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on Behalf of the People of the State of Arizona

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN THE COUNTY OF MARICOPA

STATE OF ARIZONA *ex rel.* KRISTIN K. MAYES, ATTORNEY GENERAL,

Plaintiff,

v.

MULTIPLAN, INC,, AETNA, INC., THE CIGNA GROUP, UNITEDHEALTH GROUP, INC., HUMANA, INC., ELEVANCE HEALTH, INC., HEALTH CARE SERVICE CORP., CENTENE CORP., MOLINA HEALTHCARE, INC.,

Defendants.

Case No. ____________

COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff, the State of Arizona, *ex rel.* Kristin K. Mayes, the Attorney General on behalf of the people of the State of Arizona (the "State"), brings this action against the above-named Defendants and alleges as set forth below.

I. INTRODUCTION

1. The American healthcare system is broken. The costs of medical care and prescription drugs have skyrocketed, increasingly fewer healthcare services are covered by

insurance plans, premiums for coverage are surging, medical providers' costs are increasing, and millions of Americans remain un- or underinsured. This crisis has been driven, in part, by the rise of corporate influence in all corners of the healthcare market. Insurance companies have consolidated through a series of mergers and acquisitions and formed massive conglomerates with pharmacy benefit managers and national pharmacies, while private equity firms and other corporate interests have purchased controlling interests in hospitals, medical practices, and other healthcare-related businesses. Ultimately, this shift hurts patients, their families, self-funded health insurance plans, and medical providers. It also imposes an economic burden on state and local governments, including the State of Arizona, as hospitals fail, medical practices close, and doctor and nursing shortages grow, while patients face rising insurance deductibles and forego critical medical care they cannot afford, including routine doctor visits and much-needed prescription drugs.

2. Defendant MultiPlan is a medical billing data analytics and cost-containment vendor that also develops and supplies independent preferred-provider networks. MultiPlan conspired with its clients, including the co-defendant commercial health insurance companies and other insurers ("client-insurers") and hundreds of other payors[1], (collectively its "client-payors" or "co-conspirators") to control out-of-network medical care pricing. MultiPlan has been using that control to extract more money from medical providers, patients, and employers every year. Since 2015, MultiPlan and its co-conspirators have contracted and combined to artificially suppress the prices they pay for out-of-network medical care far below reasonable levels, which has resulted in a system

[1] There are several types of payors for healthcare in the United States including large national insurance companies, Blue Cross Blue Shield plans, independent health plans, third-party administrators, bill review companies, self-funded employer plans, and other entities that pay medical bills. MultiPlan/Claritev has identified each of these types of entities as payors in its 2021, 2022, 2023, 2024, and 2025 annual reports filed with the SEC.

that underpays doctors, hospitals, and other medical facilities (collectively "healthcare providers") for their work and additionally deprives patients of quality care while increasing their out-of-pocket costs.

3. On information and belief, MultiPlan sets the prices for out-of-network medical services in the United States for all of its clients. When a healthcare provider submits a bill for out-of-network services to any client-payor, MultiPlan reprices the charges using a proprietary algorithm that sets a fixed price for each service—regardless of quality of care or many other distinguishing criteria—according to standard procedure codes known as Current Procedural Terminology ("CPT") codes.[2] This repricing can cause the CPT code for an emergency room visit in California to be paid by a client-payor at the same amount as the equivalent CPT code for an emergency room visit in Wyoming. In cases involving out-of-network healthcare providers, MultiPlan's algorithm routinely suppresses compensation (*i.e.* the price MultiPlan and client-payors pay) far below reasonable market rates.

4. MultiPlan's client-payors contribute to this illegal repricing scheme by supplying the claims, pricing, and billing data that informs MultiPlan's algorithms, which would be against each client-payor's competitive economic interests but for the market control on out-of-network services compensation rates affected by the conspiracy. On information and belief, in their agreements with MultiPlan, each client-payor agrees to share its proprietary data not only with MultiPlan—itself a competitor that uses this data to develop its algorithms and solicit new clients—but also with one another by means of the data's inclusion in MultiPlan's database, which all of the client-payors have the ability

[2] A CPT Code is a five-character numeric or alphanumeric code that offers health care professionals, insurers, and others a uniform language for coding medical services and procedures to streamline reporting, ensure accuracy and increase efficiency. The CPT code for an MRI of the brain without contrast, for example, is 70551. When insurers calculate UCR for an MRI of the brain in a particular market, they would use this code to compare different providers' charges for the same service.

to access. Plaintiff is informed and believes that through MultiPlan, the client-payors agree to share proprietary, competitively sensitive information toward the collective purpose of setting the prices they pay for out-of-network goods and services at artificially and unreasonably low rates. Sharing confidential claims data with other payors would, in a competitive market, be against each payor's economic interest, as that exposure would surrender the payor's competitive advantages and enable its rivals to strategically undermine its compensation strategies. Unlike a competitive market, however, the collective agreement between MultiPlan and the client-payors enables the co-conspirators to control the market and set the prices for goods and services they purchase, thus eliminating purchasing competition and decimating the market power of other market participants.

5. MultiPlan exerts consistent pressure to keep the client-payors in line. Once it has enlisted a client-payor into the conspiracy, MultiPlan advances the scheme by coordinating the client-insurers' conduct and confirming that their prices remain in line with that of their co-conspirators. For example, MultiPlan hosts collective meetings among the client-insurers as well as direct, one-on-one meetings with its client-payors in order to develop pricing strategies. Additionally, MultiPlan prepares regular reports for its client-payors demonstrating the savings it has generated for them using its repricing tools. Throughout these coordination efforts, MultiPlan shares client-payors' confidential claims and billing data, as well as other competitively sensitive information, among their ostensible competitors.

6. Doctors and patients cannot avoid the co-conspirators' price manipulation or the resulting harms. On information and belief, the client-payors delegate significant authority over pricing out-of-network services, negotiating with healthcare providers, and approving the terms of any resulting settlement to MultiPlan. And because most of the nation's commercial insurers are client-payors—including the largest fifteen commercial insurers, covering 81% of the out-of-network, commercial, buyer-side market—most

doctors cannot afford to turn away a client-payor's patients and must therefore either accept the co-conspirator's artificially suppressed payments or engage in a negotiations process subject to MultiPlan's authority to protect the interests of the conspiracy.

7. Patients are similarly without recourse because insurance plans unaffiliated with MultiPlan are few and far between. Healthcare providers who are forced to accept the co-conspirators' suppressed prices may choose to seek reimbursement from patients for the unpaid balance of their bills (a practice known as "balance billing"), and patients who pay up-front for out-of-network services are routinely reimbursed by client-payors at the suppressed rates set according to the co-conspirators' coordinated payment strategy. Patients must therefore shoulder the economic burden of these suppressed reimbursements despite many having paid the higher premiums and co-pays for PPO plans that claim to cover costs associated with such out-of-network services. Through MultiPlan, the co-conspirators have wielded a collective majority national health insurance market share in such a way as to effectively eliminate competition among themselves as payors and have utilized their consolidated market power to artificially suppress the prices they pay for out-of-network healthcare services. MultiPlan and its client-payors have commandeered the market and fixed prices for out-of-network services by effectively forming a buyer's "cartel."

8. According to an April 2020 study published by the Office of the New York State Comptroller, the cartel compensated out-of-network healthcare providers at considerably lower rates than the traditional basis for calculating reasonable compensation (the "Usual, Customary, and Reasonable" or "UCR" rates) for many services. According to the study, UCR rates were 1.5 to 49 times higher than the average MultiPlan rate for 35% of the service codes in the analysis.

9. Unsurprisingly, healthcare provider compensation for out-of-network services has decreased every year since MultiPlan implemented its scheme, while MultiPlan's profits have concomitantly skyrocketed. On November 5, 2024, MultiPlan's

CEO Travis Dalton reported to investors that MultiPlan had hit a "record quarterly achievement" in the third quarter of 2024 by generating a $6.4 billion reduction in payments to healthcare providers.

10. In the late 2000s, the nation's largest commercial health insurance companies, including many of the defendants here, settled claims brought by the New York Attorney General and others arising from the insurers' use of repricing algorithms developed by Ingenix, a subsidiary of UnitedHealth Group. Ingenix had designed its algorithms to drive out-of-network healthcare provider compensation below the then-current UCR rates. The New York Attorney General and other plaintiffs asserted that Ingenix had informed its algorithm with proprietary claims and billing data, polluted it with irrelevant data reflecting discounted prices, and "scrubbed" it of data reflecting the highest valid medical charges. In 2009, UnitedHealth Group and its fellow conspirators settled the claims against them for hundreds of millions of dollars. The New York Attorney General settlement also required some insurers to use a database built by a nonprofit organization, FAIR Health, Inc., to calculate out-of-network provider UCR compensation rates for the next five years. MultiPlan saw this opportunity and picked up where Ingenix had left off.

11. Like the Ingenix conspirators before them, MultiPlan and its co-conspirators reap exorbitant profits from the success of their repricing scheme. The client-payors contract with MultiPlan to reduce the amount they pay healthcare providers for their services, keeping more revenue for themselves and profiting from the enormous savings (*i.e.* underpayments) the scheme generates. MultiPlan, in turn, charges its client-payors a fee for its services, which is calculated as a fixed percentage of the savings generated by MultiPlan's repricing. So, the lower MultiPlan's algorithms depress the price for a healthcare provider's services, the more the client-payor saves, and the greater MultiPlan's fee. This incentivizes the cartel to set prices for healthcare goods and services as low as possible and leaves providers and patients to absorb the significant difference in the amount paid to the providers compared to the cost and value of the services delivered.

12. Over the past decade, Defendants' repricing scheme has placed an enormous burden on Arizona's healthcare system. And Arizona residents bear the costs: patients forego needed treatment and grow sicker; patients accrue medical debt; hospitals and other medical facilities, including state-run facilities, face provider shortages; patients are unable to pay their providers; providers' quality of care diminishes; hospitals and other medical practices close; and healthcare providers and their businesses cannot make ends meet.

13. The State seeks to put an end to Defendants' illegal repricing scheme and recover the losses suffered by Arizona and its residents. Toward that end, the State seeks injunctive and monetary relief, as well as civil penalties, for Defendants' pursuit of their illegal and anticompetitive repricing scheme in violation of the Arizona Consumer Fraud Act ("ACFA") and the Arizona Uniform State Antitrust Act.

II. THE PARTIES

A. The Plaintiff

14. This action is brought by the State of Arizona, by and through Kristin K. Mayes, Attorney General, to protect the interests of the State and its residents. Attorney General Mayes acts pursuant to her authority under A.R.S. § 41-193(A)(2), A.R.S. § 44-1528, and A.R.S. § 44-1407.

15. The State seeks relief for the harm suffered by Arizona residents due to Defendants' anticompetitive, unfair, deceptive, and fraudulent acts and practices in furtherance of the herein-described illegal pricing scheme.

B. The Defendants and Co-Conspirators[3]

16. **MultiPlan, Inc.** is a New York corporation with its principal place of business in McLean, Virginia. MultiPlan, Inc. is wholly owned by Claritev Corporation

[3] Each defendant and co-conspirator named in this complaint acted directly or through each of that entity's executives, employees, directors, and majority-owned subsidiaries. For example, UnitedHealth Group Inc. acted directly or through, among others, the following majority-owned subsidiaries: United Healthcare Insurance Company, and its affiliates; United Healthcare Services Inc.; United Healthcare Service LLC; and UMR, Inc.

(formerly MultiPlan Corporation). Claritev Corporation is a publicly traded entity.

17. On February 17, 2025, MultiPlan Corporation changed its name to Claritev Corporation.

18. **Defendant Aetna, Inc.** ("Aetna"), a subsidiary of CVS Health Corporation, is one of the largest commercial health insurance payers in the United States. Aetna is a Pennsylvania corporation headquartered in Hartford, Connecticut. Aetna is the parent company of, or an otherwise affiliated or related company to, various commercial health insurance plans and prescription drug plans that operate in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans.

19. Aetna is a member of the MultiPlan cartel and began using MultiPlan's out-of-network claims repricing services in November 2018. On information and belief, Aetna's contract with MultiPlan required it to pay MultiPlan a fee for its services calculated as a percentage of the savings produced by MultiPlan's algorithms. Aetna paid MultiPlan a percentage of the difference between the charge a healthcare provider submitted to Aetna and the underpayment generated by MultiPlan's repricing methodology.

20. Aetna pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona.

21. **Defendant The Cigna Group** ("Cigna") is one of the largest health insurance companies in the United States. It is a corporation organized under the laws of the State of Delaware, with its principal place of business in Bloomfield, Connecticut. Cigna is the parent company of, or an otherwise affiliated or related company to, various commercial health insurance plans and prescription drug plans that operate in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2)

self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans.

22. Cigna is a member of the MultiPlan cartel and began using MultiPlan's out-of-network claims repricing services, including Data iSight, on April 1, 2015. On information and belief, Cigna's contract with MultiPlan required Cigna to pay MultiPlan a fee for its services calculated as a percentage of the savings produced by MultiPlan's algorithms. Cigna paid MultiPlan a percentage of the difference between the charge a healthcare provider submitted to Cigna and the underpayment generated by MultiPlan's repricing methodology.

23. Cigna pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona.

24. **Defendant UnitedHealth Group Inc.** ("UnitedHealth") is one of the largest health insurance companies in the United States. It is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. UnitedHealth has two divisions: UnitedHealthcare, which provides health benefits plans, and Optum, which provides health services, including pharmacy benefit manager services. UnitedHealth is a vertically integrated healthcare enterprise with a portfolio of wholly owned subsidiaries comprising a massive healthcare ecosystem. These subsidiaries include the largest commercial health insurance company in the United States, UnitedHealthcare.

25. UnitedHealth's insurance plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service-only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. UnitedHealth is a member of the MultiPlan cartel and began using MultiPlan's out-of-network claims repricing services in 2016.

26. UnitedHealth executives have testified that the company began using Data iSight for parts of its business in 2016 and further expanded the use of Data iSight in July

2017. The decision to adopt MultiPlan's out-of-network claims repricing (including Data iSight) and negotiation services was based on representations made by MultiPlan throughout 2015 and 2016 that "seven of [UnitedHealth's] top ten competitors" were already "us[ing] the tool," including "BCBS," which was being particularly "aggressive" about using Data iSight to set low out-of-network compensation amounts.

27. On information and belief, UnitedHealth's contract with MultiPlan required it to pay MultiPlan a fee for its services calculated as a percentage of the savings produced by MultiPlan's algorithms. UnitedHealth paid MultiPlan a percentage of the difference between the charge a healthcare provider submitted to UnitedHealth and the underpayment generated by MultiPlan's repricing methodology.

28. UnitedHealth pays for out-of-network services performed by healthcare providers in Arizona and, on information and belief, throughout the United States.

29. **Defendant Humana Inc.** ("Humana") is a Delaware corporation with its principal place of business in Louisville, Kentucky. Humana is the parent company, or otherwise affiliated or related company, to various commercial health insurance plans and prescription drug plans that operate in the United States. The plans issue insurance or provide administrative services concerning healthcare claims in the form of: (1) fully insured commercial health insurance plans, (2) hybrid-funded health plans, (3) Medicare Advantage plans, and/or (4) Medicaid plans. On information and belief, Humana pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona. Humana is a member of the MultiPlan cartel and, on information and belief, began using MultiPlan's out-of-network claims repricing services in 2020.

30. **The Blue Cross Blue Shield Association** ("BCBSA"), sometimes called "The Blues," is an association of insurance companies throughout the United States, including, but not limited to Defendants Elevance Health, Inc. and Health Care Service Corporation, that operate under the Blue Cross and Blue Shield brands and standards under licenses to provide health insurance plans in specific geographic regions. Despite their

licenses for specific regions, their insured members sometimes require out-of-network healthcare services in other licensees' territories throughout the rest of the United States, including in Arizona.

