA, subpart A § 4). The amendments made certain provisions of the state IDR process more in line with the federal IDR process but, tellingly, did not expand the categories of health care plans to which the state Surprise Bill Law applies.

Plaintiffs also suggest that the Empire Plan is estopped from using the federal IDR process due to its prior use of the state IDR process and its statements in various plan documents representing that it was subjected to the Surprise Bill Law. We are unpersuaded. The doctrine of estoppel is generally unavailable against the State acting in its governmental capacity (*see Matter of Daleview Nursing Home v Axelrod*, 62 NY2d 30, 33 [1984]; *Matter of Hamptons Hosp. & Med. Ctr. v Moore*, 52 NY2d 88, 93 [1981]). While the doctrine may be applied against the State when it is acting in its proprietary capacity, such an estoppel is limited to cases where "a manifest injustice has resulted from actions taken [by the state] in its proprietary or contractual capacity" and the State's "misconduct has induced justifiable reliance by a party who then changed [their position] to [their] detriment" (*Allen v Board of Educ. of Union Free School Dist. No. 20*, 168 AD2d 403, 404 [2d Dept 1990], *lv dismissed* 77 NY2d 939 [1991]; *see Shawangunk Reserve Inc., v County of Ulster*, 284 AD2d 771, 773 [3d Dept 2001]; *see also Branca v Board of Educ., Sachem Cent. School Dist. at Holbrook*, 239 AD2d 494, 495-496 [2d Dept 1997]; *Carney v Newburgh Park Motors*, 84 AD2d 599, 600 [3d Dept 1981]). Such is not the case here.

Although plaintiffs note that the Empire Plan's 2020 network disclosures to enrollees stated that the "surprise bills law *requires* [t]he Empire Plan to provide information regarding your out-of-network reimbursement" (emphasis added), the No Surprises Act had not taken effect by 2020 and this does not constitute a representation that the Empire Plan would continue using the state Surprise Bill Law even upon the effective date of the comparable federal law. Plaintiffs also highlight a 2021 circular promulgated by DFS – which oversees implementation of the state Surprise Bill Law – advising that, notwithstanding the impending effective date of the recently-enacted federal No Surprises Act, "the New York IDR process will continue to apply to out-of-network emergency services and surprise bills" since New York has a specified state law on point. Notably, this circular was addressed only to the entities listed in Financial Services Law § 603 (c) and not to plans established pursuant to Civil Service Law § 162.[5] In a sworn affidavit contained in the record, Daniel Yanulavich – Director of the Employee Benefits Division of the Department of Civil Service, which administers NYSHIP – explained that "the Empire Plan previously submitted out-of-network billing disputes to the [s]tate IDR process . . . in recognition of the need to provide consumer protections in the absence of any alternate means of providing those protections" and not as a "consequence of a specified legal obligation" to do so. From our perspective, the Empire Plan's prior use of the state IDR process did not preclude it from using the federal IDR process upon the enactment of the No Surprises Act. The subsequent enactment of that law, which still shifts the burden for surprise bills from the patient to the health care plan and recognizes that available state IDR processes may be inapplicable to specific plans, serves as a reasoned explanation for the Empire Plan's change in course (*see generally Matter of Richardson v Commissioner of N.Y. City of Dept. of Social Servs.*, 88 NY2d 35, 39 [1996]; *compare Matter of United University Professions v State*, 36 AD3d 297, 299 [3d Dept 2006]). In light of our determination that the Empire Plan is not required to use the IDR process of the Surprise Bill Law, plaintiffs' argument that it is entitled to a permanent injunction is academic.

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[5] We further note that DFS' website – of which we may take judicial notice (*see Matter of Executive Cleaning Servs. Corp. v New York State Dept. of Labor*, 193 AD3d 13, 18 n 4 [3d Dept 2021]) – expressly states that "[t]he [f]ederal protections from surprise medical bills apply if your employer self-funds your coverage," making clear that state protections do not apply in that circumstance (Department of Financial Services, *Consumer Protection Under the Federal No Surprises Act*, available at https://www.dfs.ny.gov/consumers/health_insurance/protections_federal_no_surprises_act#:~:text=The%20Federal%20protections%20from%20surprise,coverage%20is%20probably%20self%2Dfunded [last accessed Oct. 10, 2024]).

Aarons, J.P., Ceresia, McShan and Mackey, JJ., concur.

ORDERED that the order is affirmed, without costs.

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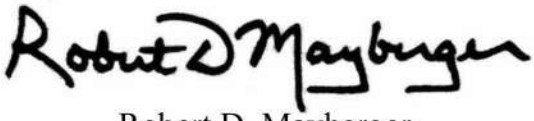

Robert D. Mayberger
Clerk of the Court

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiff,

v.

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK INC., *as Program Administrator for the Empire Plan Medical/Surgical Program*, and MULTIPLAN INC.,

Defendants.

MEMORANDUM & ORDER
22-CV-04040 (HG)

HECTOR GONZALEZ, United States District Judge:

I previously dismissed the complaint in this action because Plaintiff Long Island Anesthesiologists PLLC's ("LIA") had failed to allege an antitrust injury and could therefore not sustain its Sherman Act Section 1 or Section 2, 15 U.S.C. §§ 1–2 ("Section 1" and "Section 2"), claims against Defendants United Healthcare Insurance Company of New York Inc. ("United") and MultiPlan Inc. ("MultiPlan"). *See Long Island Anesthesiologists PLLC v. United Healthcare Ins. Co.*, No. 22-cv-4040, 2023 WL 8096909, at *3–6 (E.D.N.Y. Nov. 21, 2023) ("*LIA I*"). I also found that Plaintiff had failed to allege the existence of a Section 1 conspiracy because LIA failed to "allege any facts suggesting that United and MultiPlan conspired or agreed to work together to restrain trade unlawfully." *Id.* at *6–7. Having dismissed Plaintiff's federal claims, I also declined to exercise supplemental jurisdiction over Plaintiff's restraint of trade claim under New York's Donnelly Act, N.Y. Gen. Bus. Law §§ 340 *et seq.* ("Donnelly Act"), and its claim for unjust enrichment. *Id.* at *8.

Plaintiff moved for leave to file an amended complaint on February 2, 2024, *see* ECF No. 54, and I granted the motion, *see* May 15, 2024, Text Order. Plaintiff filed its Amended Complaint ("AC") on May 28, 2024. ECF No. 58. The AC asserts the same five claims as before. First, it alleges that United and MultiPlan have engaged in an antitrust conspiracy to restrain trade in violation of Section 1. AC ¶¶ 298–302. Next, LIA asserts that United possesses monopsony[1] power in the relevant market, that it is willfully maintaining that power through anticompetitive conduct, and that it is leveraging that power to gain an anticompetitive advantage in the relevant market, in violation of Section 2. *Id.* ¶¶ 303–07. Third, LIA asserts that United has engaged in predatory or anticompetitive conduct in an attempt to acquire monopsony power and that it has a dangerous probability of achieving monopsony power, also in violation of Section 2. *Id.* ¶¶ 308–12. Fourth, LIA asserts that United and MultiPlan have engaged in an antitrust conspiracy to restrain trade in violation of the Donnelly Act. *Id.* ¶¶ 313–18. Finally, LIA asserts that United was unjustly enriched by not reimbursing LIA at a reasonable rate. *Id.* ¶¶ 319–31.

Unfortunately for Plaintiff, the AC suffers from many of the same deficiencies as the original complaint. Each Defendant, unsurprisingly, has moved to dismiss the AC. *See* ECF No. 61-1 (United Mot.); ECF No. 62-1 (MultiPlan Mot.). Plaintiff filed an opposition, *see* ECF No. 64 (Plaintiff's Opp'n), and Defendants filed their replies, *see* ECF No. 66 (MultiPlan Reply); ECF No. 67 (United Reply). For the reasons set forth below, I again grant Defendants' motions to dismiss. I assume basic familiarity with the factual and procedural background of this case and write only as necessary to resolve the instant motions.

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[1] A monopsony is a market dominated by a single buyer who controls the market. *See Monopsony*, Black's Law Dictionary (12th ed. 2024).