31. **Defendant Elevance Health, Inc.** (formerly known as Anthem, Inc.) ("Elevance") is one of the largest health insurance companies in the United States. Elevance is licensed by BCBSA to use certain trademarks and service marks in fourteen states. It is an Indiana corporation with a principal place of business in Indianapolis, Indiana. Elevance is the parent company of, or an otherwise affiliated or related company to, various commercial health insurance plans and prescription drug plans that operate in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. On information and belief, Elevance uses MultiPlan's out-of-network claims repricing services, is a member of the MultiPlan cartel, and pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona.

32. Elevance entered into a contract with MultiPlan concerning the use of MultiPlan's out-of-network claims repricing and negotiation services. On information and belief, Elevance's contract with MultiPlan required it to pay MultiPlan a fee for its services calculated as a percentage of the savings (the difference between the charge a healthcare provider submitted to Elevance and the amount actually paid) generated by MultiPlan's algorithms.

33. **Defendant Health Care Service Corporation**, a Mutual Legal Reserve Company, ("HCSC"), is one of the largest health insurance companies in the United States. HCSC is an independent licensee of BCBSA. It is organized as a mutual reserve company under the laws of the state of Illinois with a principal place of business in Chicago, Illinois. HCSC maintains certificates of authority to conduct insurance operations in thirty-eight

states, including Arizona. HCSC offers plans to provide insurance and/or administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. On information and belief, HCSC uses MultiPlan's out-of-network claims repricing services, is a member of the MultiPlan cartel, and pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona.

34. **Defendant Centene Corporation**, a Delaware corporation headquartered in Missouri, is the parent company, or otherwise affiliated or related company, to many commercial health insurance and prescription drug plans operating in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. On information and belief, Centene uses MultiPlan's out-of-network claims repricing services, is a member of the MultiPlan cartel, and pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona.

35. **Defendant Molina Healthcare, Inc.** is a Delaware corporation with a principal place of business in Long Beach, California. Molina Healthcare is the parent company, or otherwise affiliated or related company, to various commercial health insurance plans and prescription drug plans that operate in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. On information and belief, Molina uses MultiPlan's out-of-network claims repricing services, is a member of the MultiPlan cartel, and pays for out-of-network services performed by healthcare providers in all fifty states, including Arizona.

36. With the exception of MultiPlan, the above-named Defendants are referenced collectively herein as the "Insurer Defendants."

III. JURISDICTION AND VENUE

37. Jurisdiction is appropriate in this Court pursuant to A.R.S. § 12-123. Both the nature of this case and the damages sought in this case qualify for Discovery Tier 3 pursuant to Rule 26.2(c)(3) of the Arizona Rules of Civil Procedure.

38. This Court has personal jurisdiction over each Defendant. Each Defendant: (1) transacts business and/or is admitted to conduct business within Arizona; (2) maintains substantial contacts in Arizona; and (3) committed violations of Arizona statutes in whole or part within the State of Arizona. This action arises out of and relates to each Defendant's contacts with this forum.

39. Defendants' repricing scheme has been directed at, and has had the foreseeable and intended effect of, harming consumers, healthcare professionals, and entities residing in, located in, or doing business in Arizona. All at-issue transactions occurred in the State of Arizona and/or involved Arizona residents.

40. Each Defendant purposefully availed itself of the privilege of doing business within this state, and each derived substantial financial gain from doing so. These continuous, systematic, and case-related business contacts—including the tortious acts and statutory violations described herein—are such that each Defendant should reasonably have anticipated being brought into this Court.

41. Each Defendant submitted itself to jurisdiction through affirmative conduct including but not limited to pervasive marketing, encouraging the use of its services, and purposeful cultivation of profitable relationships in the State of Arizona.

42. In summary, each Defendant has systematically served the Arizona market relating to the MultiPlan pricing scheme and has harmed consumers in Arizona such that there is a strong relationship among Defendants, this forum, and the subject of this litigation.

43. Venue is appropriate pursuant to A.R.S. § 12-401 as Maricopa County is the seat of the State government.

IV. ADDITIONAL FACTUAL ALLEGATIONS

44. MultiPlan, the Insurer Defendants, and their co-conspirators devised, have executed, and continue to execute an illegal repricing scheme that operates at the intersection of two critical and inefficient industries: healthcare and health insurance. To provide the necessary background, Plaintiff's allegations begin with (A) a discussion of the relevant mechanics of out-of-network insurance coverage. Plaintiff then (B) describes the health insurance industry's first attempt to collectively suppress the prices for out-of-network services through a UnitedHealth subsidiary known as Ingenix, for the purpose of showing knowledge, intent, and absence of mistake; and proceeds to (C) detail the operations and effects of Defendants' illegal scheme.

A. PPO Networks and Payment for Out-of-Network Services

45. In the healthcare goods and services marketplace, commercial insurers and other provider network developers (like MultiPlan here) compete to induce healthcare providers to join their provider networks and accept discounted rates in exchange for the benefits of network membership.

46. Client-insurers, who offer healthcare coverage, compete to enroll consumers ("patients") in their insurance plans, offering them defined coverage for medical care and access to the client-insurers' provider networks in exchange for set premiums and negotiated deductibles and co-pays.

47. In a functioning market, payors compete with each other regarding the reimbursement rates paid to healthcare providers for the services such healthcare providers render to patients—less any co-pay or coinsurance owed by the patient. In a healthy, competitive market, each payor exercises its independent discretion, guided by market forces, to set reasonable reimbursement rates for those services, in an effort to make their services more attractive to providers and patients than their competitors.

48. After providing services to a patient, healthcare providers issue bills for those services to patients and/or payors to secure payment, and in most cases, the billing procedure is straightforward. If a patient is uninsured, the healthcare provider bills the patient directly for the services provided and the patient pays out-of-pocket or incurs personal medical debt. If a patient has an insurance plan with a high deductible, the patient is responsible for the healthcare provider's charges until he or she reaches that deductible. If a patient is fully insured and sees an in-network provider, the healthcare provider bills the patient's insurer or insurers directly. Depending on the plan and the services provided, the insurer or insurers may charge the patient a minimal co-pay. If a patient is fully insured and sees an out-of-network provider, billing and payment procedures depend on the type of plan the patient holds, the type of services the patient receives, and the insurer's and healthcare provider's policies addressing reimbursement.

49. Insurers offer two primary coverage plans: health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs.

50. Patients with HMOs pay low premiums for coverage and low out-of-pocket costs for services, but only have coverage for services provided by the HMOs' "in-network" providers, who contract with insurers, agreeing to discounted rates in exchange for other benefits, including the HMOs directing their subscribers to them (*i.e.* "steerage") and prompt payments.

51. If a patient with an HMO plan opts to see a provider who is "out-of-network" (*i.e.* not under contract with the patient's insurer), the visit is not covered, and the patient bears full responsibility for the cost of service.

52. Patients with PPOs pay higher premiums for coverage and higher out-of-pocket costs for goods and services but have at least partial coverage for both in- and out-of-network healthcare services.

53. As with HMOs, PPOs' in-network healthcare providers contract with insurers, agreeing to discounted rates in exchange for other benefits. Unlike HMOs,

however, PPOs offer coverage for services rendered by out-of-network providers who have no contract with the insurer.

54. Patients pay more for the increased flexibility of a PPO plan. Premiums for PPO plans cost approximately $1,000 a year more on average than premiums for HMO plans. PPO plans also generally carry higher deductibles and co-pays than those offered by HMOs.

55. Nevertheless, of the more than 150 million Americans with employer-sponsored health plans, nearly half choose PPO plans, reflecting consumers' and employers' rational preference for flexibility in healthcare provider choice.

56. Insured patients seek out-of-network care for a variety of reasons. Some patients require specialized treatment not available from an in-network healthcare provider. Others have longstanding provider relationships with practitioners who have been dropped from their insurer's network or who are not included in a new insurer's network when they change plans.

57. Quality and availability of care may also come into play. In some fields of medicine and geographic regions, some providers are out-of-network because their patients are willing to pay a premium for better care; other providers are out-of-network because they cannot afford to accept the discounted rates that accompany network membership; and patients' options for in-network healthcare providers may be unavailable or present some greater risk.

58. Regardless of the reason, patients and employers with PPO plans pay more to ensure that they have coverage for necessary services when they require medical care.

59. Because insurers understand patient and employer preferences, they promote the "flexibility," "choice," and "freedom" associated with PPO plans. For example, Aetna boasts that with an Aetna PPO plan, "you'll never have to choose between flexibility and savings." Aetna also represents that its PPO plans are "great for fully insured and self-funded customers." UnitedHealth brands its PPO plans "Options PPO."

60. These statements are not empty promotional statements that consumers take lightly. They are the primary incentive for consumers to pay more for a PPO. The promise of greater flexibility in provider choice encourages consumers to select an insurer's PPO plan over its HMO plan and also over other insurers' plans.

61. While insurers promote flexibility, it is also in their financial interest to compensate healthcare providers at as low a rate as possible.

62. In-network healthcare provider compensation is negotiated and set by contract. Once a healthcare provider has joined an insurer's network, the insurer is generally contractually barred from reimbursing in-network healthcare providers below the contracted rates.

63. By contrast, payors retain ongoing discretion to determine the reimbursement rates for out-of-network services. They review out-of-network healthcare provider charges, and set an "allowable" amount based on their calculation of the UCR rate. In a healthy market, this "allowed" amount generally reflects a rate that balances the competing interests of payors and healthcare providers. The less money payors pay for healthcare providers' out-of-network services, the more revenue they keep for themselves.

64. In a competitive market, the central market force restraining payors from underpaying healthcare providers for out-of-network services is the threat that healthcare providers will stop accepting the payors' patients, resulting in those patients canceling their plans and enrolling with another payor.

65. A healthcare provider's refusal to treat an insurer's patients is the ultimate consequence of healthcare provider "abrasion," which is friction in the provider-payor relationship, often caused by the administrative burden of payor systems, continuous underpayment, and other negative aspects of provider-payor interactions. Given the risk of healthcare providers rejecting a payor's patients in a competitive market, it would be against insurers' interests to compensate providers at below-market rates.

66. Recognizing this, insurers have traditionally calculated out-of-network

provider compensation using UCR, or "Usual Customary and Reasonable," rates.

67. UCR rates are based on prevailing market rates in particular geographic areas or "the prevailing rate[s] the doctors charge when they have not negotiated a lower rate with the insurer on an in-network basis."

68. In-network healthcare providers generally accept reimbursement from contracted insurers at rates below the applicable UCR rates. In exchange, these insurers guarantee in-network healthcare providers increased patient volume, prompt and predictable payment, and other benefits that come with participation in an insurer's provider network. Without these benefits and contractual inducements, healthcare providers would not contract with insurers to join their provider networks.

69. Accordingly, pre-negotiated, discounted, in-network compensation rates bear no relation to reasonable market compensation for out-of-network medical services and have never been relevant to the fair calculation of UCR rates.

70. To calculate UCR rates, insurers previously used aggregated retail medical billing data (as opposed to aggregated payor reimbursement data, which would reflect discounted in-network rates) for similar healthcare services performed in the same geographic market.

71. Based on this aggregated data, insurers exercised their independent judgment to determine UCR rate schedules for out-of-network provider compensation for particular services and treatments, often identified by standard CPT codes, and used a percentile-based method in order to calculate the UCR rate. This method pegs the UCR rate to a benchmark percentile, which is based on bills submitted for similar medical services within a specific geographic area. Insurers have commonly used the 80th percentile, which is higher than 80% of bills in the UCR calculation, thus reflecting the prevailing market rates while eliminating the highest 20% of charges. Other insurers might peg the UCR rate to a different percentile, typically between the 70th and 90th percentiles. This UCR rate determines what is commonly known as the "allowable amount."

72. After determining the allowable amount, insurers determine what portion is payable by them under the patient's insurance policy (the "payable amount"). Typically, the payable amount is set to 80% to 90% of the allowable amount. If the payable amount is set to 90%, then the insurer would pay the lower of the provider's actual bill or 90% of the allowable amount. Therefore, if the provider's bill is less than 90% of the allowable amount, the payor would cover the whole bill; however, if the provider's bill is more than 90% of the allowable amount, the patient is responsible for the remaining 10% of the allowable amount as "co-insurance."

73. Both payors' and patients' obligations thus depend upon accurate calculation of the UCR rate, as this amount determines the allowable amount and therefore both the payable amount (the payor's obligation) and the co-insurance amount (the patient's obligation).

74. The following hypothetical demonstrates how this method of compensation is calculated. If an out-of-network physician charged $1,350 for an endoscopy for a patient with a PPO plan that (a) calculated UCR using the 80th percentile and (b) covered 90% of that allowable amount, the payor would begin by reviewing data from a UCR database on endoscopies performed in the same geographic region. If the data showed ten other endoscopies performed in that region, billed at $500, $600, $700, $800, $900, $1,000, $1,100, $1,200, $1,300, and $1,400, the insurer would sort these charges from lowest to highest to determine percentiles:

Procedure	**Percentile**							
	20th	**30th**	**40th**	**50th**	**60th**	**70th**	**80th**	**90th**
Colonoscopy	$600	$700	$800	$900	$1,000	$1,100	$1,200	$1,300

At the 80th percentile of this hypothetical, 80% of recorded charges are equal to or lower than $1,200, and 20% are higher.

75. Because the payor used the 80th percentile to calculate UCR rates, its

calculation of the UCR rate for endoscopies in this geographical area would be $1,200. This amount is less than the physician's $1,350, so the allowable amount would be capped at the UCR rate. As such, the plan would effectively reduce the physician's billed charge from $1,350 to the $1,200 allowable amount. Because the insurer covers 90% of the allowable amount, it would pay the provider 90% of $1,200, which is a payable amount of $1,080. The patient would then be obligated to pay the remaining 10%, or $120, as co-insurance.

76. In a similar hypothetical but where a payor or healthcare provider requires the patient to submit his or her own claims for out-of-network services, the patient would pay the provider's charge out-of-pocket at the point of service, and the insurer would similarly calculate the UCR, arriving at the $1,200 allowable amount, and reimburse the patient $1,080.

77. In both scenarios, correct UCR rates ensure that the payor would pay reasonable compensation to the healthcare provider, while at the same time protecting the payor from charges at the highest end of the relevant market and the patient from excessive out-of-pocket costs.

78. After a healthcare provider submits a bill to the payor, the insurer notifies the healthcare provider what the allowable amount is for a particular out-of-network claim. The provider can choose to either absorb a loss (the difference between the billed charge and the UCR-based allowable amount), dispute the payor's calculation of the UCR rate, try to negotiate the allowable amount, or attempt recover the difference from the patient through the practice of balance billing. An appropriately calculated UCR disincentivizes balance billing.

79. Though federal and state laws now prohibit balance billing under certain circumstances (*e.g.*, emergency out-of-network medical care), balance billing is still employed by providers in other settings.

80. Despite these generally accepted practices for pricing and billing out-of-

network services that encourage a competition-based distribution of costs and benefits, at least twice in the past two decades, insurers have employed anticompetitive tactics to minimize payments for out-of-network services below market rates, reducing competition to displace costs while acquiring undue benefits.

B. The Ingenix Repricing Scheme (1997-2012)

81. For decades, payors primarily calculated UCR rates using retail charge data from two major claims databases: the Prevailing Healthcare Charges System ("PHCS") and Medical Data Research ("MDR"). In 1997 and 1998, UnitedHealth purchased MDR and PHCS, respectively, through a newly formed subsidiary known as Ingenix.

82. Through Ingenix, UnitedHealth, one of the nation's largest health insurance companies, gained significant control over how the entire industry set UCR rates and, correspondingly, over compensation levels for out-of-network healthcare providers nationwide. UnitedHealth further enhanced that power by contracting with its competitor insurance companies to control the out-of-network marketplace and reprice out-of-network provider claims using their collective proprietary claims and billing data.

83. UnitedHealth exploited that control in keeping with its own interests. Because UnitedHealth was one of the nation's largest insurers, provided out-of-network coverage for millions of consumers, and possessed substantial control over out-of-network provider compensation for an entire industry, it was able and incentivized to reduce the UCR rates by skewing downwards the claims and billing data that informed its algorithms. And, with the cooperation of its competitor insurance companies, that is what it did.