FACTUAL BACKGROUND

I draw the following facts from the AC.[2] LIA is a private anesthesia services provider located in Suffolk County, New York. AC ¶¶ 1, 19. LIA provides anesthesia services to patients at Good Samaritan Hospital Medical Center in West Islip, New York, and at other physicians' offices and surgery centers throughout the New York metropolitan area. *Id.* ¶¶ 20, 24. LIA, like many anesthesiology practices in the New York metropolitan area, has an out-of-network relationship with most health insurance providers. *Id.* ¶¶ 36–38. United is a health insurer and health plan provider and a subsidiary of UnitedHealth Group Incorporated ("UHG"), a multi-national managed healthcare and insurance company and the world's second largest healthcare company by revenue. *Id.* ¶¶ 2–3, 39–45. Relevant to the instant action, United is also the administrator of the Empire Plan, a health plan in which roughly 1.2 million public-sector employees in the New York metropolitan area are enrolled. *Id.* ¶¶ 2–3, 71–76, 94. Approximately 40% of LIA's revenue comes from the Empire Plan and LIA alleges that the Empire Plan makes up a similar share of revenue for other anesthesia groups in the New York metropolitan area. *Id.* ¶¶ 3, 104–05.

According to LIA, prior to January 2022, the Empire Plan reimbursed out-of-network physicians at amounts approximating the "usual, customary, and reasonable" rate for medical services in the geographic area in which the services were provided. *Id.* ¶ 95. This practice did not change when, in March 2015, the Empire Plan began using the independent dispute

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[2] I am "required to treat [Plaintiff's] factual allegations as true, drawing all reasonable inferences in favor of Plaintiff[] to the extent that the inferences are plausibly supported by allegations of fact." *In re Hain Celestial Grp., Inc. Sec. Litig.*, 20 F.4th 131, 133 (2d Cir. 2021). I therefore "recite the substance of the allegations as if they represented true facts, with the understanding that these are not findings of the [C]ourt, as [I] have no way of knowing at this stage what are the true facts." *Id.*

resolution ("IDR") process established by the New York Surprise Bill Law ("Surprise Bill Law") to settle reimbursement disputes between health plans and out-of-network physicians. *Id.* ¶¶ 107–16. However, in January 2022, after the Federal No Surprises Act ("No Suprises Act") took effect, LIA alleges that the Empire Plan decreased the rates at which it reimbursed out-of-network providers by more than 80% after determining that it was not bound by the Surprise Bill Law. *Id.* ¶¶ 4, 120–29.

According to Plaintiff, MultiPlan coordinates a repricing scheme among health insurance payers to suppress payments to health care providers. *Id.* ¶ 170. MultiPlan allegedly uses analytic tools to adjust out-of-network claims, reducing reimbursement amounts to a value below what the provider originally requested. *Id.* ¶¶ 170–71. MultiPlan provides this service to all 15 of the largest health insurers in the United States. *Id.* ¶ 181. MultiPlan profits from repricing claims by charging health care payers, such as United, a fee based on the savings between a provider's original claim and the reduced amount accepted after repricing. *Id.* ¶ 172. According to LIA, because insurers know competitors are using the same repricing tools, they can reduce reimbursement rates without fear that providers and enrollees will go somewhere else. *Id.* ¶¶ 174–77.

Plaintiff alleges that after the Empire Plan determined that it was not covered by the Surprise Bill Law's IDR process, MultiPlan began to communicate with LIA and other anesthesiology providers, identifying itself as working with United, in an effort to pressure providers into accepting the lower reimbursement rates offered by MultiPlan. *Id.* ¶¶ 4, 154–59. In these communications, MultiPlan allegedly demanded rapid response times and requested onerous and detailed documentation from providers related to reimbursement claims. *Id.* ¶¶ 154–59. Plaintiff alleges that these communications are designed to force anesthesia

providers to abandon their challenges to the Empire Plan's newly decreased reimbursement rates and that the tactic has been effective because practices lack the resources to pursue challenges to the reimbursement amounts. *Id.* ¶¶ 159–61.

LIA alleges that United's decision to lower reimbursement rates for anesthesia services will decrease the availability of high-quality anesthesia services in the New York metropolitan area and hinder out-of-network practices' ability to recruit and retain new talent. *Id.* ¶¶ 5, 200–22. Due to United's size and market share, LIA claims that the lower rates will force many anesthesia practices out of the market by going out of business or being compelled to sell their practices. *Id.* ¶¶ 7, 224–28. Additionally, LIA alleges that patients with high-deductible plans or significant cost-sharing requirements for out-of-network services could face substantially higher costs for medically necessary services. *Id.* ¶ 229. LIA claims that United's actions aim to drive anesthesia providers out of business to benefit its "subsidiary," OptumCare, which employs physicians, including anesthesia providers. *Id.* ¶¶ 7, 225–27, 291–94. According to LIA, OptumCare is the largest employer of physicians in the United States and employs more than 50 anesthesiologists in the New York metropolitan area. *Id.* ¶¶ 53, 60.

LEGAL STANDARD

"Rule 8(a)(2) provides that a complaint must include a short and plain statement of the claim showing that the pleader is entitled to relief." *Mohammad v. N.Y. State Higher Educ. Servs. Corp.*, 422 F. App'x 61, 62 (2d Cir. 2011).[3] A complaint must "give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests." *Swierkiewicz v. Sorema N. A.*, 534 U.S. 506, 512 (2002). The Second Circuit has defined "fair notice" in this

[3] Unless otherwise indicated, when quoting cases, all internal quotation marks, alteration marks, emphases, footnotes, and citations are omitted.

context as "that which will enable the adverse party to answer and prepare for trial . . . and identify the nature of the case." *Wynder v. McMahon*, 360 F.3d 73, 79 (2d Cir. 2004). A shotgun pleading that is neither clear nor concise goes against the fundamental principles of Rule 8. *See Digilytic Int'l FZE v. Alchemy Fin., Inc.*, No. 20-cv-4650, 2022 WL 912965, at *5 (S.D.N.Y. Mar. 29, 2022) ("Shotgun pleadings are those which incorporate by reference the previous paragraphs of allegations and merely recite the elements of each claim, leaving defendants and the court to parse out which facts apply to which claim."); *see also Litwak v. Tomko*, No. 16-cv-00446, 2018 WL 1378633, at *6 (M.D. Pa. Mar. 19, 2018) (finding that a complaint that "intermingles seemingly unrelated fact[s] and conclusory statements with claims based on a variety of legal theories" is "a shotgun pleading" that "does not comply with the mandates of Rule 8").

Additionally, a complaint must plead "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim is plausible 'when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.'" *Matson v. Bd. of Educ.*, 631 F.3d 57, 63 (2d Cir. 2011) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). "The purpose of a motion to dismiss for failure to state a claim under Rule 12(b)(6) is to test the legal sufficiency of [p]laintiff['s] claims for relief." *Amadei v. Nielsen*, 348 F. Supp. 3d 145, 155 (E.D.N.Y. 2018). Although all allegations contained in a complaint are assumed to be true, this tenet is "inapplicable to legal conclusions." *Iqbal*, 556 U.S. at 678.

DISCUSSION

I. Issue Preclusion

Defendants argue that Plaintiff's antitrust claims are precluded by the decision of the New York Supreme Court, Albany County, in *Joseph v. Corso*, No. 902227-22, 2023 WL

12011473 (N.Y. Sup. Ct. July 13, 2023), which addressed the applicability of the Surprise Bill Law to the Empire Plan.[4] *See* ECF No. 61-1 at 14; ECF No. 62-1 at 13. Specifically, Defendants point to the *Joseph* court's holdings that: (1) "the Surprise Bill Law is not an applicable insurance law to the Empire Plan" and (2) "United cannot and does not . . . control the Empire Plan's coverage or reimbursement decisions." 2023 WL 12011476, at *2–3; *see also* ECF No. 61-1 at 14; ECF No. 62-1 at 13. Plaintiff responds that the first *Joseph* holding is irrelevant "because the No Surprises Act merely created the opportunity upon which Defendants' unlawful scheme was able to be applied to the Empire Plan." ECF No. 64 at 27. Additionally, Plaintiff contends that the second holding from *Joseph* "related only to United's inability to control the Empire Plan's decision to follow the No Surprises Act." *Id.* at 29.