84. On information and belief, Ingenix gathered data from its co-conspirator insurers and then tainted its consolidated database of out-of-network claims with claims submitted for *in*-network services, which reflected deeply discounted rates negotiated by providers in exchange for network access and patient steerage. Negotiated in-network rates did not represent reasonable rates of compensation for *out*-of-network providers.

85. On information and belief, by including in-network claims in its database, Ingenix artificially depressed the prevailing market rates for out-of-network provider services and, in turn, depressed the compensation amounts generated by the Ingenix algorithm.

86. On information and belief, UnitedHealth, through Ingenix, further skewed the results to insurers' benefit by eliminating amounts on the high end of the spectrum from its databases, while the insurers who contributed data to the database did the same. On information and belief, Aetna, Ingenix's single largest data contributor, for example, "pre-scrubbed" its claims data, eliminating the highest 20% of valid medical charges before sending the data to Ingenix.

87. This and other forms of data manipulation skewed the distribution of compensation payments in Ingenix's databases well below the distribution in the actual marketplace.

88. Ultimately, the rate calculations Ingenix's algorithms generated skewed 10-28% lower than traditional UCR. This resulted in underpayments to providers and exposed patients to balance billing. These underpayments also increased profits for insurers—the less money insurers paid to providers, the more they kept for themselves.

89. The Ingenix scheme operated for about a decade until provider and consumer complaints about unreasonably low out-of-network provider compensation and rampant balance billing brought the scheme to its breaking point and triggered investigations into Ingenix's practices.

90. In 2000, the American Medical Association and several state medical associations filed a class action lawsuit against UnitedHealth alleging that Ingenix had improperly reduced out-of-network compensation to healthcare providers. The suit settled in 2009, with UnitedHealth agreeing to pay $350 million to class members.

91. In February 2008, the New York Attorney General announced an investigation into the Ingenix scheme, describing it as "a scheme by health insurers to

defraud consumers by manipulating reimbursement rates" to out-of-network providers. The New York Attorney General's office reviewed more than one million claims as part of its investigation and concluded, among other things, that "Ingenix [wa]s essentially the black box for consumers," in that it "forced consumers to write a blank check" for procedures without knowing how much they would ultimately have to pay out of pocket.

92. After a year of investigation, in January 2009, the New York Attorney General announced a settlement between the State of New York and UnitedHealth. UnitedHealth agreed to shut down Ingenix and contribute $50 million to the formation of an independent non-profit organization, FAIR Health, Inc. ("FAIR"), which would establish a new system for calculating out-of-network provider compensation on a UCR basis. UnitedHealth agreed to use FAIR to calculate out-of-network compensation for at least five years, and to refrain from using, owning, operating, or funding any other UCR database during that time. Ultimately, the Attorney General promised, the state's agreement with UnitedHealth would "keep hundreds of millions of dollars in the pockets of over one hundred million Americans."

93. Similar settlements between the New York Attorney General and the other major insurers followed. Aetna agreed to pay $20 million for the creation of FAIR, to contribute untainted data to the new database, and to use FAIR for five years. Cigna and WellPoint, Inc. (later known as Anthem, and then Elevance) agreed to pay $10 million and to use FAIR for five years. Other, smaller insurers reached settlement agreements that required them to contribute between $200,000 and $1.6 million.

94. With Ingenix no longer an option, even insurers that had not settled with the New York Attorney General had to find a new UCR database to calculate provider compensation. Because UnitedHealth had purchased and consolidated the two major databases in operation a decade earlier (leaving few, if any, privately controlled alternatives in the marketplace), many insurers migrated to FAIR.

95. FAIR's pro-competitive methodology gradually corrected the corrupted UCR database it had inherited from UnitedHealth. As FAIR collected more accurate data from insurers (many of which were required by their settlement agreements to submit "clean," unscrubbed charge data), UCR rates and provider compensation approached reasonable, competitive market levels.

96. Some of that increase was attributable to inflation, but the remainder reflected the normalization of the UCR database and a return to a dataset that accurately reflected prevailing market rates free from manipulation. As a result, providers collected more accurate and fair compensation from insurers for the medical care they provided, and patients received the out-of-network coverage they had contracted and paid for, without the burden of exorbitant balance bills.

C. MultiPlan Replaces Ingenix as the Industry Price Setter

97. As Ingenix came under scrutiny, MultiPlan began acquiring competitors and technology companies, and it became both (1) a cost-containment and data analytics vendor for health insurance companies and (2) an independent developer and marketer of preferred provider networks.

98. As a cost-containment vendor, like Ingenix before it, MultiPlan contracts with insurers to use its repricing tools and algorithms, collectively known and referred to herein as "Data iSight," which purports to generate fair provider compensation amounts for out-of-network claims.

99. As a developer of preferred provider networks, MultiPlan contracts with providers and rents that in-network list of providers to its clients.

100. MultiPlan uses Data iSight to adjust charges submitted in connection with its own PPO networks, which MultiPlan rents to payors for use as a primary network or to complement their own PPO networks.

101. Both of MultiPlan's lines of business are relevant to Plaintiff's claims.

1. MultiPlan Consolidates Market Resources and the Co-Conspirators Join Forces

102. As far back as August 2009, with Ingenix under attack, MultiPlan saw an emerging gap in the market for repricing out-of-network claims. Because it was not owned by an insurer, MultiPlan marketed its new product to insurers as an independent, legal alternative to Ingenix.

103. In 2010, MultiPlan acquired Viant, Inc., a data analytics firm that, like Multiplan, operated a rental PPO network, but the acquisition also added non-network cost management services, post-payment audit and recovery services, analytics-based services, and additional network access to MultiPlan's business portfolio.

104. In 2011, MultiPlan acquired National Care Network, LLC ("NCN") for $50 million. At the time, NCN developed powerful data-driven tools and technology solutions. At the time of MultiPlan's acquisition, NCN had a patent application pending for the software program that would eventually become Data iSight.

105. In 2014, MultiPlan completed its series of acquisitions by adding a company called Medical Audit and Review Solutions ("MARS") to its analytics-based services portfolio. MARS is a provider of medical necessity auditing and case review services, providing its PROBE Audit Risk System ("PARS") platform that combines actuarial analytics and clinical reviews to identify opportunities to pay lower prices for out-of-network goods and services.

106. While undertaking these acquisitions, MultiPlan underwent efforts to secure all major insurers as clients, making MultiPlan the dominant repricing service. Every new client strengthened its position as it approached other payors about contracting to use Data iSight. As with Ingenix before it, signing a critical mass of payors to use MultiPlan's algorithms would effectively close the market for repricing out-of-network services and allow the cartel to set the prices for those services far below fair market value.

107. On information and belief, MultiPlan marketed its product to insurers by promoting its ability to facilitate collective action. For example, MultiPlan advertised its platform as a way for insurers to outsource the repricing and negotiation of out-of-network claims to a single industry-wide decision-maker, enabling "[c]ommercial plans of any size" to obtain significant "discounts on out-of-network charges" while ensuring "low provider abrasion" and "minimizing the balance billing of their members."

108. Insurers were quick to sign up. Once the five-year terms in their settlement agreements with the New York Attorney General began to expire in 2015, the major insurers contracted with MultiPlan to use its Data iSight technology as a substitute for exercising their own discretion to set reimbursement rates for out-of-network services.

109. By 2018, MultiPlan had reached agreements with nearly every major insurer in the United States. For example, on April 1, 2015, after Defendant Cigna completed its five-year obligation to use FAIR, it agreed to use MultiPlan's technology to reprice out-of-network claims. On information and belief, Cigna also delegated authority to MultiPlan to negotiate with providers who pushed back and agreed to pay MultiPlan a fee based on a percentage of the underpayment its algorithms generated.

110. In 2015, a Cigna executive cautioned colleagues, that "[w]e cannot develop these charges internally (think of when Ingenix was sued for creating out-of-network reimbursements)". She opined: "We need someone (external to Cigna) to develop acceptable" rates.

111. Plaintiff is informed and believes that MultiPlan's efforts to secure major insurers as clients included meetings and presentations, during at least one of which MultiPlan told Cigna that many other payors were already using its methodology and that Cigna could increase its revenue substantially by bringing itself into alignment with its competitors.

112. Plaintiff is informed and believes that MultiPlan's presentations to Cigna explicitly compared Cigna's out-of-network pricing for specific services to that of its

competitors. Plaintiff is informed and believes that Cigna agreed to let MultiPlan set the prices for out-of-network goods and services beginning in April 2015 because it understood that MultiPlan's widely used methodology would achieve lower prices.

113. On information and belief, after Cigna became a co-conspirator, MultiPlan crowed about its success in cutting Cigna's payments to providers for out-of-network claims during meetings, and in a slide deck entitled "Cigna & MultiPlan Governance Meeting, June 21, 2021," MultiPlan touted its success working with Cigna to cut prices for out-of-network goods and services. On information and belief, the message to Cigna was simple—the illegal scheme was working.

114. UnitedHealth and MultiPlan entered into a Network Access Agreement effective on January 1, 2010, in which UnitedHealth agreed to use MultiPlan's PPO network as a complementary PPO network. On July 1, 2017, after UnitedHealth's obligation to use FAIR expired, the company implemented Data iSight for parts of its business and further expanded its use of Data iSight in October 2017, after amending its Network Access Agreement with MultiPlan.

115. In that amendment, UnitedHealth agreed to use several MultiPlan services, including Data iSight, to set its out-of-network prices in collective accordance with its competitors' prices, and Plaintiff is informed and believes UnitedHealth also agreed that MultiPlan would negotiate the price of out-of-network goods and services for UnitedHealth if a provider pushed back on the prices set by MultiPlan.

116. Plaintiff is informed and believes, under this agreement, MultiPlan charged UnitedHealth a fee equivalent to a percentage of the underpayment generated by using MultiPlan's pricing methodology.

117. Plaintiff is informed and believes that MultiPlan convinced UnitedHealth to use its repricing tools and recruited it into its repricing conspiracy by touting the benefits of pricing collectively. On or about October 1, 2015, for example, MultiPlan sent UnitedHealth a presentation entitled "Data iSight: Maximize Savings Using a Patented

Methodology." Plaintiff is informed and believes that this presentation promised that UnitedHealth could substantially increase its revenues if it used MultiPlan's common pricing methodology instead of independently determining out-of-network provider compensation rates.

118. MultiPlan also induced UnitedHealth to join the conspiracy by disclosing that its competitors had already entered into similar agreements with MultiPlan. In 2016, MultiPlan's Chief Revenue Officer, Dale White, emailed UnitedHealth executives, explaining that seven of UnitedHealth's top ten competitors were already using MultiPlan's out-of-network pricing methodology. White encouraged UnitedHealth to do the same, writing: "[i]mplementation of these initiatives in 2016 will go a long way to bringing United back into alignment with its primary competitor group [*i.e.*, the Blues, Cigna, Aetna] on managing out-of-network costs."

119. UnitedHealth executives found its competitors' use of Data iSight compelling. Rebecca Paradise, UnitedHealth's Vice President of Out-Of-Network Payment Strategy, having received White's email, later explained that the fact that the methodology "was widely used by our competitors" was a key factor in UnitedHealth's decision to use MultiPlan's repricing tools.

120. MultiPlan also provided UnitedHealth confidential and competitively sensitive information about the prices its competitors were paying for out-of-network goods and services.

121. In a September 8, 2016, email, John Haben, a UnitedHealth executive, indicated specific knowledge of competitors' pricing formulas adopted through Data iSight. He wrote that "MultiPlan said seven of our top ten competitors use the tool today." He continued: "BCBS [Blue Cross Blue Shield] is even more aggressive and is accessing the option of moving DIS [Data iSight] up even higher to have IPR/OPR (R&C repricing) which is option 3 . . . ." In the same email, Haben demonstrated specific knowledge of the

pricing "option" adopted by UnitedHealth's rival, Blue Cross Blue Shield, in MultiPlan's Data iSight formula.

122. Testifying under oath, Haben has conceded that he learned Blue Cross Blue Shield's pricing formula from MultiPlan. Haben also testified that he shared this information about Blue Cross Blue Shield pricing with other UnitedHealth executives to convince them to use MultiPlan's repricing technology.

123. Aetna entered into a Network Rental Agreement with MultiPlan with an effective date of January 1, 2011. In that contract, Aetna agreed to use MultiPlan's PPO network as a complementary PPO network to extend the reach of Aetna's PPO networks.

124. Then, after meeting with MultiPlan, effective on December 9, 2018, Aetna amended its Network Rental Agreement and contracted to use Data iSight to reprice providers' charges for out-of-network goods and services. Aetna also delegated negotiation authority to MultiPlan and agreed to pay MultiPlan a fee equivalent to a percentage of the underpayment generated by MultiPlan's technology. This fee was set at 12% of the underpayments generated.

125. Plaintiff is informed and believes that Aetna's November 19, 2018 "Medical Reimbursement Analysis Services" agreement with MultiPlan became publicly available in December 2021 and provides a clear example of the terms of MultiPlan's agreements with its clients. The Aetna agreement provided, in relevant part, that:

- Aetna would "forward . . . out-of-network, non-contracted claims" to MultiPlan, which would use its "Data iSight . . . proprietary process" to "determine[] payment allowance[s]" from those claims;
- Aetna would have "access" to "on-line results from Data iSight" and to the "data used to populate [MultiPlan's] claims database," which "underl[ies] the Data iSight application";
- Aetna would complete a "Data iSight Client Preferences form" indicating its pricing preferences for out-of-network claims (a form of competitively sensitive information), but its preferences would be expressed based on certain "business criteria," which MultiPlan would unilaterally define, and which would be "mutually agreed upon" by MultiPlan and Aetna;

- MultiPlan would handle all "disputes" over compensation and, as part of this negotiation function, would "[c]ontact the provider to attempt to negotiate a revised billed amount in accordance with [the] predesignated [mutually agreed upon] parameters not to exceed the original billed charge";
- "Where the negotiated amount is less than the original billed charge," MultiPlan must "obtain the provider's signed agreement to the revised amount or secure proper documentation stating no 'balance bill' to the patient except for deductible, co-insurance and non-covered services based on the provider's adjusted price";
- Aetna will "pay providers" no less than the rate determined and negotiated by MultiPlan (the "negotiated rate") so long as the "negotiated rate" is "consistent with the business criteria mutually agreed upon between [Aetna] and [MultiPlan]"; and
- Aetna will pay a fee to MultiPlan equivalent to 12% of the "savings" (i.e., the underpayment) generated by using MultiPlan's pricing methodology compared to the provider's billed charges.

126. On information and belief, the other Insurer Defendants, as well as hundreds of other payors, executed similar contracts with MultiPlan and began using Data iSight to reprice out-of-network claims between 2015 and 2018.

127. On information and belief, all client-payors contracted with MultiPlan to pay a fee for its services calculated as a percentage of the difference between the charge a provider submitted to them and the underpayment generated by MultiPlan's algorithms.

128. To date, MultiPlan has contracted with more than 700 payors nationwide, representing more than 80% of all commercial out-of-network payments by dollar volume in the United States.

129. On information and belief, all client-payors agreed to provide MultiPlan—and through MultiPlan to each other—proprietary, competitively sensitive information, including data concerning the amount they pay providers for in- and out-of-network services and their internal pricing strategies and preferences.

130. On information and belief, MultiPlan pools this competitor pricing data in its system as a single benchmarking dataset that it uses to inform its pricing algorithms.

131. On information and belief, MultiPlan's sales and national accounts teams

also use the data to convince its clients to further lower out-of-network prices and to enlist new clients into the cartel.

132. On information and belief, MultiPlan retains all competitor data in a massive database—by February 2026, MultiPlan touted that it had "approximately 15 petabytes of data"—to which all clients have access.

133. On information and belief, client-payors agree to share their proprietary claims and pricing data with their competitors to achieve the collective purpose of setting the prices they pay for out-of-network goods and services at artificially and unreasonably low rates.

134. MultiPlan and its clients understand the implications of this data sharing. MultiPlan has touted its "incomparable database"—populated with some 135 million claims a year, or "360,000 claims a day," from "700-plus commercial insurance customers"—as the most "impressive" fact about the company, and the real reason insurers stand to benefit from the decision to outsource the pricing of their out-of-network claims to MultiPlan. In the words of one MultiPlan executive, Mark Tabak, MultiPlan's database creates a "data advantage" that places a "moat" around MultiPlan that drives high recurring revenues.

135. In May 2023, MultiPlan boosted its ability to exchange real-time pricing data by acquiring Benefit Science Technologies with its machine learning artificial intelligence ("AI") analytics tools. In June 2023, MultiPlan announced a new product known as PlanOptix, which "enables customers to quickly query and navigate over 500 billion records" with the assistance of AI analytics tools. For example, a client-payor can "prepare and execute strategic contract negotiations with providers, understand competitive positioning to drive sales and retention strategies; improve stop-loss premiums, optimize provider networks and more."

136. When MultiPlan first announced PlanOptix, it had already "ingested data on over 70 payers," including "all of the national major carriers as well as many of the regional

ones." So, per its client-payors' request, MultiPlan enhanced PlanOptix to show competitor pricing data "not just at a global level, but even at a [] service level right, labs and X-rays versus inpatient, inpatient versus outpatient." Using PlanOptix, MultiPlan explained, client-payors would be able to answer questions like "[w]here do I sit versus my competitor?" and "[h]ow do I ensure that I'm negotiating correctly when I measure myself against my competitors?"

137. On information and belief, PlanOptix enables members of the cartel to monitor one another's adherence to their anticompetitive agreement to eliminate pricing competition on out-of-network goods and services by allowing the client-payors to directly compare how much they pay to a particular provider for a particular type of out-of-network service. Prior to launch, MultiPlan demonstrated that analysis, as shown below:

138. PlanOptix allowed client-payors to compare their claims and prices "against competitors . . . down to an MSA level [] of detail." The example above, from an investor presentation demonstrating how the tool works in practice, shows a comparison between the prices that one plan pays at the Mayo Clinic Arizona for specific out-of-network services and the prices that two other plans pay at the same clinic for the same out-of-network services. PlanOptix shows the average prices that Blue Cross Blue Shield pays and the percentage difference between those prices and the prices that UnitedHealth and Aetna pay. Using PlanOptix, client-payors can directly compare their prices for out-of-network services to the prices set by other client-payors for the same services.

139. Ultimately, PlanOptix is another MultiPlan tool that allows every member of the cartel to monitor the effectiveness of the cartel in real time, ensure that its reimbursement rates to healthcare providers are in line with its competitors' rates, and determine whether another member is paying healthcare providers more than the coordinated rates.

140. On information and belief, at the November 28, 2023, Bank of America Leveraged Finance Conference, a MultiPlan executive confirmed PlanOptix's purpose is to "enable payers to benchmark themselves against their competitors." He explained that, using PlanOptix, a payor would know "whether they're above or below or on par with their competition," including with regard to amounts paid to "a specific provider."

141. All told, MultiPlan commingles its client-payors' confidential pricing data to further and protect Defendants' illegal scheme. Each time a client-payor uses MultiPlan's common pricing methodology, it willingly transmits confidential claims data into the data pool to further and protect the cartel's illegal scheme.

142. Sharing competitively sensitive information is anticompetitive by nature—no insurer in a healthy market would willingly disclose its proprietary claims, pricing, and billing information to a competitor, let alone to *all* of its major competitors. By acting as MultiPlan client-payors, the co-conspirators act against their individual interests in

furtherance of the collective price-fixing scheme.

143. On information and belief, MultiPlan recruits new participants into the scheme to further drive down the prices set for out-of-network goods and services by funneling current confidential pricing data to competing payors, converting them to client-payor members of the cartel. This practice additionally prevents current cartel members from leaving.

144. In 2021, UnitedHealth created an out-of-network pricing methodology known as Naviguard, which one analyst described as "an in-house replacement for MultiPlan." However, MultiPlan demonstrated its ability to enforce the cartel, convincing UnitedHealth to abandon the project shortly before it was set to launch.

145. UnitedHealth planned to aggressively price the Naviguard product. Instead of taking a cut of the difference between the billed amount and the allowed amount for out-of-network goods and services, it planned to offer a fixed, per-member, per-month fee. Compared to "shared savings fees," Naviguard's pricing had the potential of dramatically lowering fees charged to many of its clients. For one county in Texas, for example, UnitedHealth's analysis showed that shared savings fees would drop from $263,000 for MultiPlan's services in 2019 to $30,000 per year with Naviguard.

146. UnitedHealth developed a "roadmap" to terminate its contract with MultiPlan by 2023 in anticipation of Naviguard coming online, but on information and belief, it ultimately scrapped its plan after MultiPlan offered UnitedHealth a deal to stay in the cartel. UnitedHealth amended and restated its contract with MultiPlan in 2022.

147. UnitedHealth's decision not to bring out-of-network pricing in-house after spending significant time, effort, and money on Naviguard are actions against self-interest, which are indicative of MultiPlan's efforts to enforce the cartel and an illegal conspiracy to fix healthcare provider compensation rates for out-of-network services.

2. How Defendants Use Data iSight to Reduce Provider Compensation

148. MultiPlan's Data iSight program determines healthcare provider compensation rates for out-of-network claims, paying less than the provider's billed charge in virtually every instance.

149. Pricing determinations involve both an algorithmic component and direct input from MultiPlan personnel, who work with client-payors to choose pricing strategies, which function as maximum price algorithmic overrides, to fix and standardize rates and manipulate the market. For the purposes of this Complaint, Plaintiff refers to MultiPlan's repricing tools collectively as "Data iSight."

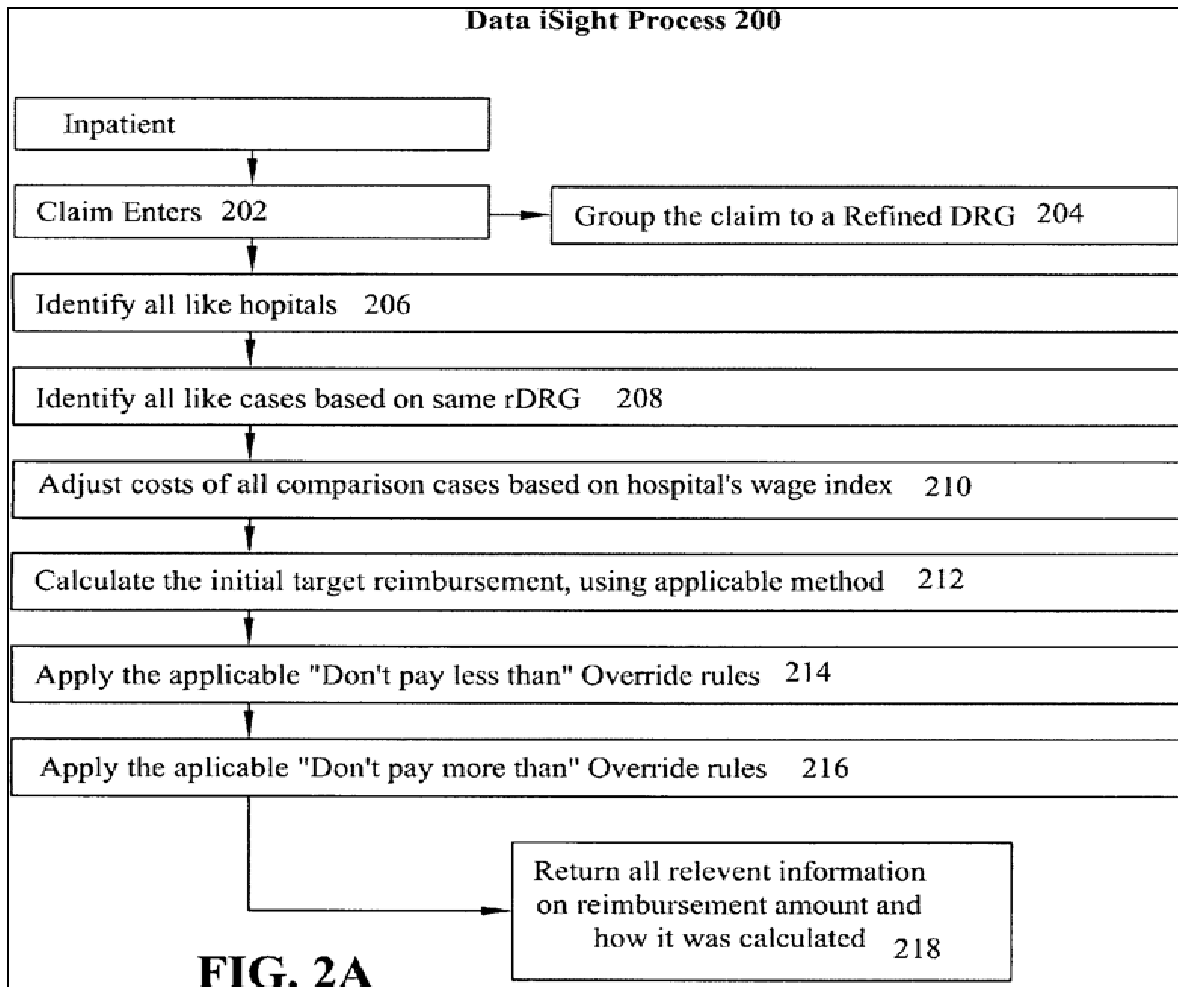
150. The precise method by which MultiPlan sets compensation rates is proprietary. However, public statements by MultiPlan employees, promotional materials, and U.S. Patent No. 8,103,522 (the "'522 patent") describe MultiPlan's repricing methodology.

151. Client-payors that contract with MultiPlan to use Data iSight send their out-of-network claims to MultiPlan for repricing via an electronic data connection. On information and belief, these claims come to MultiPlan with detailed information, such as the procedure code, dates of service, the billed amount, and an alphanumeric code indicating whether the claim is subject to a payor's previously disclosed UCR out-of-network rates. Once MultiPlan receives a claim, that data is loaded into MultiPlan's "fair reimbursement determination" tool, known internally as "FReD," which then routes the claim to Data iSight.

152. Data iSight's algorithm next establishes a comparator set, in most cases, it simply calculates the median payment amount for like services.

153. According to the '522 patent, the process of establishing a comparator set depends in part on what kind of claim is being repriced. For an inpatient hospital care claim, Data iSight uses refined Diagnosis Related Group ("rDRG") values as benchmarks. rDRG is a system developed from the original DRG system adopted by the Centers for Medicare

and Medicaid Services ("CMS") for Medicare hospital reimbursements; it classifies claims according to type of care, severity, and complexity. When repricing an inpatient claim, Data iSight searches the MultiPlan claims database for other claims for the same rDRG value at "like" hospitals and makes a cost adjustment based on the treating hospital's wage index, as shown in Figure 2A of the '522 patent, below:



154. For outpatient treatment claims, Data iSight uses the Healthcare Common Procedure Coding System ("HCPCS"), another CMS-developed system.

155. HCPCS is a collection of standardized codes that represent medical procedures, supplies, products, and services used to facilitate the processing of health insurance claims. Data iSight searches the MultiPlan claims databases for other bills for

the same services, on a code-by-code basis, and then makes an adjustment based on the wage index where the treatment was rendered, as shown in Figure 2B of the ’522 patent below:

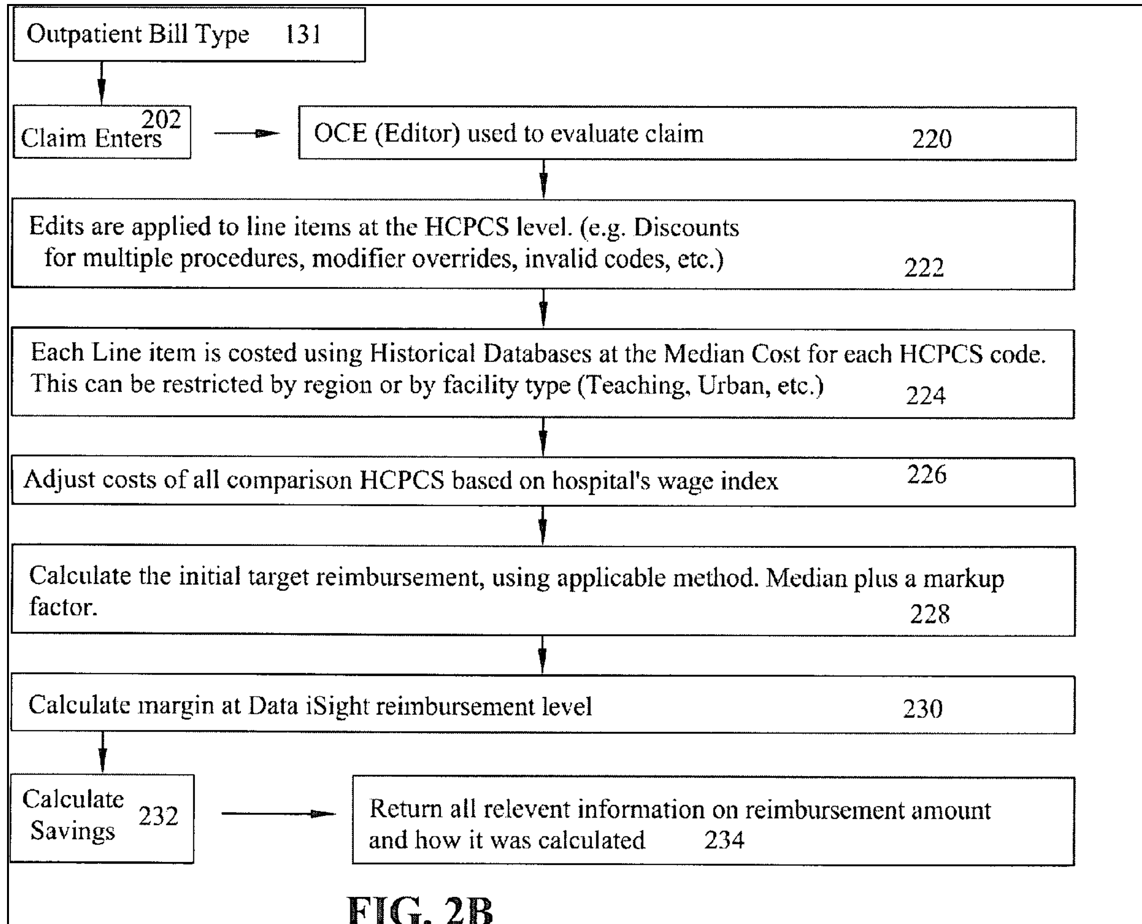


FIG. 2B

156. MultiPlan claims that Data iSight is a fair and transparent way to calculate compensation rates based on reasonable benchmarks. In reality, however, MultiPlan ensures that Data iSight always generates artificially low compensation rates, and those rates are driven even further down over time.

157. MultiPlan, like Ingenix before it, corrupts its dataset with in-network payments. These payments are then fed to Data iSight as comparators for *out*-of-network services. As explained above, healthcare providers agree to accept deeply discounted in-network compensation rates in exchange for benefits like steerage, the increased patient volume that results, and prompt payment. By tainting its database with in-network

payments, MultiPlan drives down compensation levels for out-of-network healthcare providers, who do not receive in-network benefits.

158. MultiPlan also applies algorithmic overrides to ensure that healthcare provider payments never approach reasonable compensation. MultiPlan instructs many of its large client-insurers (including the Insurer Defendants) to set manual overrides, like caps on payment. These overrides provide MultiPlan with an additional means to control and coordinate client-insurer behavior, thereby reducing member and healthcare provider abrasion and accelerating the cartel's goal of suppressing industry-wide out-of-network healthcare provider compensation rates.