I agree with Plaintiff that the *Joseph* decision has no bearing on this case—the gravamen of which is that Defendants engaged in anticompetitive conduct in violation of the Sherman Act. Because *Joseph* considered only whether United controlled the Empire Plan's decision to follow the No Surprises Act—and did not assess United's alleged use of its administrator role to manipulate reimbursement rates—this issue was not actually litigated in *Joseph*, and collateral estoppel does not bar Plaintiff's claims. *See Heriveaux v. Lopez-Reyes*, No. 17-cv-9610, 2018 WL 3364391 (S.D.N.Y. July 10, 2018) ("[C]ollateral estoppel does not bar Plaintiff's claim because the . . . issue was not actually litigated or decided."), *aff'd*, 779 F. App'x 758 (2d Cir. 2019).

II. Plaintiff's Federal Claims

Plaintiff asserts three claims under the Sherman Act. First, Plaintiff claims that United and MultiPlan engaged in an antitrust conspiracy to restrain trade in violation of Section 1. AC

[4] The Appellate Division recently affirmed the Supreme Court's *Joseph* decision. *See Joseph v. Corso*, 221 N.Y.S.3d 279 (N.Y. App. Div. 2024).

¶¶ 298–302. Next, Plaintiff alleges that United violated Section 2 because it possesses monopsony power that it is willfully maintaining through anticompetitive conduct. *Id.* ¶¶ 303–07. And, finally, Plaintiff alleges that United violated Section 2 because it has engaged in predatory or anticompetitive conduct in an attempt to acquire monopsony power. *Id.* ¶¶ 308–12.

In attempting to remedy the deficiencies I identified in *LIA I*, Plaintiff abandons the "short and plain statement" required by Rule 8 in favor of a sprawling and unfocused pleading. However, the issue with the prior Complaint was not its length. The AC now spans 331 paragraphs but fails to include a single factual allegation that plausibly suggests United and MultiPlan conspired to restrain trade. Instead, Plaintiff devotes extensive portions of the AC to irrelevant or tangential matters. Eighteen paragraphs are devoted to detailing the size and revenues of UHG—an entity that is not even a party to this action. *See* AC ¶¶ 39–47, 62–70. Fourteen more describe OptumCare, another non-party, and its subsidiaries, most of which operate outside the alleged geographic market at issue here. *See id.* ¶¶ 48–61. Plaintiff also includes nine paragraphs summarizing media reports about UHG that bear no apparent connection to the claims at issue. *See id.* ¶¶ 235–43. Throughout, the AC intermixes sweeping allegations untethered to any identified cause of action—for example, claims that MultiPlan engages in a price coordination scheme involving "all the top 15 health insurers" in the country. AC ¶¶ 276–83. This kitchen-sink approach obscures rather than clarifies the basis for Plaintiff's claims and falls short of Rule 8's basic pleading requirements. *See Javier v. Beck*, No. 13-cv-2926, 2014 WL 3058456, at *1 (S.D.N.Y. July 3, 2014) ("The Complaint is a sprawling 287-paragraph jumble that is far from the short and plain statement prescribed by Rule 8."). This lack of clarity is not merely a pleading defect under Rule 8—it reflects a more fundamental failure to meet the plausibility standard required by Rule 12. In particular, Plaintiff's allegations

fall short of establishing antitrust standing, which is a necessary threshold in any private antitrust action.

A. Antitrust Standing

As I explained in *LIA I*, 2023 WL 8096909 at *3–4, in an antitrust case, a private plaintiff must have constitutional standing under Article III as well as antitrust standing. *See Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 535 n.31 (1983). Antitrust standing is "a threshold, pleading-stage inquiry and when a complaint by its terms fails to establish this requirement [the court] must dismiss [the case] as a matter of law." *Gatt Commc'ns Inc. v. PMC Assocs. L.L.C.*, 711 F.3d 68, 75 (2d Cir. 2013). To establish antitrust standing with respect to both its Section 1 and Section 2 claims as a private plaintiff, LIA must do more than allege an injury causally related to unlawful conduct—it must plausibly allege that it suffered "injury of the type the antitrust laws were intended to prevent and that flows from that which makes [D]efendants' acts unlawful." *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977). Therefore, an injury does not constitute an "antitrust injury" unless "it is attributable to an anti-competitive aspect of the practice under scrutiny." *See Atl. Richfield Co. v. USA Petrol. Co.*, 495 U.S. 328, 334 (1990).

Courts in this Circuit "employ a three-step process for determining whether a plaintiff has sufficiently alleged antitrust injury." *Gatt*, 711 F.3d at 76. First, a plaintiff must "identify the practice complained of and the reasons such a practice is or might be anticompetitive." *Id.* Next, the court "identif[ies] the actual injury the plaintiff alleges[, which] requires [the court] to look at ways in which the plaintiff claims it is in a worse position as a consequence of the defendant's conduct." *Id.* Finally, the court must "compare the anticompetitive effect of the specific practice at issue to the actual injury the plaintiff alleges." *Id.*

Here, I find that Plaintiff has again failed to plead an antitrust injury. According to Plaintiff, it has been injured because "United has engaged in predatory or anticompetitive conduct including, but not limited to, dramatically decreasing the reimbursement rate for anesthesia services in the relevant market to below-market and below-cost levels to drive anesthesia providers from the market." AC ¶ 309. Plaintiff also alleges that MultiPlan assists United in its efforts by "using data-driven negotiation and/or reference-based pricing methodologies" to "reduce out-of-network reimbursement rates." *Id.* ¶¶ 197–99. Plaintiff further avers that the dramatic reduction in reimbursement rates has resulted in "decreased output and quality in the market for anesthesia services in the New York metropolitan area." *Id.* ¶¶ 228, 261, 283, 286.

In *LIA I*, 2023 WL 8096909 at *5–6, I found that Plaintiff had not sufficiently alleged antitrust injury because: (1) Plaintiff did not sufficiently allege "an actual adverse effect on competition as a whole in the relevant market but ha[d] merely alleged that it ha[d] been harmed as an individual competitor" and (2) without a plausible allegation of conspiracy or "something more," a "health plan lowering reimbursement rates paid to a physician practice is generally insufficient to establish antitrust injury." As discussed further herein, while the AC attempts to address these issues identified in *LIA I* by adding allegations regarding other anesthesia service providers and communications between Defendants, those allegations, without more, are also not enough to establish antitrust standing. *See generally* AC ¶¶ 162–221.

i. Plaintiff Still Does Not Allege Antitrust Injury Based on Lowered Reimbursement Rates

In an attempt to show market-wide harm, Plaintiff now alleges that three other anesthesia providers were affected by reduced reimbursement rates—two of which appear to claim direct harm, and one of which describes broader, generalized harm to anesthesia providers. *Id.* ¶¶ 200–

21. However, "[h]arm to competition is different than harm to a . . . group of competitors, which does not necessarily constitute harm to competition." *In re Google Digital Advert. Antitrust Litig.*, 627 F. Supp. 3d 346, 380 (S.D.N.Y. 2022). And, more importantly, the harm Plaintiff alleges is not "the type the antitrust laws were intended to prevent." *Brunswick*, 429 U.S. at 489.

In the AC, LIA points to the statements of Long Island Anesthesia Partner's ("LIAP") Chief Operating Officer, in which he notes that "if low Empire Plan reimbursement levels continue unabated [LIAP] would, at the very least, be forced to significantly curtail its services and not allow its hospital clients to open all required operating rooms on any given day." AC ¶ 208. The AC alleges that the reduced Empire Plan reimbursement rates forced LIAP to withdraw from a new ambulatory surgery center, terminate both of its general surgeons, and severely limit its ability to service the five hospitals on Long Island where it is the exclusive anesthesia provider. *See id.* ¶¶ 212–13. Plaintiff also provides the example of New York Cardiovascular Anesthesiologists ("NYCA"), whose President states that the low Empire Plan reimbursement rates will force NYCA to significantly curtail its services, "preventing it from opening all required operating rooms," causing "significant delays in the provision of care", and resulting in "significant increases in adverse health outcomes." *Id.* ¶¶ 216–17. Finally, the AC recounts statements of the Chief Executive Officer of North American Partners in Anesthesia, headquartered on Long Island, in which he alleges that the reduction of reimbursement rates has exacerbated a shortage of anesthesia practitioners to the point where "[h]ospitals may not have enough anesthesia providers to support their patient population." *Id.* ¶ 221.