159. Under MultiPlan's agreements with its client-insurers, the client must complete a "Data iSight Client Preferences form." The client-insurer and MultiPlan must mutually agree on these preferences; the insurer cannot set its own preferences independently of MultiPlan. In Aetna's agreement, the form is referenced as the basis for determining whether negotiated rates are consistent with the "mutually agreed upon" "business criteria." Upon information and belief, MultiPlan maintains control over these selections, enabling and driving coordination via MultiPlan across the Insurer Defendants and co-conspirators.

160. The "business criteria" on these preference forms are seven "methods" for setting rates, all predetermined by MultiPlan. Most cap the amount the client-insurer is willing to pay for a particular service, regardless of reasonableness or the median value the algorithm would produce without interference. One available Data iSight "method" is "[r]eimbursement at which X% of Hospitals are profitable." Using this method, client-insurers and MultiPlan might decide to compensate healthcare providers at a level where some hospitals will lose money for the services provided—which is a punitive level of compensation and the opposite of fair and reasonable.

161. Another method is "[r]eimbursement at X% of Medicare," whereby MultiPlan and the client-insurer agree to pay no more than a certain percentage of what

Medicare pays as compensation for a service. The five remaining are shown below in Table 1 of the '522 patent:

Available Methods	
Fl	Reimbursement at which X % of Hospitals are profitable
F2	Reimbursement at which the average mark-up is X %
F3	Reimbursement at X % of Cost
F4	Reimbursement at X % of Medicare Reimbursement
F5	Reimbursement at X % of Charges
F6	Reimbursement at X Percentile of Billed Charges
F7	Reimbursement at Average Billed Charges

162. Data iSight uses these "methods" to set an "initial target" compensation amount. The initial target amount largely determines how healthcare providers, including those who participate in the MultiPlan PPO network (i.e. MultiPlan's *in*-network providers), will be compensated for claims they submit to MultiPlan's payor clients.

163. Worse still, Data iSight often yields final compensation amounts that are *even lower* than these artificially low calculations. That's because on information and belief, MultiPlan instructs many client-payors to apply additional overrides to determine the final provider compensation amount. These overrides are shown in Table 1 of the '522 patent:

Available Overrides	
O1	Don't Pay Less Than X % of Claim's Cost
O2	Don't Pay Less Than X % of Claim's Charge
O3	Don't Pay Less Than X % of Claim's Reimbursement
O4	Don't Pay More Than X % of Claim's Cost
O5	Don't Pay More Than X % of Claim's Charge
O6	Don't Pay More Than X % of Claim's Reimbursement
O7	Don't Pay More Than Billed Charges

164. While some of MultiPlan's available "overrides" appear to be floors on payment (e.g., "Don't pay less than"), these apparent "floors" can also be paired with "ceilings" ("Don't pay more than"). By applying both a floor and a ceiling on payment, the conspirators effectively collectively determine the exact level at which compensation rates will be set.

165. According to MultiPlan's Senior Vice President of Healthcare Economics, Sean Crandell, Data iSight also applies "operational overrides" on top of the overrides agreed upon by individual client-insurers. These operational overrides are always in place and establish the upper and lower limits to the [Data iSight] price to help keep client-insurers' prices in alignment.

166. Because of these overrides, Data iSight payment levels are often pegged to Medicare rates, which often do not even cover healthcare providers' costs. As MultiPlan knows and has admitted internally, pricing out-of-network claims based on Medicare rates is "inherently misleading" because "the average consumer does not understand just how low Medicare rates are."

167. In reality, even former MultiPlan employees described the rates generated by Data iSight, which can range from 160% to 260% of Medicare rates, as "ridiculously low" and "crazy low." MultiPlan has also admitted that "[t]he use of Medicare as the basis for calculating out-of-network reimbursement creates a flawed equation from inception," and that "there is no guarantee the resulting allowed amounts will cover a provider's costs."

168. On information and belief, MultiPlan continually drives healthcare provider compensation lower by recycling the adjusted compensation amounts generated by Data iSight and feeding them back into its algorithms to calculate median compensation levels for new claims moving forward, feeding new, artificially suppressed data into the algorithm drives median compensation further down.

169. On information and belief, as the market adjusts to newly suppressed compensation levels, MultiPlan instructs client-insurers to enter even lower rate caps,

driving provider compensation further downward. On information and belief, at the same time, MultiPlan assures and reassures its clients that they will remain in the "middle of the pack" compared to their competitors, helping to avoid competitive harms that would result in a normal, unrestrained market.

170. MultiPlan polices its client-insurers' pricing strategies to ensure they are aligned with the pricing strategies of the cartel as a whole. For example, in 2017, while reaching "mutual agreement" as to the business criteria and overrides to be used to set UnitedHealth's out-of-network healthcare provider compensation rates, MultiPlan explained that with an "override" of 350% of Medicare rates, UnitedHealth would be "leading the pack" alongside another competitor in terms of how low it could drive out-of-network provider compensation. On information and belief, in response, UnitedHealth reduced its payment ceiling from 500% of Medicare rates in 2016, to 350% in 2018, and in a plan discussed at a "CEO Call" in 2018, MultiPlan and UHC devised a plan to reduce its payment rate to 250% "to align with competitors."

171. On information and belief, the rate determinations generated by Defendants' overrides do not factor geographic differences in the cost of key inputs like labor. On information and belief, the chart below reflects data for the same service rendered by healthcare providers in nine different states. Note that all claims are for the same procedure or treatment (reflected by the CPT code),[4] provided in different states, billed at different amounts, within a five-month period in 2019. The fifth column reports the UCR amount at 70% of what the FAIR database would have generated for each claim. Note that applying traditional UCR rates, the compensation generated for providers in different states and at different facilities ranges from $632.52 to $1,136.52.

[4] CPT 99284 is the code for "[e]mergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity."

CPT Code	Location	Date	Submitted Claim	70% of FAIR Health	MultiPlan Pricing/Payment
99284	Wyoming	1/21/19	$799	$654.36	$413.39
99284	Arizona	1/25/19	$1,212	$1,062.60	$413.39
99284	New Hampshire	1/25/19	$1,047	$632.52	$413.39
99284	Oklahoma	2/8/19	$990	$903.84	$413.39
99284	Kansas	2/10/19	$778	$837.48	$413.39
99284	New Mexico	2/19/19	$895	$1,136.52	$413.39
99284	California	3/25/19	$937	$667.80	$413.39
99284	Nevada	3/30/19	$763	$778.68	$413.39
99284	Pennsylvania	5/20/19	$1,094	$760	$413.39

172. Although both the billed charges and FAIR reflect differences among the claims, likely attributable to variances in treatment, expertise, facilities, geography, and other relevant considerations, MultiPlan's algorithms paid all healthcare providers the same, drastically reduced, amount: $413.39.

173. MultiPlan's prices are consistent across all client-insurers. MultiPlan pays a healthcare provider who has submitted a claim to UnitedHealth under a particular CPT code the same fixed amount as a healthcare provider who has submitted to Cigna under the same code. As Sean Crandell, MultiPlan's Senior Vice President of Healthcare Economics, testified under oath:

> Q. During the same time period, 2017 to 2020, was the out-of-network pricing recommended by Data iSight to United the same or different as that recommended to [UnitedHealth's] competitors?
>
> A. It was the same.

174. As part of the same testimony, Crandell was asked: "[I]f the Data iSight tool is used among various different companies in the industry, do the recommended payment rates generated by Data iSight tool vary depending on which client you're running that calculation for?" Crandell answered: "No." When asked whether the tool could even factor in who the client is, he answered: "No, it can't. The system that generates the methodology

cannot even factor in [who] the client [is].”

3. MultiPlan’s Illusory Negotiation Services

175. Client-payors can delegate to MultiPlan all authority to negotiate out-of-network claims in the event a healthcare provider rejects the Data iSight-generated offer; Plaintiff is informed and believes that in more than 700 (out of approximately 1,100) payors in the United States use a single negotiator for out-of-network claims. By appointing a single negotiator of out-of-network prices, MultiPlan and its client-payors deprive healthcare providers of the competition that would naturally flow from each client-payor making its own decisions in negotiating the price of out-of-network services.

176. If healthcare providers engaged in multiple negotiations with multiple payors, healthcare providers could leverage the competitive dynamics among the payors to achieve a more competitive prevailing price for out-of-network goods and services relative to the fixed prices that MultiPlan imposes on healthcare providers.

177. This arrangement also enforces the client-insurers’ agreement to use a common rate-setting methodology. Because MultiPlan takes over reimbursement negotiation on payors’ behalf, client-payors are not free to deviate from the cartel’s set reimbursement rates.

178. On information and belief, MultiPlan’s negotiations work as follows. After rendering services to a patient, the healthcare provider submits its bill, which MultiPlan processes through Data iSight. Multiplan then sends an initial compensation offer to the healthcare provider (or its agent), and if the healthcare provider requests higher compensation, it enters the negotiation phase of its dealings with MultiPlan.

179. As one healthcare provider’s office manager explained to the New York Times, “[i]t’s not a real negotiation.” Indeed, as revealed through a New York Times investigation, MultiPlan leaves healthcare providers with little choice but to accept the initial offer. MultiPlan employs “tactics meant to pressure medical practices to accept low payments,” including “all-caps admonitions and deadlines just hours away.” In fact,

MultiPlan negotiators' bonuses and performance evaluations are tied to their success at reducing payments, incentivizing them to take a hardline approach.

180. Plaintiff is informed and believes that many healthcare providers simply accept MultiPlan's low reimbursement rates because they have experience with its illusory negotiation and appeal process.

181. Plaintiff is informed and believes that regardless of the reason, MultiPlan affords healthcare providers ten days or fewer to challenge their repriced charge or lose the option to accept it altogether. MultiPlan warned one healthcare provider, for example, that if it did not accept a lowball offer within eight days, its claim would be "subject to a payment as low as 110% of Medicare rates based on the guidelines and limits on the plan for this patient."

182. If healthcare providers attempt to push back on MultiPlan's reimbursement rates for out-of-network services, MultiPlan uses its pooled pricing data to keep them in line. MultiPlan's financial negotiation, or FNX, team access this data to determine how low they can push healthcare provider compensation for out-of-network services.

183. A member of MultiPlan's FNX team can see in granular detail the out-of-network reimbursement rates a provider has accepted for particular services. This detailed pricing data allows MultiPlan to determine the point at which a provider will break and accept the cartel's out-of-network pricing.

184. Some healthcare providers' claims are not even eligible for negotiation. Records reviewed by the New York Times showed that "[i]nsurers can set negotiation parameters for MultiPlan, including not negotiating at all"; indeed, "[m]ultiple providers and billing specialists [have] said that in recent years they had increasingly been told their claims weren't eligible for negotiation."

185. MultiPlan does not stop at forcing healthcare providers to accept the extremely low reimbursement rates generated by Data iSight. To avoid backlash, MultiPlan also prohibits healthcare providers who accept these lowball payments from balance billing

patients. MultiPlan requires healthcare providers to sign an agreement stating they will not "balance bill" the patient.

186. Prohibiting balance billing as a condition of payment, however, does not eliminate balance billing. While the prohibition has prevented industry-wide use of balance billing, some providers simply disregard it. These providers, faced with the prospect of losing funds they may need to continue operating their practices, continue to balance bill patients.

187. Other patients, who pay in full at the time of service and seek reimbursement from a client-payor, are often stuck with the client-payors' lowball compensation amounts. These patients are unable to recover the amount they expected from their insurer despite paying a higher premium for the out-of-network benefits supposedly provided by PPO plans.

188. MultiPlan has gotten away with these tactics because virtually every major commercial healthcare insurer uses its repricing methodology, which leaves healthcare providers and patients with no recourse. As a result, in most cases, healthcare providers, across all claim types, accept MultiPlan's initial compensation offer because they have no other meaningful choice.

189. When a healthcare provider attempts to negotiate MultiPlan's initial offer, the healthcare provider is not negotiating with a single payor—it is effectively negotiating against the entire industry. In the words of one analyst, MultiPlan knows it can get away with acting "like a mafia enforcer for insurers," because virtually every payor employs MultiPlan's services.

190. MultiPlan touts high healthcare provider acceptance rates as evidence that the compensation it pays for out-of-network services is reasonable. To the contrary, MultiPlan's acceptance rates evidence a cartel that employs strong-arm tactics that offer healthcare providers no meaningful choice. The fact that healthcare providers are forced to accept unreasonable compensation confirms that MultiPlan and its co-conspirators have

significant market power; they have eliminated the threat of competition and with it, any limitation on the behavior of the cartel's members.

191. Regardless of MultiPlan's relative success in limiting balance billing, patients nationwide suffer losses as a direct result of MultiPlan and its co-conspirators' scheme. The New York Times describes one case in which MultiPlan repriced an insured patient's bill for heart surgery with an out-of-network healthcare provider down to $5,449.27, leaving the patient responsible for the balance of more than $100,000. Another patient suffering from Crohn's Disease was charged thousands of dollars for necessary treatments. Yet another was charged tens of thousands for treatment for opioid addiction.

192. Ultimately, despite paying thousands of dollars a year for the supposed benefits offered by a PPO plan, many insured patients—and particularly those required to pay for healthcare services up front—are faced with a choice: either pay for their own out-of-network medical care and potentially incur significant medical debt, or limit or forego treatment and live with an untreated or undertreated illness. All the while, MultiPlan and its co-conspirators line their own pockets at the expense of patients' health and financial well-being.

4. MultiPlan Also Uses Data iSight to Reduce Payments for Its Own Provider Networks

193. MultiPlan also develops its own preferred provider networks, contracting with healthcare providers nationwide. MultiPlan, however, is not an insurer; for a fee, it rents its networks to client-payors who wish to supplement their existing networks and to those who lack the resources to build their own. Today, MultiPlan maintains a nationwide PPO network of more than 1.4 million healthcare providers.

194. The value of MultiPlan's network depends on the number of healthcare providers who participate. The more healthcare providers MultiPlan enlists, the more attractive its network becomes to potential client-payors, and, in turn, the more MultiPlan

can charge for access. For this reason, MultiPlan touts the participation of the more than 1.4 million healthcare providers in its network as a major "competitive advantage."

195. A variety of entities subscribe to MultiPlan's Primary PPO Network ("MultiPlan's Network"), including private- and public-sector employers, tribal entities, and union benefit plans. On information and belief, like other networks, when a patient is covered by MultiPlan's Network but elects to see a healthcare provider who is out-of-network, MultiPlan reviews the out-of-network bill and sets a price for the out-of-network services using Data iSight.

196. In its pursuit of healthcare providers, MultiPlan's Network competes with insurers, like the Insurer Defendants, that offer PPO plans and operate their own networks. As MultiPlan admitted on August 18, 2020, MultiPlan "compete[s] with regional PPOs targeting primary network business." In its Form 10-K for 2023, and in years prior, MultiPlan admitted that it also competes "with PPO networks owned by [its] large Payor customers." MultiPlan deleted this admission from its public filings after it was first sued in connection with its repricing scheme.

197. Other payors recognize that MultiPlan is a competitor. In a prepared statement before the U.S. House of Representatives Judiciary Committee Subcommittee on Regulatory Reform, Commercial and Antitrust Law on September 29, 2015, Elevance's CEO Joseph Swedish explained that in "various segments and services," "traditional insurance providers," "companies offering rental networks (e.g., MultiPlan . . .)" and other market participants are engaged in "robust competition."

198. On information and belief, to attract healthcare providers to its network, MultiPlan offers healthcare providers competitive compensation rates and other inducements, such as patient steerage and prompt payments. In a competitive market, if MultiPlan offered compensation rates or other terms inferior to those offered by its competitors, healthcare providers would not be willing to join the MultiPlan network. If MultiPlan offered healthcare providers in a particular region $800 for a particular

procedure while Aetna and Cigna offered $1000, in a competitive market, healthcare providers would have leverage to pressure MultiPlan to raise its rates, and if it failed to comply, healthcare providers would refuse to participate in its networks.