Plaintiff argues that these allegations are sufficient to allege antitrust injury because "courts have repeatedly found allegations regarding the reduced availability and number of providers and a decline in quality of patient care to be sufficient to state an antitrust injury."

ECF No. 64 at 10 (citing *Angelico v. Lehigh Valley Hosp., Inc.*, 184 F.3d 268, 276 (3d Cir. 1999); *Reddy v. Puma*, No. 06-cv-1283, 2006 WL 2711535, at *4–5 (S.D.N.Y. Sept. 19, 2006); *N.Y. Medscan LLC v. N.Y. Univ. Sch. of Med.*, 430 F. Supp. 2d 140, 148–49 (S.D.N.Y. 2006)). These cases, however, are easily distinguishable from the allegations here. In all of them, the plaintiffs were *excluded* from the market. *See Angleico*, 184 F.3d at 274 (concluding that "Angelico's alleged injury is of the type the antitrust laws were meant to redress" because he was "shut out of competition for anticompetitive reasons"); s*ee also Reddy*, 2006 WL 2711535, at *2 (finding antitrust injury where the harm was caused by "a pattern of exclusionary behavior," including discouraging physicians from referring patients to plaintiffs and instructing physicians "not to provide post-operative care" to plaintiffs' patients); *N.Y. Medscan*, 430 F. Supp. 2d at 144 (finding antitrust injury where the harm was due to "the termination of plaintiffs as a[n] . . . approved provider" of radiology treatments "so as to eliminate the only viable competition"). That is not the case here.

Plaintiff does not allege it has been excluded from the market. Even with reduced reimbursement rates, Plaintiff can still provide out-of-network anesthesia services or negotiate in-network participation. *See* AC ¶¶ 117–19, 203–05. Indeed, according to Plaintiff, the reason it and "similarly situated anesthesia groups" have not entered an "in-network participating provider agreement" with the Empire Plan is to "preserve the favorable out-of-network Empire Plan reimbursement rates." *Id.* ¶ 117–19. Instead of exclusion due to anticompetitive conduct, what Plaintiff actually complains of is the reduction of reimbursement rates, which has made its medical practice less profitable. *Id.* ¶¶ 120–21, 200–02. Plaintiff's alleged "market-wide impact" stems from "lowered Empire Plan reimbursement rates." *Id.* ¶ 220. However, lowering reimbursement rates to out-of-network providers is neither inherently unlawful nor

anticompetitive under the antitrust laws. *See W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 103 (3d Cir. 2010) ("A firm that has substantial power on the buy side of the market (i.e., monopsony power) is generally free to bargain aggressively when negotiating the prices it will pay for goods and services."). Therefore, even "if [Plaintiff and similarly situated anesthesia providers] were injured, it was not by reason of anything forbidden in the antitrust laws." *Brunswick*, 429 U.S. at 488. Plaintiff's allegations reflect harm to a subset of providers—not to competition itself—and stem from reimbursement practices that, even if harmful to the bottom-line of Plaintiff and the other providers it references in the AC, do not constitute antitrust violations. *See Atl. Richfield*, 495 U.S. at 334 (finding that an injury "will not qualify as antitrust injury unless it is attributable to an anti-competitive aspect of the practice under scrutiny"). As such, Plaintiff has not alleged a cognizable antitrust injury.

ii. Plaintiff Has Not Pled "Something More" in Addition to the Lowering of Reimbursement Rates

Although the Second Circuit does not appear to have decided the issue, as discussed above and in *LIA I*, both LIA and United agree that establishing antitrust injury requires "something more" than lowering reimbursement rates paid to a physician practice. *See* ECF No. 61-1 at 20; ECF No. 64 at 11–12; *see also Westchester Radiological Assocs. P.C. v. Empire Blue Cross & Blue Shield, Inc.*, 707 F. Supp. 708, 717 (S.D.N.Y. 1989) ("The law does not prevent a buyer with market power from negotiating a good price, or from specifying what it will buy."); *Kartell v. Blue Cross Blue Shield of Mass., Inc.*, 749 F.2d 922, 925, 929 (1st Cir. 1984) (Breyer, J.) ("A legitimate buyer is entitled to use its market power to keep prices down.").

Plaintiff provides three examples of situations in which courts have found the existence of "something more," in addition to lowered reimbursement rates, to support a plausible inference of antitrust injury. *See* ECF No. 64 at 12. In Plaintiff's first example, the court found

that plaintiff could overcome the "natural inference that as a buyer of anesthesiology services on behalf of patients, [d]efendant has incentives to procure the best quality at the lowest price" by plausibly alleging the existence of a "Blues Conspiracy" through "amended license agreements" between BlueCross BlueShield-Michigan and other "Blues" that geographically divided markets and prevented competition among the "Blues." *Anesthesia Assocs. of Ann Arbor, PLLC v. Blue Cross Blue Shield of Mich.*, No. 20-cv-12916, ECF No. 52 at 6–31 (E.D. Mich. Sept. 28, 2022) (denying in part and granting in part leave to amend). In Plaintiff's second example, the Third Circuit found that it was plausible that paying depressed reimbursement rates unreasonably restrained trade where the complaint also alleged that a health care provider paid plaintiff depressed reimbursement rates, "not as a result of independent decision making, but pursuant to a conspiracy with [defendant], under which [defendant] insulated [the health care provider] from competition in return for [the health care provider] taking steps to hobble [plaintiff]." *W. Penn*, 627 F.3d at 103–04. Finally, in Plaintiff's third example, the court found that allegations that defendant subjected plaintiff to a series of "unnecessary audits as a means to claw-back previously disbursed reimbursements," "inefficient procedure codes and requirements" that forced plaintiff "to schedule patients for two different procedures where one would suffice," and "steer[ing] patients away from independent physicians to its own facility," taken in concert with plaintiff's alleged reimbursement reductions, constituted a plausible pleading of antitrust injury. *Presque Isle Colon & Rectal Surgery v. Highmark Health*, 391 F. Supp. 3d 485, 499–500 (W.D. Pa. 2019). Plaintiff, however, has failed to allege similar facts here.

Plaintiff argues that "[t]here are three theories that the AC puts forward to allege 'something more'" akin to the examples it provides. ECF No. 64 at 12. Those theories are:

> (1) "Defendants engaged in anticompetitive conduct by subjecting anesthesia providers to unreasonable timeframes[,] . . . refusing to negotiate in good faith on

> reimbursement pricing, and flooding anesthesia providers with large volumes of correspondence"; (2) "Defendants engaged in a horizontal conspiracy to suppress reimbursement payments"; (3) Defendants have a "scheme to drive Plaintiff and other anesthesia providers out of business, cause them to sell their practices to hospitals, or force them in-network."

Id. at 12–13. As to Plaintiff's first theory, Plaintiff's allegations that it was subject to "unreasonable timeframes" and "flood[ed]" with "large volumes of correspondence" are distinguishable from the interference with treatment decisions and patient steering in *Presque Isle*, 391 F. Supp. 3d at 499–500. Furthermore, "[a] firm that has substantial power on the buy side of the market (*i.e.*, monopsony power) is generally free to *bargain aggressively* when negotiating prices it will pay for goods and services." *W. Penn*, 627 F.3d at 103 (emphasis added). Even assuming *arguendo* that MultiPlan's negotiation tactics are unethical or even unlawful, and may have caused significant financial losses to Plaintiff and its peers, "[s]uch harm . . . [is] not the type of injur[y] the antitrust laws were intended to prevent." *See Phila. Taxi Ass'n, Inc. v. Uber Techs., Inc.*, 218 F. Supp. 3d 389, 392 (E.D. Pa. 2016) (finding that plaintiffs failed to establish antitrust standing despite harm to plaintiffs' "operations, investments, and earnings" and allegations that defendant's "participation in the market [was] illegal under state and local regulations"), *aff'd*, 886 F.3d 332 (3d Cir. 2018). Plaintiff may have been injured by a violation of insurance law, or maybe even by fraud, but it does not have an *antitrust* injury.

As to Plaintiff's second and third theories, they necessarily fail because, as discussed herein, *see infra* § II.C.i, Plaintiff has not plausibly alleged a conspiracy, horizontal or otherwise, between United and MultiPlan. Therefore, "[t]here is nothing special here to take this case outside of the general rule" that a buyer is entitled to use its market power to reduce reimbursement rates. *Kartell*, 749 F.2d at 929, 932.