199. Plaintiff is informed and believes that MultiPlan induces healthcare providers to join its PPO network with the promise of attractive contractual compensation rates. On information and belief, MultiPlan's standard "Participating Provider Agreement" outlines certain "Contract Rates" which are "equal to eighty (80%) percent" of the provider's "[b]illed [i.e., retail] charges." On information and belief, the rates specified in most standard network agreements are, by contrast, pegged to Medicare rates (e.g., 200% of Medicare rates), meaning they are far lower.

200. But MultiPlan's promise is illusory. Plaintiff is informed and believes that unlike most standard network agreements, which obligate insurers to pay specific amounts to doctors for covered services, MultiPlan's Provider Participation Agreement does not bind any client-payor to a specific payment. Instead, it provides that MultiPlan may, "in its sole discretion," rent out its network to insurers who may opt out of the "Contract Rates" specified in the MultiPlan agreement and instead who may pay the healthcare provider based on the "out-of-Network benefit level" specified in the patient's PPO plan. Specifically, these agreements state:

> [MultiPlan] may, in its sole discretion, include Group and each Participating Professional as a Network Provider in any or all [of MultiPlan's rental] Network(s). Group and each Participating Professional acknowledge that certain Programs offered by [MultiPlan's insurer] Clients accessing the Network (i) may not include a network option; or (ii) **may cover Covered Services under the Participant's Program at . . . out-of-Network benefit level.**

201. On information and belief, MultiPlan knows, but does not disclose, that many of the claims submitted by participating healthcare providers will be compensated at rates far lower than MultiPlan's purported "Contract Rates" under option (ii).

202. On information and belief, many client-payors who rent MultiPlan's Network treat these claims as out-of-network claims (under option (ii)) instead of as in-network claims, and they submit the claims to MultiPlan to calculate compensation using Data iSight. In doing so, these client-payors cheat providers out of compensation at a fair rate and burden patients who paid a premium for coverage, and may have believed they were seeing an in-network provider, with artificially inflated medical bills.

203. This in-network provider agreement is yet another industry-control-dependent benefit to cartel members. MultiPlan's standard Network Rental Agreement affords client-insurers substantial discretion in how they wish to compensate participating healthcare providers. For example, Plaintiff is informed and believes that Aetna's agreement allows Aetna to "pay claims from [providers participating in MultiPlan's PPO network] in accordance with a Member's [*i.e.* the patient's] plan of benefits (e.g., benefit plans providing benefit levels at Reasonable and Customary, percentage of Medicare, or otherwise) in lieu of" the contract rates MultiPlan promotes to induce healthcare providers' participation MultiPlan's PPO network.

204. Through its network rental business, MultiPlan has aggregated petabytes of claim and compensation data. This data reflects not only what healthcare providers charge for in-network and out-of-network services, but also what those healthcare providers are willing to accept as payment for those services. MultiPlan refers to this nonpublic data, its intellectual property, and its algorithms, fittingly, as the "crown jewels of the company."

5. The Co-Conspirators' Ongoing Communications Further the Repricing Cartel

205. MultiPlan employs standardized tactics in managing its client relationships. After signing a contract, MultiPlan provides the client-payor with a constant flow of competitively sensitive information via meetings, presentations, telephone calls, emails, and video conferences. This information includes comparisons between the prices that the client-payor is paying for particular out-of-network services and the prices that the client-

payor's competitors are paying for the same services. The message from these presentations is clear: client-payors can cut the prices they pay drastically without falling behind their competitors if they agree to work together. They stand to profit far more collectively than they do standing alone.

206. MultiPlan serves as the go-between amongst the individual cartel members, coordinating one-to-one meetings among executives and at hosted events. These meetings serve not only as an information exchange, but also to assure MultiPlan's client-payors that using a common pricing methodology and setting prices unreasonably low will not put them at a competitive disadvantage with respect to other client-payors.

207. MultiPlan's meetings take many forms. For example, MultiPlan hosts "Client Advisory Board" meetings for its clients on an annual basis. At these meetings, MultiPlan executives present slides touting the cartel's success, and suggests that its clients, all competitors, should continue to use MultiPlan's algorithms to set prices even lower.

208. MultiPlan also uses Client Advisory Board meetings to reassure attendees that the repricing scheme is on track. In 2019, for example, MultiPlan hosted a Client Advisory Board meeting at Montage Laguna Beach, a luxury resort in Orange County, California. Executives from MultiPlan, UnitedHealth, Aetna, Cigna, Humana, and several other payors attended the event. Plaintiff is informed and believes that at the meeting, MultiPlan's Vice President of Sales and Account Management, Dale White, described ways in which commercial payors might "overcom[e] obstacles" with respect to cutting out-of-network pricing. A UnitedHealth executive testified later that "a lot of people in the insurance industry" attended the meeting, and "talk[ed] about . . . things they've implemented, other things they're looking at" with respect to setting prices for out-of-network goods and services.

209. MultiPlan also uses the Client Advisory Board meetings to invite new payors to join the cartel. According to a 2017 MultiPlan document, prospective client-payors sat

next to existing clients at dinner at the 2015 meeting for this purpose. On information and belief, MultiPlan expected its co-conspirators to help recruit new payors into the cartel by endorsing MultiPlan's pricing methodology and the effectiveness of the collective repricing scheme during dinner.

210. On information and belief, MultiPlan's healthcare economics and sales and account management teams prepare routine presentations for individual client-payors, during which they share competitively sensitive pricing information provided by the client's competitors. The pricing information is current and detailed, and it allows MultiPlan's clients to identify particular claims and particular payors. Exchanges of proprietary pricing data, standing alone, can have pernicious effects on competition. In fact, in this context, sharing such information among competitors makes economic sense only as a means to align prices for out-of-network claims.

211. On information and belief, MultiPlan further promotes and protects the cartel by issuing secret "whitepapers" to potential clients explaining how MultiPlan's pricing methodology eliminates out-of-network pricing competition. This helps strengthen the cartel by recruiting more payors to join. On information and belief, as part of its recruitment effort, MultiPlan directly communicates with potential client-payors (the competitors of its existing payor clients) and discloses to them the prices that participating payors are paying for out-of-network goods and services relative to Medicare.

212. On information and belief, MultiPlan tells these potential client-payors how much they could save using Data iSight and assures them that if they join the cartel, they will be aligned with other payors. MultiPlan gives each of its competitors the blueprint for conspiring: (a) the prices they need to set, (b) financial motivation for setting those lower prices, and (c) assurances that competitors would be setting the same prices.

213. MultiPlan's efforts to enlist and retain payors in this scheme have been spectacularly successful. To date, MultiPlan has enlisted all of the major national commercial insurers and hundreds of others to participate in its repricing scheme,

combined with them to control the U.S. market for out-of-network provider services, and together they have successfully fixed prices for most out-of-network provider claims.

214. MultiPlan and its client-payors reap billions of dollars in profits from their scheme, as described in greater detail below.

6. MultiPlan's Contingent Fee Structure

215. The MultiPlan repricing scheme reaps enormous profits for its co-conspirators. For each claim MultiPlan reprices, it collects a fee from the client-insurer calculated based on the difference between the healthcare provider's billed charges and the amount of compensation the healthcare provider eventually accepts.

216. On information and belief, MultiPlan typically collects a percentage of the savings it generates and has charged some client-insurers, including Aetna, as much as 12%. This arrangement incentivizes MultiPlan to generate the lowest healthcare provider compensation possible, regardless of whether the rates applied are usual, customary, or reasonable. MultiPlan refers to the fees it charges insurers as a "percentage of savings" or "PSAV." These fees comprise a majority of MultiPlan's annual revenues.

217. By 2019, MultiPlan was processing more than 135 million out-of-network healthcare claims annually, totaling $106 billion in billed charges, and generating more than $19 billion in "savings" for its client-insurers. In 2022, MultiPlan processed approximately 240 million claims (totaling over $155 billion in billed charges), and identified $22.3 billion in "savings" for its clients. And by 2025, MultiPlan reported processing approximately 360 million claims annually, generating $25.0 billion in potential savings on $179.8 billion in claims charges.

218. MultiPlan reported $561 million in 2019 revenues from its analytics-based repricing services, leaping to $713 million by 2022. On November 5, 2024, MultiPlan's current CEO, Travis Dalton, reported to investors that MultiPlan had hit a "record quarterly achievement" by generating $6.4 billion in reduced compensation rates during the third quarter of 2024. Dalton did not advertise, of course, that MultiPlan collected these fees at

healthcare providers' and patients' expense.

7. MultiPlan's Insurer Clients Charge Employers Exorbitant Fees

219. MultiPlan's client-payors also manage self-funded PPO plans for many employers. Like the fees MultiPlan collects from client-insurers, the fees client-payors collect from these self-funded PPO plans are calculated as a percentage of the savings on repriced claims and are labeled a "shared savings" or a "processing" fee.

220. Self-funded employers' PPO plans are also known as "Administrative Services Only" or "ASO" plans. Under the ASO model, an employer group (rather than a commercial insurer) is responsible for reimbursing healthcare providers for its employees' claims instead of paying a commercial insurer to cover those claims, and the employer group carries the risk of loss.

221. Because employers do not have the resources to develop their own PPO networks, they pay a fixed administrative services fee per member, per month (a "PMPM" fee) to an outside organization (a payor) to administer an ASO plan.

222. In addition, employers and insurers enter "shared savings agreements" that permit the insurers to send ASO employers' out-of-network claims to a third-party vendor (here, MultiPlan) to set out-of-network prices.

223. Large employers, which make up a substantial portion of the market for commercial insurance, are almost all on ASO contracts.

224. These shared services fees are not negligible—a self-insured group may be bound to a fee of up to 35% of the difference between the healthcare provider's out-of-network billed charges and the compensation amount MultiPlan generates. In some instances, the fees paid to an insurance company and MultiPlan for processing a claim have far exceeded the amount paid to the healthcare providers who actually treated the patient. Cigna, for example, collected almost $4.47 million from employers for processing claims from eight addiction treatment centers in California, while the centers received $2.56 million. MultiPlan pocketed $1.22 million from the same claims.

225. UnitedHealth disclosed that its "shared savings program" was directly linked to its use of MultiPlan's pricing methodology. A notification concerning Nokia Corporation's ASO plan notes that Nokia participates in a "shared savings program" administered by UnitedHealth. That notice states that the shared savings fees associated with that program are based on the underpayments generated by Data iSight.

226. In addition, Aetna created the "National Advantage Program," or NAP. Under the NAP, ASO subscribers to Aetna's PPO plans paid Aetna a substantial portion of the underpayment generated by Aetna's agreement to use MultiPlan's Data iSight pricing methodology.

227. These arrangements hurt group subscribers, including businesses and unions. According to the New York Times, a trustee for an Arizona union health plan covering about 1,500 Phoenix-area electricians "was stunned" to learn what she and her colleagues had paid Cigna for "cost-containment" services. Their annual fees had risen from just over $550,000 in 2016, when Cigna first signed with MultiPlan, to $2.6 million in 2019. The trustee commented: "It's very frustrating to go out and have someone pitch us that they're going to save us money and then end up lining their pockets[.]"

228. UnitedHealth collected a $50,650 fee from New England Motor Freight, arising from a $152,594 bill, which MultiPlan and UnitedHealth had repriced to $7,879. UnitedHealth refused to provide the employer with the underlying data and declined to issue a refund or offer any other solution because, as one executive stated, "[w]e have to be concerned about setting precedent."

229. These shared savings agreements generate tremendous profits for Multiplan's clients at the expense of employers, healthcare providers, and patients.

8. The MultiPlan Cartel Harmed Providers, Patients, and Employers

230. MultiPlan touts its services as tools to support "transparency, affordability, and quality across the healthcare system." It also claims that its algorithms "identify and negotiate fair out-of-network provider reimbursements." Nothing could be further from the

truth. In fact, the MultiPlan cartel causes patients, healthcare providers, and employers to suffer direct economic harm.

231. The Insurer Defendants then tout the flexibility and provider choice offered in exchange for the higher premiums associated with PPO plans, which they represent will cover and provide reasonable reimbursement for out-of-network claims.

232. As explained above, patients who pay medical bills out-of-pocket and seek reimbursement through their PPO plans are reimbursed at the suppressed rates generated by MultiPlan, leaving them to pay for their own medical care on top of higher premiums for PPO insurance plans with "better" coverage. Similarly, patients with high deductibles are credited a reimbursement based on an artificially suppressed compensation amount, such that it takes longer—and costs more—to finally reach their deductibles. And, despite MultiPlan's efforts to prevent healthcare providers from balance billing patients, the practice endures, which also leaves some patients responsible for the difference between healthcare providers' billed charges and MultiPlan's lowball provider compensation.

233. Defendants' scheme also causes patients indirect harm by limiting healthcare providers' ability to provide medical care. The cartel's underpayments limit healthcare providers' revenue and thereby limit the time and resources healthcare providers are able to allocate to improving patient care. On information and belief, healthcare providers who lose money on out-of-network treatments are left to cover those losses by abbreviating appointments so they can see more patients, skipping patient follow-ups, cutting nursing and administrative staff, foregoing purchases of advanced equipment, declining to see patients on a *pro bono* basis, and in some instances, healthcare providers must close their practices, stop accepting insurance, or pivot their practices to so-called concierge medicine, further limiting patients' access to covered, affordable healthcare. This harms healthcare providers and patients alike and significantly reduces the overall quality of available care.

234. Small and independent healthcare providers are especially susceptible to the price-fixing of the MultiPlan cartel. One healthcare provider interviewed by the New York

Times reported that she has typically charged Medicaid rates for the services she provides, but in 2023, an Aetna subsidiary informed her that fair payment for her services was less than half of what Medicaid paid, “based on calculations by MultiPlan.” As a result, she was forced to stop accepting patients covered by the Aetna subsidiary.

235. This problem is particularly acute in the context of mental health and substance use disorder (“MHSD”) treatment. On information and belief, MultiPlan’s pricing scheme often results in payments for MHSD treatment claims that are less than 10–20% of the amount that would be expected for the same services based on traditional methods of calculating rates (i.e., UCR). This massive underpayment of MHSD treatment pressures existing healthcare providers to close or reduce services and causes patients to lose treatment access—a particularly problematic outcome given the lack of qualified providers across the country.

236. In its May 1, 2024 report, The New York Times reported that one healthcare provider felt that MultiPlan had “decimated my life” and caused “the closing of my business,” which “left patients having to travel 2.5 hours for surgery.”

237. The MultiPlan cartel’s underpayments have already caused some healthcare providers to fail, thereby limiting the supply of healthcare goods and services available to consumers.

238. America’s hospitals face an economic crisis, with many struggling to break even due to rising costs and insufficient payments. Over half of U.S. hospitals ended 2022 operating at a loss, a trend that continued into 2023. In addition, a 2023 survey from the American Medical Group Association that collected data from over 15,000 healthcare providers found that “median loss per physician for system-affiliated groups is now more than $249,000, as operating expense increases outpace revenue gains.” In Arizona, according to a 2023 review, 56% of hospitals report losses on patient services.

239. In Arizona, eight hospitals were recently identified as at risk of closing or reducing services. And while the cartel’s pricing is not the primary cause, underpayments

increase the financial strain on these hospitals.

240. The MultiPlan cartel takes particular advantage of hospital emergency departments. Hospital emergency rooms are obligated to preserve patients who require emergency treatment regardless of ability to pay or the type or amount of insurance coverage available. Emergency rooms cannot decline to treat patients with insurance plans connected to MultiPlan. As such, hospital emergency rooms rely on the commercial insurance networks that contract with MultiPlan for reasonable compensation for emergency services.

241. At the same time, demand for emergency department medical services is highly inelastic. Patients often have little choice regarding which hospital they are taken to and are rarely able to avoid or defer emergency medical treatment. By colluding to underpay emergency services providers, MultiPlan and its clients have been bleeding emergency rooms dry.

242. Private medical groups also struggle to stay above water. On average, their expenses outpace the payments that they receive for providing care. While revenue per physician has increased by 9.1% since 2020, the median expense per physician has increased by 26.5%. Just like other providers, these medical groups cannot afford to be underpaid. When they are, access to and the quality of care could decline, which, in turn, harms patients.

243. For the foregoing reasons, and as described throughout this Complaint, the MultiPlan repricing scheme harms Arizona healthcare providers. Providers of out-of-network healthcare services are left with no choice but to accept artificially suppressed payments for the services they provide. Because most client-insurers and other client payors that contract with MultiPlan use its repricing technology, its networks, or both, healthcare providers have no viable financial choice but to accept patients with insurance plans affiliated with MultiPlan. And if healthcare providers try to fight back and negotiate with client-insurers, MultiPlan takes the reins and strong arms providers into accepting

MultiPlan's initial offer. As a result, healthcare providers are forced to accept payments below UCR rates, and in many cases, may not be able to cover the costs of care and other expenses as a result.

244. The illegal repricing scheme described herein also harms employers with self-funded plans. After entering into agreements with MultiPlan to limit out-of-network pricing competition, client-payors charge exorbitant fees to employers with ASO plans in exchange for setting low out-of-network prices. These charges often exceed the amount paid to the healthcare provider.

245. Theoretically, competing payors could pass along the "savings" generated by underpaying out-of-network healthcare providers in the form of lower per member per month fees for providing administrative services. That is not happening. The sole beneficiaries of the MultiPlan cartel are the cartel members—they reap the benefits of massive profits, executive compensation, and stock buybacks, while the rest of the U.S. healthcare system struggles to survive on the suppressed amounts that the cartel pays for out-of-network goods and services. Therefore, as a result of the MultiPlan repricing scheme, providing health insurance grows *more* expensive for employers and healthcare grows *more* expensive for patients.

9. The MultiPlan Cartel Comes to Light

246. The MultiPlan cartel has endured because its members have successfully concealed their illicit conduct for years. Due to its devastating effects on healthcare providers, patients, patients' families, and state and local governments, however, MultiPlan, the Insurer Defendants, and the other co-conspirators could not keep their scheme concealed forever.

247. On April 7, 2024, The New York Times published the first three in a series of articles reporting the results of its investigation into MultiPlan and its co-conspirators' repricing scheme. The Times interviewed more than one hundred people, including patients, doctors, billing specialists, advisers to employer health plans, and former

MultiPlan employees, reviewed more than 50,000 of pages of documents, petitioned two federal courts for materials that had been filed under seal, and revealed that MultiPlan runs a "lucrative, little-known alliance" of healthcare payors that underpays healthcare providers and undermines the value of commercial insurance. The Times concluded, all told, that "MultiPlan has helped drive down payments to medical providers and drive up patients' bills, while earning billions of dollars in fees for itself and insurers."

248. On May 1, 2024, The New York Times published another article specifically focused on Congressional interest in investigating MultiPlan's price-fixing. The article noted that "[a] data analytics firm [MultiPlan] has helped big health insurers cut payments to doctors, raising concerns about possible price fixing." It tied MultiPlan and its co-conspirators' success to the use of algorithms, citing regulators' and antitrust scholars' concern that "algorithms can enable sophisticated collusion that is difficult to police. Competitors no longer need to meet in secret to hatch a conspiracy and communicate among themselves to perpetuate it. They can simply agree to fix prices using a common algorithm." The article also quotes Barak Orbach, a law professor at the University of Arizona, who opined, "[t]his should trigger an investigation by the agencies […] There seems to be a really strong case."

249. The MultiPlan repricing scheme has sparked calls for a federal investigation as well. On April 9, 2024, the Senate Finance Committee and Bernie Sanders, Chairman of the Senate Health, Education, Labor, and Pensions ("HELP") Committee, sent a letter to MultiPlan's CEO, Travis Dalton. In it, the Senators warned that their committees "are engaged in ongoing legislative work to put a stop to practices by plan service providers that drive up health care costs for consumers while padding their own profits."

250. The Senators continued: "In the early 2000s, it appears your company negotiated with health care providers to reach these rates, but now through the Data iSight product, appears to use an opaque process to set recommended payments for out-of-network services. Because your company is paid more when it reaches lower payment

amounts, the payments to health care providers are often far lower than the billed amount, with some describing these amounts as 'crazy low.' When the plan is only willing to pay this low amount, patients are on the hook for the remaining bill, which in extreme cases can total hundreds of thousands of dollars."

251. On March 27, 2025, the Antitrust Division of the Department of Justice ("DOJ") filed a Statement of Interest in multidistrict litigation pending in the Northern District of Illinois brought by providers against MultiPlan and certain of its clients challenging their repricing scheme as violative of the Sherman Antitrust Act and state consumer protection statutes. *See* Statement of Interest of the United States [ECF No. 382], *In re MultiPlan Health Ins. Provider Litig*, No. 1:24-cv-6795 (MDL No. 3121) (N.D. Ill. Mar. 27, 2025).

252. The DOJ disputed two key points raised by the Defendants in their motions to dismiss, asserting that: (1) "Under well-established precedent, there can be concerted action subject to Section 1 [of the Sherman Antitrust Act] in setting the starting points of prices even if the conspirators have some discretion in choosing how often to follow them"; and (2) "sharing information through an algorithm provider can create the same anticompetitive effects as a direct exchange between competitors" and violate the antitrust laws. *See id.* at 4-7. The DOJ urged the court to resolve Defendants' motions to dismiss with these principles in mind.

253. Finally, the Capitol Forum has reported that the Antitrust Division of DOJ "has launched a criminal price-fixing probe into [MultiPlan]."

254. It is little wonder that MultiPlan's conduct is the subject of federal antitrust scrutiny. The MultiPlan scheme is blatantly illegal. It is *per se* illegal for competitors to fix the prices that they will pay for goods and services by agreeing to use a common pricing methodology. It is *per se* illegal to fix the maximum price that competitors will pay for a particular good or service. It is *per se* illegal for competitors to fix the starting point for supposed pricing negotiations. Even if MultiPlan's pricing enforcement activities can be

couched as a "negotiation," it is *per se* illegal for competitors to agree that one company will handle pricing negotiations on their behalf. Each of those agreements is independently illegal and the agreements taken together are also illegal.

255. Even were this conduct not illegal *per se*, it is illegal under the rule of reason. The cartel dominates the market for out-of-network goods and services. It harms competition and injures healthcare providers by systematically underpaying them for out-of-network care in comparison to the prices that would have been paid absent the cartel.

256. There are no redeeming procompetitive virtues to underpaying doctors and hospitals for necessary out-of-network care. Even if there were somehow a procompetitive benefit to underpaying America's front-line healthcare workers (there is not), that benefit could easily have been achieved by less restrictive means, such as using existing unilateral pricing methods to set out-of-network prices.

257. Beyond the antitrust implications, Defendants have deceived consumers, healthcare providers, and employers by representing that their goal is to achieve fair pricing in the market for out-of-network healthcare services. The Insurer Defendants specifically have misrepresented that their PPO plans offer "flexibility," "options," and "choice" for consumers who want quality, out-of-network healthcare, supposed benefits for which the Insurer Defendants charge premiums compared to HMOs. In reality, consumers' out-of-network care may barely be covered, leaving consumers responsible for unreasonably high percentages of their healthcare providers' billed charges in addition to the elevated premiums that they pay for PPO plans.

258. Through the claims asserted below, the State of Arizona seeks to remedy and enjoin the harms resulting from Defendants' illegal repricing scheme.

V. CAUSES OF ACTION

<u>COUNT I</u>

Violations of the Arizona Uniform State Antitrust Act, A.R.S. § 44-1401, *et seq.* (against all Defendants)

259. The State re-alleges and incorporates herein by reference each of the allegations set forth in paragraphs 1-258.

260. The Arizona Uniform State Antitrust Act declares unlawful any "contract, combination or conspiracy between two or more persons in restraint of, or to monopolize, trade or commerce, any part of which is within this state." A.R.S. § 44-1402.

261. Defendants are "persons," under A.R.S. § 44-1401, which defines the term to include any "individual, corporation, business trust, partnership, association or any other legal entity."

262. Section 44-1407 of the Arizona Revised Statutes authorizes the Attorney General to bring an action in the name of the State for violations of the Arizona Uniform State Antitrust Act to recover "appropriate injunctive or other equitable relief," civil penalties, and, as determined by the court, "taxable costs, such other fees and expenses reasonably incurred and reasonable attorney fees."

263. The relevant geographic market for the State's antitrust claim is the United States, including Arizona. Defendants' scheme operates nationwide and, using the same tools, generates unreasonably low fixed prices for out-of-network provider services in every state, including Arizona.

264. The relevant product market for the State's claim is the market for out-of-network healthcare provider goods and services covered by commercial payors or by self-funded employer group plans operating under an ASO model with a commercial payor serving as the plan's third-party administrator. Excluded from the relevant market are out-of-network healthcare provider goods and services covered by the federal No Surprises Act, effective January 1, 2022, including, but not limited to, emergency medical services.

The relevant market also excludes out-of-network provider goods and services for patients covered by HMOs or other "narrow networks," as the commercial payors do not agree to pay for out-of-network care under those types of plans, and therefore do not reprice the resulting charges through MultiPlan.

265. Though out-of-network service coverage is not a discrete product sold to patients (insurance policies package both in- and out-of-network services together), the transactions at issue are between third-party payors (insurers) and healthcare providers, with the insurers in the role of purchasers of healthcare goods and services. And though individual out-of-network services may not be reasonably interchangeable, these services can be considered together because the competitive conditions across individual out-of-network healthcare services are so similar with respect to their purchase by insurers that it is appropriate to combine the services together into a single "cluster" market.

266. Because out-of-network healthcare providers do not contract with an insurer, and thus lack bargaining power, they remain vulnerable to unilateral reductions in price (here, reimbursement rates) imposed by dominant buyers (like Defendants). If a hypothetical monopsonist insurer were to reduce the prices it paid for out-of-network healthcare goods and services by a small, significant amount (5-10%) on a sustained basis, out-of-network healthcare providers would lack the flexibility to shift their out-of-network services to other buyers or otherwise alter their market behavior. Out-of-network providers also cannot turn (or threaten to turn) to other payors for compensation because—due to their out-of-network status—they do not control which payors pay for their services.

267. Observed market characteristics define the boundaries of the relevant market. Out-of-network healthcare services covered by commercial payors or the relevant self-funded employer plans are naturally distinct from similarly covered in-network services in terms of pricing and the relationship between healthcare provider and insurer. In-network providers contract with insurers and agree to discounted rates in exchange for the benefits of networks membership, such as steerage, whereas out-of-network healthcare providers

opt to forego these benefits because, for example, they can command higher rates from patients who pay out-of-pocket or they cannot afford to accept client-insurers' discounted rates. This distinguishes the out-of-network market because providers set their own rates, which are determined by market forces, without a reliable or fixed source of future business.

268. According to a report by the Office of the New York State Comptroller, UCR-based compensation rates for services provided in the market for out-of-network healthcare services are generally 1.5 to 100 times higher than the average in-network rate for the same services.

269. The commercial insurance industry recognizes the market for out-of-network healthcare services as economically distinct from the market for in-network healthcare services. Payors offer different financial terms and different treatment to in- and out-of-network providers. They also recognize that prices for out-of-network goods and services are distinct from in-network prices based on how they organize their businesses. Commercial insurers have separate employees in different departments that oversee issues related to payments to out-of-network providers. Defendants also create shared-savings and cost-management programs specific to out-of-network providers. Similarly, MultiPlan recognizes these markets as distinct by focusing its business model on out-of-network pricing.

270. Commercial insurers' forward-facing statements reflect their recognition of the distinctions between the two markets. For example, UnitedHealth tells plan members: "When doctors and facilities are in[-network], it means they've agreed to provide services at a discount. So, when you choose their services, your costs will be lower. Providers who are not [in-network] could charge more. That means their services could cost you more or may not be covered at all." UnitedHealth has also explained in various securities filings that "[s]ome providers that render service to our members do not have contracts with us."

271. Aetna tells plan members: "You generally pay less when you visit doctors

and other health care providers that belong to the Aetna® network . . . If you go outside the network, your benefits are not based on a negotiated rate, but rather on the recognized charge for a given service." And, like UnitedHealth, Aetna discloses in certain SEC filings that "[s]ome providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these nonparticipating providers as to the amount of compensation that is due to them for services rendered to our members."

272. Finally, Cigna advises members: "When health insurers don't have a contracted relationship with out-of-network doctors and facilities, they can't control what is charged for services. And rates may be higher than the discounted in-network rate." Certain of Cigna's SEC filings also set out-of-network services apart, disclosing that "[o]ut-of-network providers are not limited by any agreement with us in the amounts they bill. … [B]enefit plans place limits on the amount of [out-of-network] charges that will be considered for reimbursement and regulations seek to prescribe payment levels, establish methodologies and dispute resolution processes[.]"

273. The public recognizes the markets for in- and out-of-network services as distinct as well. When consumers consider health insurance plans, they choose whether to pay higher prices for the flexibility and range of options offered by a PPO plan with out-of-network coverage or pay less for an HMO plan with coverage restricted to in-network providers. Plan members may base their choices on criteria like whether a preferred provider has contracted to be included in an insurer's network or whether the member or a family member has a condition that requires care by an out-of-network specialist.

274. The above-defined market for out-of-network providers is highly concentrated, and therefore susceptible to anticompetitive, concerted action. There are high barriers to entry on the buyer side that make it difficult for new insurers to enter the relevant market. These barriers include state and federal regulatory requirements as well as the costs associated with developing physician and patient networks, developing bill processing and

payment systems that integrate with providers' systems or are otherwise capable of large-scale processing, and developing and managing a broad pool of subscribers to spread risk.

275. On the supplier side, out-of-network healthcare providers face high exit barriers when seeking compensation for services they provide. Approximately 90% of U.S. healthcare costs are paid by third-party payors, including commercial insurers. Given this reality—along with laws and regulations limiting providers' ability to directly bill patients in certain circumstances—out-of-network healthcare providers have few, if any, substitutes for commercial third-party payors for their services. The only way for out-of-network healthcare providers to "exit" this third-party payer system is to refuse to treat patients unless they pay out-of-pocket, which many patients cannot afford.

276. The relevant market is further susceptible to collusion because providers submit out-of-network claims using standardized CPT codes, which facilitate claims processing generally, but also allow repricing vendors, like MultiPlan and Ingenix before it, to assign claims for each service a specific, common, artificially suppressed price for healthcare providers nationwide and reprice claims consistently for like claims submitted by healthcare providers to different client-insurers across the country.

277. Finally, and critically, there is direct evidence that commercial insurers who provide (or administer employer plans that provide) out-of-network coverage have exercised dominant market power as buyers in the relevant product market—they have already exploited this market's susceptibility to anticompetitive conduct. Many of the Insurer Defendants—including the nation's largest commercial insurers—also participated in the Ingenix scheme that led to the New York Attorney General and other legal settlements. By the time MultiPlan solicited their business, these Defendants knew exactly what they were doing—they understood what MultiPlan was proposing, how it would save them money, how it would harm providers, employers, patients, and local and state governments and, critically, they knew that their scheme was wrong. They had a choice. The FAIR database calculated provider payments at UCR rates for a flat fee and, over the

course of five years, had made significant progress returning compensation to a reasonable level. The insurers also had the resources to develop their own pricing tools. Still, to a one, and without hesitation, the Insurer Defendants and their co-conspirators abandoned FAIR and migrated to MultiPlan, effectively choosing to fix prices and line their pockets at the expense of providers, patients, employers, and state and local governments.

278. MultiPlan and its clients are responsible for more than 81% of all compensation paid by commercial insurers to out-of-network providers. They therefore control more than 81% of the buyer-side of the relevant market.

279. The repricing scheme described throughout this Complaint had actual anticompetitive effects in the United States and Arizona markets for covered out-of-network healthcare provider goods and services.

280. The contract, combination, or conspiracy alleged herein is a horizontal conspiracy among competitors in the market for covered out-of-network healthcare provider services.