In sum, Plaintiff's allegations—focused on reduced reimbursement rates and generalized harm to certain providers—fail to demonstrate harm to competition or the kind of exclusionary conduct necessary to establish antitrust injury. Nor has Plaintiff plausibly alleged "something more" that would take this case outside the bounds of ordinary price negotiations. Accordingly, Plaintiff has not pled a cognizable antitrust injury.

B. Relevant Market

Although Plaintiff has not adequately alleged an antitrust injury, I nonetheless address the sufficiency of Plaintiff's alleged relevant market, as this is a separate and independent basis for dismissing Plaintiff's Sherman Act claims. "To survive a motion to dismiss, a Sherman Act claim must," in addition to plausibly alleging antitrust standing, "define a relevant market." *In re Inclusive Access Course Materials Antitrust Litig.*, 544 F. Supp. 3d 420, 432 (S.D.N.Y. 2021) (citing *Concord Assocs., L.P. v. Ent. Props. Tr.*, 817 F.3d 46, 52 (2d Cir. 2016)). "For antitrust purposes . . . [a] relevant product market consists of products that have reasonable interchangeability for the purposes for which they are produced—price, use and qualities considered." *Concord*, 817 F.3d at 52. However, in the case of a monopsony, the market is reversed. "[T]he market is not the market of competing sellers but of competing buyers. This market is comprised of buyers who are seen by sellers as being reasonably good substitutes." *Todd v. Exxon Corp.*, 275 F.3d 191, 202 (2d Cir. 2001) (Sotomayor, J.).

Plaintiff's alleged product market "reflects a failure to reverse all of the factors involved in light of the buyer-side nature of the alleged activity." *Id.* Here, Plaintiff alleges that the relevant product market is "the provision of medically necessary anesthesia services to patients." AC ¶ 244. United argues that Plaintiff's "alleged market is inconsistent with its antitrust theory" and I agree. *See* ECF No. 61-1 at 24–25. To support the interchangeability of the products in its alleged relevant market, Plaintiff alleges that only anesthesiologists with proper education,

training, and experience can provide these services, and other clinicians lack the expertise to be reasonable substitutes. *Id.* ¶¶ 249–50. However, that describes *Plaintiff's* own, seller side of the market; because Plaintiff is alleging a buyer-side conspiracy and monopsony power, "the proper focus is the commonality and interchangeability of the buyers, not the commonality or interchangeability of the sellers." *Todd*, 275 F.3d at 202. "While acknowledging that market definition is frequently a fact-intensive inquiry where courts are hesitant to grant a motion to dismiss," I nevertheless find Plaintiff's failure to describe the market of competing *buyers* of anesthesia services to be incongruent with its theory of antitrust injury. *Integrated Sys. & Power, Inc. v. Honeywell Int'l, Inc.*, 713 F. Supp. 2d 286, 298 (S.D.N.Y. 2010). As such, Plaintiff has failed to adequately allege a relevant product market, and its Sherman Act claims fail for this reason as well. *See Chapman v. N.Y. State Div. for Youth*, 546 F.3d 230, 238 (2d Cir. 2008) ("[W]here the plaintiff . . .alleges a proposed relevant market that clearly does not encompass all interchangeable substitute [buyers] . . . the relevant market is legally insufficient and a motion to dismiss may be granted.").[5]

C. Plaintiff's Conspiracy and Monopsony Claims

Having determined that Plaintiff has insufficiently alleged both antitrust standing and a relevant market, I may dismiss both the Section 1 and 2 claims on either of those bases alone. *See, e.g.*, *Apotex, Inc. v. Acorda Therapeutics, Inc.*, No. 11-cv-8803, 2013 WL 12617608, at *3 (S.D.N.Y. Feb. 7, 2013) (finding that a "plaintiff seeking relief under Sections 1 and 2 . . . must establish, as a threshold matter," that it has suffered antitrust injury), *aff'd*, 823 F.3d 51 (2d Cir. 2016); *Fifth & Fifty-Fifth Residence Club Ass'n, Inc. v. Vistana Signature Experiences, Inc.*,

[5] Because I find Plaintiff's alleged product market to be inadequate, I need not address its alleged geographic market as "[c]ourts have found that failure to adequately plead either of these markets is sufficient to justify dismissal." *TechReserves Inc. v. Delta Controls Inc.*, No. 13-cv-752, 2014 WL 1325914, at *4 (S.D.N.Y. Mar. 31, 2014).

No. 17-cv-1476, 2018 WL 11466157, at *12 (S.D.N.Y. Sept. 28, 2018) ("To state a claim under either [S]ection [1] or [2,] . . . a plaintiff must plausibly allege a relevant market."). Even so, assuming *arguendo* that Plaintiff had cleared those hurdles, its claims would still fail because it fails to adequately allege an actionable conspiracy.

i. Plaintiff's Section 1 Conspiracy Claim Against United and MultiPlan

First, I will consider Plaintiff's Section 1 conspiracy claim. To survive dismissal of its Section 1 claim, Plaintiff must allege "a combination or some form of concerted action between at least two legally distinct economic entities" that constitutes "an unreasonable restraint of trade." *Primetime 24 Joint Venture v. NBC*, 219 F.3d 92, 103 (2d Cir. 2000). "Proof of unilateral action does not suffice;" rather, the facts alleged "must reveal a unity of purpose or a common design and understanding, or a meeting of minds in an unlawful arrangement." *Anderson News, LLC v. Am. Media, Inc.*, 680 F.3d 162, 183 (2d Cir. 2012). This requires allegations of "direct or circumstantial evidence that reasonably tends to prove that [Defendants] had a conscious commitment to a common scheme designed to achieve an unlawful objective." *Id.* at 184. A complaint claiming conspiracy "must provide some factual context suggesting that the parties reached an agreement, not facts that would be merely consistent with an agreement." *Id.*

In *LIA I*, I found that Plaintiff had not plausibly alleged a conspiracy between United and MultiPlan. *See* 2023 WL 8096909, at *6 ("Plaintiff has not put forth sufficient facts to state a claim that United and MultiPlan were engaged in a conspiracy let alone a horizontal conspiracy, which requires an agreement between two or more competitors."). Here, even with the additional allegations in the AC, Plaintiff still fails to plausibly allege that Defendants entered into an unlawful agreement. In its AC, Plaintiff now alleges that although MultiPlan "appears to

be nothing more than a United vendor," United and MultiPlan are actually horizontal competitors because they compete directly in the Preferred Provider Organization ("PPO") network business. AC ¶¶ 162–69. According to Plaintiff, MultiPlan solicited United to employ MultiPlan's data-driven pricing methodology, a service already provided to many of United's competitor insurers, to suppress out-of-network reimbursement rates. *Id.* ¶ 279. Plaintiff alleges that in 2016, MultiPlan's Chief Revenue Officer wrote an email to United executives informing them that seven of United's top ten competitors were using MultiPlan's repricing services and that "implementing these initiatives will go a long way to bring UnitedHealth back into alignment with its primary competitor group . . . on managing out-of-network costs." *Id.* ¶ 185. United then allegedly agreed to employ MultiPlan for its repricing services. *Id.* ¶ 279. In January 2022, when the Empire Plan began following the No Surprises Act IDR process, United allegedly engaged MultiPlan to use its repricing service and negotiate reimbursement rates to "below competitive levels" for out-of-network claims on behalf of United and the Empire Plan. *Id.* ¶¶ 280–85.

Even with the benefit of my prior decision in *LIA I*, the new allegations in the AC fall well short of adequately alleging an antitrust conspiracy. First, Multiplan and United are not competitors in Plaintiff's alleged relevant antitrust market and therefore cannot have plausibly engaged in a "horizontal conspiracy." *See* ECF No. 64 at 14–16. "Horizontal conspiracies involve agreements among competitors at the same level of competition to restrain trade, such as agreements among manufacturers to fix prices for a given product and geographic market." *JLM Indus., Inc. v. Stolt-Nielsen SA*, 387 F.3d 163, 179 (2d Cir. 2004). Plaintiff contends that United and MultiPlan are horizontal competitors because they both own PPO networks and allegedly compete to contract with medical providers. AC ¶¶ 163–67. But Plaintiff defines the relevant

product market as the provision of medically necessary anesthesia services. *Id.* ¶ 244. There is no allegation—nor could there be—that United and MultiPlan compete in the provision of such services. Moreover, while Plaintiff asserts in a conclusory fashion that the two Defendants own PPOs and that their PPOs compete, the alleged conspiracy arises specifically from United's administration of the Empire Plan, in which United is alleged to have enlisted MultiPlan to reprice anesthesia claims. *See id.* ¶¶ 4, 163. Critically, neither United nor MultiPlan was acting as a PPO in this context: United was functioning as a claims administrator for the Empire Plan, and MultiPlan was merely acting as a vendor to United by providing repricing services at United's direction. *See id.* ¶¶ 79, 197–99 ("It is [the] extension of the [MultiPlan] repricing strategy to the [No Surprises Act] environment that is at work in the events underlying this lawsuit.").

Plaintiff does not allege that MultiPlan competed with United in this capacity or that it independently contracted with providers for Empire Plan claims. Instead, the AC itself describes a vertical relationship: MultiPlan is alleged to act as a vendor, providing repricing or billing support services to United. *See id.* ¶ 4 (United "enlisted [MultiPlan] to assist it in a scheme" to reduce reimbursement rates.); *see also id.* ¶ 184 (describing United as MultiPlan's "largest customer"). That both entities may operate PPOs elsewhere in the healthcare ecosystem does not convert this vertical service-provider relationship into a horizontal conspiracy. *See United States v. Aiyer*, 470 F. Supp. 3d 383, 403 (S.D.N.Y. 2020) ("A horizontal conspiracy exists when the coconspirators are competitors at the same level of the market structure rather than combinations of persons at different levels of the market structure . . . which are termed vertical restraints."), *aff'd*, 33 F.4th 97 (2d Cir. 2022). To hold otherwise would be to condemn seemingly every business relationship between large healthcare companies aimed at improving their respective

margins as potentially illegally anticompetitive. Plaintiff's failure to allege that United and Multiplan were acting as competitors in the relevant context is fatal to its horizontal conspiracy theory. *Ivoclar Vivadent, Inc. v. Ne. Dental & Med. Supplies, Inc.*, No. 04-cv-0262, 2006 WL 8455722, at *4 n.13 (W.D.N.Y. Aug. 30, 2006) ("A restraint is not horizontal because it has horizontal effects but rather because it is the product of a horizontal agreement, i.e., a restraint imposed by agreement between competitors."). As explained in *In re Aluminum Warehousing Antitrust Litigation*, "[p]laintiffs claim to have alleged a horizontal conspiracy in restraint of trade, but they do not allege that [defendants] are horizontal competitors. In the absence of the latter, the former cannot be correct." No. 13-md-2481, 2014 WL 4277510, at *32 (S.D.N.Y. Aug 29, 2014).

Second, Plaintiff still fails to allege facts suggesting a "meeting of minds in an unlawful arrangement." *Anderson News*, 680 F.3d at 183. The AC asserts that United and MultiPlan conspired to suppress reimbursement rates to drive out anesthesia providers, allegedly to benefit United's "subsidiary" healthcare provider, OptumCare. AC ¶¶ 291-94. But as the Supreme Court made clear in *Twombly*, "a bare assertion of conspiracy will not suffice" to survive a motion to dismiss. 550 U.S. at 556. First, Plaintiff's own allegations contradict the assertion that OptumCare is United's subsidiary. According to Plaintiff, "UHG divides its businesses into two main platforms: Optum and UnitedHealthcare." AC ¶ 47. UnitedHealthcare Insurance Company of New York—the named Defendant—is a subsidiary of UnitedHealthcare. *Id.* ¶¶ 11, 71. Optum, meanwhile, includes separate business segments, including Optum Health, which houses OptumCare. *Id.* ¶¶ 48–49. Plaintiff alleges that OptumCare operates physician practices, including several in the New York metropolitan area that employ anesthesiologists. *See id.* ¶ 54–60. Plaintiff repeatedly characterizes OptumCare as "United's subsidiary"—a designation

plainly inconsistent with the corporate structure alleged in the AC. *See e.g., id.* ¶¶ 225, 292. Based on that structure, United and OptumCare are at most sister companies, operating in distinct business units under UHG's broader corporate umbrella. *See Holland v. JPMorgan Chase Bank, N.A.*, No. 19-cv-00233, 2019 WL 4054834 (S.D.N.Y. Aug. 28, 2019) (finding that two sister companies "were entitled to the presumption of separateness afforded to related corporations"); *see also Karupaiyan v. CVS Health Corp.*, No. 19-cv-8814, 2021 WL 4341132, at *2 n.3 (S.D.N.Y. Sept. 23, 2021) ("Although CVS, Aetna, and AHM are all part of the same corporate family, the character of these distinct entities is highly relevant to several of [p]laintiff's claims.").

This mischaracterization is not a trivial error; it undermines the plausibility of Plaintiff's theory. The AC lacks any allegation that United and OptumCare communicated, coordinated, or otherwise shared a common objective. Absent such factual support, the theory that United conspired with MultiPlan to drive competitors out of the market for the benefit of a legally distinct sister company is not just implausible—it is wholly speculative. *Cf. In re Suboxone (Buprenorphine Hydrochloride & Naloxone) Antitrust Litig.*, No. 13-md-2445, 2017 WL 4642285, at *6–7 (E.D. Pa. Oct. 17, 2017) (rejecting plaintiffs' "single economic entity" theory between defendant and a sister company where the complaint did "not contain a single factual allegation" from which the court could "reasonably infer that [defendant] exercised any control or pervasive domination over" its sister company). Again, it is worth backing up and considering the breadth of this argument. As LIA would have it, so long as an antitrust plaintiff can identify some potential benefit to some member of an alleged co-conspirator's corporate family connectable to the alleged agreement, he would plausibly allege an antitrust conspiracy. But that mix-and-match approach, which would have the practical effect of punishing affiliated

businesses for competing in different markets, would prohibit on competition grounds virtually all commercial relationships between them, an impermissible result under *Twombly*. *See* 550 U.S. at 566 ("[I]f alleging parallel decisions to resist competition were enough to imply an antitrust conspiracy, pleading a [Section] 1 violation against almost any group of competing businesses would be a sure thing.").

Furthermore, Plaintiff's factual allegations do not support the conclusion that the agreement between United and Multiplan had an unlawful objective of reducing competition. Instead, they merely suggest that United engaged Multiplan to reduce out-of-network reimbursement rates. AC ¶¶ 185, 189. As has now been discussed at length, "[t]he existence of a lawful business relationship does not plausibly suggest a separate, unlawful agreement to restrain trade." *Honeywell Int'l Inc. v. Ecoer Inc.*, No. 24-cv-1464, 2024 WL 3521591, at *7 (S.D.N.Y. July 23, 2024). None of Plaintiff's factual allegations suggests that United and MultiPlan entered into an agreement to eliminate competition in the market for anesthesia services. To the contrary, Plaintiff's allegations suggest that it was in the Defendants' independent self-interests to lower reimbursement rates. *See* AC ¶ 172 ("[MultiPlan] makes money on claims repricing by charging its health care payer customers a fee based on the difference between a healthcare providers' original claim and the amount the provider accepts following [MultiPlan]'s repricing of the claim."); *see also id.* ¶¶ 89–90 ("keeping out-of-network reimbursement rates as low as possible brings substantial financial benefits to United" because it charges a "savings fee each time it secures a discount on out-of-network provider's billed charges"). Plaintiff's factual allegations do not "tend to exclude independent self-interested conduct as an explanation for [D]efendants' parallel behavior." *Twombly*, 550 U.S. at 552. Rather, the most straightforward explanation for the agreement between United and MultiPlan,

based on the facts alleged, is that it served their common financial interests. *See Caithness Long Island II, LLC v. PSEG Long Island LLC*, No. 18-cv-4555, 2019 WL 6043940, at *4 (E.D.N.Y. Sept. 30, 2019) ("[A]n antitrust plaintiff's complaint can be dismissed where there is an obvious alternative explanation to the facts underlying the alleged conspiracy among the defendants."). More fundamentally, by Plaintiff's own explanation, it would work against the alleged co-conspirators' own economic interests to agree to try to wipe out the provision of anesthesia services. Such conduct would not just reduce their ability to aggressively reduce reimbursements to out-of-network providers; it would eliminate it altogether. And even if United could eventually try to redirect some of the anesthesia services to its sister company, MultiPlan lacks any non-speculative reason to join in such a scheme. *See Anderson News, L.L.C. v. Am. Media, Inc.*, 899 F.3d 87, 112 (2d Cir. 2018) (finding that "defendants had an unlikely motive to conspire" given that "the alleged conspiracy [was] economically implausible"). Accordingly, I find that Plaintiff's factual allegations concerning a Section 1 conspiracy are not "enough to raise a right to relief above the speculative level," *Twombly*, 550 U.S. at 555, and grant Defendants' motion to dismiss the Section 1 claim for this additional reason.

ii. Plaintiff's Monopsonization and Attempted Monopsonization Claims Against United

As discussed in the introduction to this section, because Plaintiff has not plausibly alleged antitrust injury or a relevant antitrust market, its Section 2 claims necessarily fail. *See supra* at 17–18. I nonetheless consider whether Plaintiff has adequately stated claims against United for monopsonization and attempted monopsonization under Section 2. "Monopsony power is market power on the buy side of the market. As such, a monopsony is to the buy side of the market what a monopoly is to the sell side and is sometimes colloquially called a buyer's monopoly." *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 549 U.S. 312, 320

(2007). I apply the same pleading standard to a Section 2 monopsony claim that I would use for a monopoly claim. *See id.* at 322 ("The kinship between monopoly and monopsony suggests that similar legal standards should apply to claims of monopolization and to claims of monopsonization."). "In order to state a claim for monopsonization under Section 2 of the Sherman Act, a plaintiff must [allege]: (1) the possession of monopsony power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident." *Sitts v. Dairy Farmers of Am., Inc.*, 417 F. Supp. 3d 433, 476 (D. Vt. 2019). "With respect to this second element, the possession of [monopsony] power will not be found unlawful unless it is accompanied by an element of anticompetitive conduct." *Mazda v. Carfax, Inc.*, No. 13-cv-2680, 2016 WL 7231941, at *15 (S.D.N.Y. Dec. 9, 2016), *aff'd sub nom. Maxon Hyundai Mazda v. Carfax, Inc.*, 726 F. App'x 66 (2d Cir. 2018). "To [state] a claim for attempted monopsonization, a plaintiff must [allege]: (1) that the defendant has engaged in predatory or anticompetitive conduct with (2) a specific intent to monopsonize and (3) a dangerous probability of achieving monopsony power." *Sitts*, 417 F. Supp. 3d at 476. "Both [monopsonization] and attempted [monopsonization] claims therefore have anticompetitive conduct as one of their elements." *Mazda*, No. 13-cv-2680, 2016 WL 7231941 at *15. Because it is essential to both claims, I address that element first.

Plaintiff alleges that United unilaterally "engaged in predatory or anticompetitive conduct." *See* AC ¶¶ 304–06, 309–11. "[S]ingle-firm activity is unlike concerted activity covered by [Section] 1, which inherently is fraught with anticompetitive risk." *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 459 (1993). Indeed, Congress treats "concerted behavior more strictly than unilateral behavior." *Am. Needle, Inc. v. NFL*, 560 U.S. 183, 190 (2010). The

purpose of distinguishing between concerted and independent action is to avoid "judicial scrutiny of routine, internal business decisions" and "chilling vigorous competition through ordinary business operations." *See id.* The Second Circuit has described anticompetitive conduct as "conduct without a legitimate business purpose that make sense only because it eliminates competition." *In re Adderall XR Antitrust Litig.*, 754 F.3d 128, 133 (2d Cir. 2014). "That definition is a narrow one, which works to ensure that exceptions to the general rule that 'businesses are free to choose the parties with whom they will deal, as well as the prices, terms, and conditions of that dealing' are 'rare.'" *Twin Bridges Waste & Recycling, LLC v. Cnty. Waste & Recycling Serv., Inc.*, No. 21-cv-263, 2021 WL 4192606, at *7 (N.D.N.Y. Sept. 14, 2021) (quoting *Pac. Bell Tel. Co. v. linkLine Commc'ns, Inc.*, 555 U.S. 438, 448 (2009)).

Therefore, I must determine whether Plaintiff's allegations plausibly meet this narrow standard for alleging anticompetitive conduct. Plaintiff claims that United maintains monopsony power and is leveraging it by suppressing reimbursement rates to eliminate competition, which would allow it to dominate the anesthesia services market through its OptumCare sister company. AC ¶¶ 291–95, 305–306. Although Plaintiff claims that United's suppression of reimbursement rates is exclusionary, AC ¶ 305, I find that, as alleged in the AC, United's actions are consistent with standard business incentives rather than anticompetitive conduct. *See In re Adderall*, 754 F.3d at 133 ("Anticompetitive conduct is conduct without a legitimate business purpose that makes sense only because it eliminates competition").

As alleged in the AC, "keeping out-of-network reimbursement rates as low as possible brings substantial financial benefits to United" because it charges a "savings fee each time it secures a discount on out-of-network provider's billed charges." AC ¶¶ 89–90. Absent factual allegations that United is engaged in "something more than business activity that occurs in the

normal competitive process," its conduct aligns with lawful competitive behavior rather than exclusionary conduct. *See In re Google*, 627 F. Supp. 3d at 379; *see also In re Adderall*, 754 F.3d at 135 (finding plaintiff had not alleged anticompetitive conduct where plaintiff did not allege a "course of dealing suggesting a willingness to forsake short-term profits to achieve an anticompetitive end"). Furthermore, again, "[a] firm that has substantial power on the buy side of the market (i.e., monopsony power) is generally free to bargain aggressively when negotiating the prices it will pay for goods and services." *W. Penn*, 627 F.3d at 103.

Plaintiff's Section 2 claims fail at the threshold because the AC does not plausibly allege that United's conduct lacked a "legitimate business purpose" or that it "makes sense only because it eliminates competition." *In re Adderall*, 754 F.3d at 133. Absent such allegations, Plaintiff has not established the essential element of anticompetitive conduct, and both Section 2 claims must be dismissed on that basis. *See Apotex Corp. v. Hospira Healthcare India Priv. Ltd.*, No. 18-cv-4903, 2020 WL 58247, at *5 (S.D.N.Y. Jan. 6, 2020) (dismissing Section 2 claims where plaintiff did not plausibly allege anticompetitive conduct).

Even assuming that Plaintiff had plausibly alleged anticompetitive conduct, the monopsony claim independently fails because Plaintiff does not plausibly allege that United possesses monopsony power in the relevant market. Plaintiff alleges that "United possesses monopsony power in the market for the reimbursement of anesthesia services in the New York metropolitan area," AC ¶ 304, but elsewhere defines the relevant product market as "the provision of medically necessary anesthesia services to patients," *see id.* ¶¶ 244–54. That inconsistency with market definition is fatal. *See Chapman*, 546 F.3d at 238.

Plaintiff's attempted monopsony claim is likewise deficient. Plaintiff merely recites the required elements—specific intent and a dangerous probability of achieving monopsony

power—without factual support. *See Spectrum Sports*, 506 U.S. at 456; *see also* AC ¶¶ 310–11 ("United undertook this conduct with the specific intent to monopsonize. United has a dangerous probability of achieving monopsony power."). While Plaintiff appears to allege that United seeks monopsony power by reducing reimbursement rates to below-cost levels to drive out anesthesia providers, AC ¶ 309, that theory is implausible: as discussed, driving providers from the market would reduce supply and potentially increase costs—an outcome contrary to United's interests as the Empire Plan's administrator. Moreover, Plaintiff offers no coherent explanation as to how this strategy would give United monopsony power over reimbursement.

To the extent Plaintiff suggests United is using monopsony power to create monopoly power for OptumCare, the allegations are equally deficient. The AC notes only that OptumCare employs "over 50 anesthesiologists," *id.* ¶ 60, without identifying the total number of providers in the market or OptumCare's share—basic facts needed to assess market power. *See Spectrum Sports*, 506 U.S. at 459 ("[D]emonstrating the dangerous probability of [monopsonization] in an attempt case also requires inquiry into the . . . defendant's economic power in that market.").

To summarize, Plaintiff's Section 2 claims rest on a speculative theory of market manipulation unsupported by concrete, plausible allegations of anticompetitive conduct, monopsony power over the relevant market, or a dangerous probability of market dominance. These deficiencies, both individually and collectively, require dismissal of Plaintiff's Section 2 monopsonization and attempted monopsonization claims.

III. Plaintiff's State Law Claims

Plaintiff also claims that United and MultiPlan engaged in an antitrust conspiracy to restrain trade in violation of the Donnelly Act and that United[6] was unjustly enriched by receiving fees and retaining reimbursement through Defendants' alleged scheme of improperly reducing LIA's reimbursement rates. AC ¶¶ 313–30. Having dismissed all of Plaintiff's claims over which I have "original jurisdiction," I "may decline to exercise supplemental jurisdiction over" Plaintiff's pendant state law claims. *See* 28 U.S.C. § 1367(c)(3). As is well established, Section 1367 does not create "a mandatory rule to be applied inflexibly in all cases." *Carnegie-Mellon Univ. v. Cohill*, 484 U.S. 343, 350 n.7 (1988). Nevertheless, "in the usual case in which all federal-law claims are eliminated before trial, the balance of factors to be considered under the pendent jurisdiction doctrine—judicial economy, convenience, fairness, and comity— will point toward declining to exercise jurisdiction over the remaining state-law claims." *Id.*; *see also Kolari v. N. Y.-Presbyterian Hosp.*, 455 F.3d 118, 123 (2d Cir. 2006) (reversing a district court decision to retain supplemental jurisdiction over state law claims after dismissal of the federal claim, citing "the absence of a clearly articulated federal interest").

Despite the general presumption, I conclude that judicial economy calls for exercising supplemental jurisdiction over Plaintiff's Donnelly Act Claim. The Donnelly Act "is modeled after the Sherman Act and should generally be construed in light of Federal precedent." *Biocad JSC v. F. Hoffman-La Roche*, 942 F.3d 88, 101 (2d Cir. 2019). Accordingly, "[t]he standard for a well-pleaded Donnelly Act claim is the same as a claim under Section 1 of the Sherman Act." *Nat'l Gear & Piston, Inc. v. Cummins Power Sys., LLC*, 861 F. Supp. 2d 344, 370 (S.D.N.Y.

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[6] In the original complaint, Plaintiff asserted its unjust enrichment claim against both United and MultiPlan. *See* ECF No. 1 ¶¶ 204–09. Plaintiff now asserts this claim only against United. *See* AC ¶¶ 319–30.

2012). Given my decision on Plaintiff's Section 1 claim, "it would be the height of inefficiency to defer a decision on [its Donnelly Act] claim to a state court." *Nunez v. N.Y. State Dep't of Corr. & Cmty. Supervision*, No. 14-cv-6647, 2017 WL 3475494, at *4 (S.D.N.Y. Aug. 11, 2017), *aff'd sub nom. Nunez v. Lima*, 762 F. App'x 65 (2d Cir. 2019); *accord Avery v. DiFiore*, No. 18-cv-9150, 2019 WL 3564570, at *5 (S.D.N.Y. Aug. 6, 2019). Having already determined that Plaintiff's AC failed to state a claim under Section 1, it necessarily follows that Plaintiff's Donnelly Act claim also fails and Defendants' motions to dismiss are granted. *See Biocad*, 942 F.3d at 101 ("As [plaintiff] has not stated a plausible claim for relief under the Sherman Act, its Donnelly Act claim similarly fails.").

By contrast, I decline to exercise supplemental jurisdiction over Plaintiff's unjust enrichment claim. Plaintiff's unjust enrichment claim is subject to different standards than Plaintiff's antitrust claims and must be analyzed separately. Thus, this is the "usual case" in which the balance of relevant factors "point toward declining to exercise jurisdiction." *Carnegie-Mellon Univ.*, 484 U.S. at 350 n.7.

IV. Leave to Amend

Plaintiff asks that, in the event that the Court dismisses its claims, the Court allow it another opportunity to amend. *See* ECF No. 64 at 31. Although the Second Circuit "strongly favors liberal grant of an opportunity to replead after dismissal of a complaint under Rule 12(b)(6)," the Court declines to grant Plaintiff leave to amend yet again. *See Noto v. 22nd Century Grp., Inc.*, 35 F.4th 95, 107 (2d Cir. 2022) (affirming denial of leave to amend). "A court should freely give leave when justice so requires, but it may, in its discretion, deny leave to amend for good reason, including futility, bad faith, undue delay, or undue prejudice to the opposing party." *MSP Recovery Claims, Series LLC v. Hereford Ins. Co.*, 66 F.4th 77, 90 (2d Cir. 2023) (affirming denial of leave to amend). The mere fact that Plaintiff's opposition brief

provides no explanation about how it intends to amend its complaint to address any deficiencies I have identified is sufficient reason to deny leave to amend. *See Gregory v. ProNAi Therapeutics Inc.*, 757 F. App'x 35, 39 (2d Cir. 2018) (affirming denial of leave to amend where "plaintiffs sought leave to amend in a footnote at the end of their opposition to defendants' motion to dismiss" and "included no proposed amendments"). Moreover, "[a] court may deny leave to amend where the plaintiff has already had the opportunity to amend its [c]omplaint, and there is no indication that amendment would not be futile." *Champions League, Inc. v. Woodard*, 224 F. Supp. 3d 317, 326 (S.D.N.Y. 2016). That is especially so here, where Plaintiff has already had the "benefit of a [full] ruling." *See Loreley Fin. (Jersey) No. 3 Ltd. v. Wells Fargo Sec., LLC*, 797 F.3d 160, 190 (2d Cir. 2015). The defects in Plaintiff's antitrust claims "are substantive and arise from [Plaintiff's] own allegations, not from inadequate or inartful pleading." *Apotex*, 2020 WL 58247, at *7. Accordingly, leave to amend is denied.

CONCLUSION

For the reasons set forth above, the Court GRANTS with prejudice Defendants' motions to dismiss Plaintiff's Sherman Act and Donnelly Act claims and declines to exercise supplemental jurisdiction over Plaintiff's unjust enrichment claim, which it dismisses without prejudice. *See* ECF No. 61-1; ECF No. 62-1. The Clerk of Court is respectfully requested to enter judgment and close this case.

SO ORDERED.

/s/ Hector Gonzalez
HECTOR GONZALEZ
United States District Judge

Dated: Brooklyn, New York
April 7, 2025

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------X
LONG ISLAND ANESTHESIOLOGISTS PLLC,

Plaintiff,

v.

JUDGMENT
22-CV-04040 (HG)

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator for the Empire Plan Medical/Surgical Program, and MULTIPLAN INC.,

Defendants.
----------X

A Memorandum and Order of the Honorable Hector Gonzalez, United States District Judge, having been filed on April 7, 2025, granting with prejudice Defendants' motions to dismiss Plaintiff's Sherman Act and Donnelly Act claims; and declining to exercise supplemental jurisdiction over Plaintiff's unjust enrichment claim, which it dismisses without prejudice, *See* ECF No. 61-1; ECF No. 62-1; it is

ORDERED and ADJUDGED that Defendants' motions to dismiss Plaintiff's Sherman Act and Donnelly Act claims are granted with prejudice; and that the Court declines to exercise supplemental jurisdiction over Plaintiff's unjust enrichment claim, which it dismisses without prejudice. *See* ECF No. 61-1; ECF No. 62-1.

Dated: Brooklyn, New York
April 8, 2025

Brenna B. Mahoney
Clerk of Court

By: */s/Jalitza Poveda*
Deputy Clerk

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORKT

LONG ISLAND ANESTHESIOLOGISTS PLLC, ,	:	
Plaintiff,	:	Case No. 22-cv-04040-HG
vs.	:	
	:	**NOTICE OF APPEAL**
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN, INC.,	:	
Defendants.	:	

PLEASE TAKE NOTICE that the Plaintiff, Long Island Anesthesiologists, PLLC., by its attorneys, Harris Beach Murtha Cullina PLLC, hereby appeals in accordance with Fed. R. App. P. 4 to the United States Court of Appeals for the Second Circuit, from the attached Judgment of this Court, filed April 8, 2025 (Dkt 70), and from each and every part thereof.

Dated: Uniondale, New York
May 2, 2025

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