281. Alternatively, the contract, combination, or conspiracy alleged herein is a "hub-and-spoke" conspiracy with MultiPlan at the center and its insurer-clients as the "spokes." Circumstantial evidence of an express or tacit agreement among the insurer-client "spokes" (*i.e.* the "rim"), who would not otherwise use MultiPlan and supply their confidential, competitively sensitive information to MultiPlan with knowledge that it would be seen and used by their competitors, is set forth throughout this Complaint.

Defendants' *Per Se* Violations of the Uniform State Antitrust Act

282. Defendants have committed *per se* violations of the Arizona Uniform State Antitrust Act by forming and maintaining a cartel to artificially suppress below fair and reasonable levels covered out-of-network healthcare provider compensation rates in the United States, including Arizona. Defendants have achieved this end by, among other things, exchanging nonpublic, competitively sensitive claims, billing and pricing information among one another, *i.e.* among competitors.

283. Direct evidence shows that MultiPlan and its clients, all competing payors, agreed to use a common pricing methodology to set the prices for covered out-of-network goods and services well below a fair market rate. This evidence includes billing data, contracts between MultiPlan and competing commercial healthcare payors, and internal communications between MultiPlan and other members of the cartel.

284. Billing and other data show that MultiPlan designed its pricing tools to apply a common methodology for pricing out-of-network goods and services across the country, including in Arizona, regardless of quality of service, or many other relevant, potentially distinguishing criteria. MultiPlan adjusts prices downward according to CPT code, such that its insurer-clients compensate providers in different regions with the same amount for each coded service. MultiPlan sets prices so that MultiPlan and its client-insurers (the buyers here) pay a fixed price for a given service without regard to extenuating circumstances or any opportunity for provider negotiation. These fixed prices, and the absence of any opportunity to negotiate, allow MultiPlan and its co-conspirators to set unreasonably low, below-market prices while avoiding provider "abrasion."

285. MultiPlan and its client-insurers, including the Insurer Defendants, feed MultiPlan's algorithms their competitively sensitive billing, pricing, and in- and out-of-network claims data in order to generate fixed prices that fall well below UCR rates. As their illegal repricing scheme continues, Defendants and their co-conspirators provide Multiplan with new data based on these low, fixed prices, which MultiPlan feeds to the algorithm again. This continuous recycling generates lower and lower fixed prices as time passes, driving healthcare provider compensation ever-downward and placing quality provider care further out of patients' reach.

286. To that end, the State is informed and believes that MultiPlan requires each client-insurer to submit real-time, non-public pricing information to its database, including: (1) claims (both in- and out-of-network) received from healthcare providers; (2) compensation paid to those healthcare providers, whether in-network or out-of-

network; and (3) proprietary pricing preferences and strategies, which MultiPlan solicits (among other ways) through its mandatory "Data iSight Client Preferences form."

287. Defendants' repricing scheme affords them control of the nationwide market for covered out-of-network healthcare provider services, including in Arizona, because MultiPlan has entered into standard repricing services agreements with approximately 700 commercial insurers (out of roughly 1,100 in the United States), including the largest fifteen, yielding MultiPlan and its clients' substantial control over the prices paid for out-of-network services nationwide, including in Arizona.

288. The State is informed and believes that MultiPlan's standard repricing services agreements with its hundreds of client-payors expressly contemplate, among other things, that the client-payor will: (1) use MultiPlan's pricing methodology (Data iSight) instead of exercising its own, independent discretion to set out-of-network healthcare provider compensation rates; (2) delegate to MultiPlan the task of "negotiating" with healthcare providers, with MultiPlan conditioning payment on healthcare providers' agreement not to balance bill patients; (3) adhere to MultiPlan's pricing determinations, both with regard to the initial "offer" and any amount below that offer that MultiPlan sets after healthcare provider pushback; (4) share competitively sensitive claims, pricing, and billing data with MultiPlan, and with its other competitors through MultiPlan; (5) have access to MultiPlan's claims database, which houses the client-insurer's own sensitive competitively sensitive claims, pricing, and billing data, as well of that of its competitors; and (6) pay MultiPlan a fee calculated as a percentage of the savings generated by MultiPlan's repricing tools.

289. MultiPlan's private statements to insurers also confirm that concerted action is the point of MultiPlan's business model. As alleged throughout this Complaint, MultiPlan not only collects competitively sensitive information from its client-insurers, but also acts as a go-between among them, telling each client who else is part of the cartel, what its rivals are paying for particular out-of-network goods and services, and which

pricing strategies its competitors are employing—all so that MultiPlan can instruct each client-insurer to implement the same pricing strategies and moves.

290. Competitively sensitive billing, claims, and pricing information (including the caps and overrides applied by insurers, via mutual agreements with MultiPlan) would not be shared among these Defendants in a competitive market. An insurer equipped with access to a competitor's pricing data and strategies would have a competitive advantage and could capture market share by paying out-of-network healthcare providers at higher rates than a lower-paying competitor. It would be against any single insurer's economic interests in a competitive market to share its claims, billing, pricing, and other data with MultiPlan under the circumstances presented unless it knew that its competitors were doing the same.

Circumstantial Evidence of Agreement

291. In addition to direct evidence of a horizontal agreement to fix prices, there is substantial circumstantial evidence of Defendants' anticompetitive agreement. the State describes that evidence throughout this Complaint. It includes, but is not limited to, the following.

Actions Against Interest

292. Defendants have acted against their individual economic self-interests to maximize profits for the cartel.

293. It is against the economic interest of each individual Insurer Defendant to pay below-market rates to out-of-network healthcare providers, because doing so in a competitive market is known to cause provider "abrasion"—meaning healthcare providers refusing to treat an insurer's patients on an out-of-network basis in order to avoid insufficient compensation. In the absence of collusion, insurers would pay competitive rates to achieve greater provider satisfaction and prevent patient loss.

294. It is also against the Insurer Defendants' economic self-interests to pay elevated fees calculated as a percentage of savings for MultiPlan's repricing services when

there are less expensive products on the market that would generate fair and reasonable out-of-network compensation rates. MultiPlan's contingent fees far exceed, for example. the flat annual fee the Insurer Defendants would have to pay (and did pay) to use FAIR. The Insurer Defendants abandoned FAIR to pay higher fees because, and only because, they sought the collective advantages offered by an anticompetitive scheme and fixed prices.

295. It would similarly be against the economic self-interest of any individual Insurer Defendant (each of which is a sophisticated, well-resourced company) to use MultiPlan rather than developing its own internal repricing algorithms and avoiding third-party fees altogether. As MultiPlan has admitted, anyone can "create their own algorithms." Defendant UnitedHealth *did* develop such an algorithm, through Naviguard, but abandoned its significant investment for a sweetheart deal—a contingent fee discount—to stay in the MultiPlan cartel. Absent collusion, in a competitive market, this decision would lack sense.

296. Finally, absent collusion, it would be against each insurer's economic interest to share competitively sensitive information, including claims, billing, and pricing data, with its competitors due to the risk of competitive harm.

Parallel Conduct

297. Defendants' parallel conduct—and its sudden onset in or around 2015—further evidences their concerted action. The Insurer Defendants and many of their co-conspirators migrated from FAIR to MultiPlan between 2015 and 2018, with those bound by settlements with the New York Attorney General transitioning as soon as the terms of those settlements permitted. These insurers remained free to continue with FAIR, find a third vendor, or develop their own algorithms. Yet, all major insurers and hundreds of others chose MultiPlan, within the short span of three years. As a result, since 2016, out-of-network compensation rates have fallen year-over-year, whereas before 2016, they had been on the rise.

298. The Insurer Defendants' parallel and abrupt migration to MultiPlan was not

a product of independent decision-making, but rather of their collusion, all facilitated by MultiPlan.

299. The Insurer Defendants and their co-conspirators had prior experience with Ingenix and knew that their simultaneous transition to a common algorithm would allow them to fix and drive prices down, to their common benefit.

300. Each Insurer Defendant and co-conspirator also knew that its competitors had contracted with MultiPlan. MultiPlan shared this information with potential clients as it solicited their business and induced the insurers to contract to use its tools by sharing rivals' competitively sensitive information.

301. Reviewing their own contracts, and aware that their competitors had already signed with MultiPlan, each insurer knew that its competitors had agreed to (1) delegate their rate-setting and negotiation authority to MultiPlan; (2) exchange competitively sensitive information using MultiPlan as a conduit; and (3) pay MultiPlan on a contingent, percentage of savings basis. MultiPlan reinforced this collective knowledge with routine group meetings, public representations (*e.g.*, representations about how many of the nation's "top" insurers had entered "multi-year contracts" with MultiPlan), and private communications with individual clients.

Opportunities for Information Exchange

302. As detailed above, MultiPlan created numerous opportunities for Defendants to exchange information, including competitively sensitive information, and coordinate their pricing strategy.

303. MultiPlan, for example, hosted "Client Advisory" and other meetings, providing opportunities for the cartel to gather, strategize, check in, and share information to move their scheme forward. Defendants also used these meetings to recruit new cartel members, further strengthening their hold on and control over the market for out-of-network provider services.

304. MultiPlan also hosts "road shows," visiting various insurance companies,

including the Insurer Defendants, to provide updates regarding its claims repricing services. At these road shows, MultiPlan executives share detailed descriptions of Data iSight's repricing methodology, the "savings" achieved by various MultiPlan customers, and recommendations to further reduce out-of-network compensation. During a roadshow in late 2021, MultiPlan bragged that it was reducing payments for out-of-network services by 61-81%. Upon information and belief, MultiPlan meets with each of its clients every year at such road shows.

305. MultiPlan and the Insurer Defendants have opportunities to collude at other industry gatherings as well. Aetna, Centene, Cigna, CVS Health (Aetna's parent company), Elevance, HCSC, Humana, and other insurers are members of AHIP (formerly, "America's Health Insurance Plans"), a trade organization of insurers that regularly holds conferences and meetings, both public and private, where its members participate in private, closed-door meetings.

306. Numerous executives employed by the Insurer Defendants and their co-conspirators sit on AHIP's Board of Directors, including: Gail K. Bourdreaux, President and CEO of Elevance; Bruce D. Broussard, President and CEO of Humana; David Cordani, Chairman and CEO of Cigna; Sarah London, CEO of Centene; Karen S. Lynch, President and CEO of CVS Health (Aetna's parent); and Maurice Smith, President, CEO, and Vice Chair of HCSC.

307. MultiPlan also served as a go-between among its insurer clients, meeting with each insurer individually to pass information and strategy proposals across the group. As with larger group meetings, MultiPlan used these individual sessions to reassure its clients that all co-conspirators were on track, to pass competitively sensitive information among the insurers, and to strategize with the collective on ways to drive prices even lower.

308. Finally, MultiPlan developed a massive database of its competitors' (i.e. clients') billing, pricing, and claims data, and granted its clients access. This repository of competitively sensitive information allowed Defendants to share information electronically

and set their prices and pricing strategies accordingly.

Defendants' Acts in Furtherance of the Illegal Repricing Scheme

309. Defendants' acts in furtherance of their anticompetitive repricing scheme include, but are not limited to the following:

(a) MultiPlan, on its own and through a series of acquisitions, developed repricing tools that employed algorithms that would suppress provider compensation well below UCR;

(b) MultiPlan developed repricing tools that employed algorithms that would fix provider compensation by CPT regardless of several relevant, distinguishing criteria;

(c) MultiPlan solicits payors to contract to use its repricing tools and share their confidential claims, billing, and claim settlement data with MultiPlan and other payors;

(d) MultiPlan built and maintains a database of competing payors' confidential claims and billing data and made it available to its clients;

(e) MultiPlan uses competitor claims and billing data to feed and develop its algorithms;

(f) MultiPlan uses competitor claims and billing data to solicit new clients and convince existing clients to agree to drive provider compensation ever-lower;

(g) MultiPlan uses its repricing algorithms to fix provider compensation for in-network services rendered by providers who participate in MultiPlan's own networks;

(h) the Insurer Defendants contracted with MultiPlan to participate in its repricing scheme;

(i) the Insurer Defendants transmit their confidential billing, pricing, and claims data to MultiPlan to feed its algorithms;

(j) the Insurer Defendants transmit their confidential billing, pricing, and claims data to MultiPlan knowing that MultiPlan will share it with their competitors;

(k) the Insurer Defendants delegate all authority for repricing and negotiating provider claims, and for communicating with providers about the same,

to MultiPlan; and

(l) the Insurer Defendants pay provider claims at the suppressed rates generated by MultiPlan's repricing tools.

310. There are no procompetitive justifications for Defendants' cartel, or any aspect of Defendants' anticompetitive scheme. Any proffered justifications, to the extent cognizable, could be achieved through less restrictive means.

311. Arizona patients, providers, and employers have suffered injury to their business or property and will continue to suffer economic injury and deprivation of the benefit of free and fair competition unless Defendants' conduct is enjoined.

312. Restitution is appropriate to restore what was lost to those harmed by Defendants' unlawful practices, which here includes the amounts that Arizona patients and employers overpaid, and the amounts by which providers were underpaid, for out-of-network healthcare goods and services and related fees.

313. Disgorgement of any ill-gotten gains Defendants obtained by their unlawful practices is appropriate. Disgorgement here should include, but is not limited to, Defendants' excess profits that they received through their illegal practices.

314. The Court should also impose a civil penalty of not more than one hundred fifty thousand dollars for each of Defendants' violations of the Arizona Uniform State Antitrust Act, pursuant to A.R.S. § 44-1407.

315. Accordingly, the State seeks all legal and equitable relief as allowed by law, including restitution, disgorgement, injunctive relief, attorneys' fees and costs of investigation and prosecution of this action, all appropriate civil penalties and fees, and any other relief to which Plaintiff may be entitled for Defendants' violations of the Arizona Uniform State Antitrust Act.

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COUNT II

Violations of the Arizona Consumer Fraud Act, A.R.S. § 44-1521, *et seq.* (the "ACFA")
(against all Defendants)

316. The State re-alleges and incorporates herein by reference each of the allegations set forth in all previous paragraphs.

317. The Arizona Consumer Fraud Act prohibits, "[t]he act, use or employment by any person of any deception, deceptive or unfair act or practice, fraud, false pretense, false promise, misrepresentation, or concealment, suppression or omission of any material fact with intent that others rely on such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice." A.R.S. § 44-1522(A). It is the Arizona Legislature's stated intent that courts may use as a guide for interpreting this provision interpretations given by the Federal Trade Commission ("FTC") and federal courts to FTC Act Sections 5, 12, and 15.

318. Both MultiPlan and the Insurer Defendants engage in activities "in connection with" the "sale or advertisement" of "merchandise," as the ACFA defines "merchandise" broadly to include "any objects, wares, goods, commodities, intangibles, real estate or services." *Id.* § 44-1521(5).

319. Defendants are "persons" within the meaning of, and subject to, the provisions of the Consumer Fraud Act, A.R.S. § 44-1521(6).

320. The Arizona Attorney General is authorized by statute to enforce the ACFA whenever the Attorney General "has reasonable cause to believe that a person has engaged in, is engaging in or is about to engage in any" practice which violates the Consumer Fraud Act. A.R.S. § 44–1524.

321. The Attorney General may seek injunctive relief, restitution, and disgorgement. A.R.S. §44-1528(A)(1)-(3).

322. The Attorney General may also recover a civil penalty of not more than $10,000 per violation, if the violation was willful. A.R.S. § 44-1531(A). A willful violation "occurs when the party committing the violation knew or should have known that his conduct was of the nature prohibited" by the Act. *Id.* § 44-1531(B).

323. The Attorney General is further "entitled to recover costs, which in the discretion of the court may include a sum representing reasonable attorney's fees for the services rendered, for the use of the state." A.R.S. § 44-1534.

324. These remedies are cumulative and "in addition to all other causes of action, remedies and penalties available." A.R.S. § 44-1533(A).

325. Through their formation of and participation in the MultiPlan Scheme, Defendants have violated the ACFA by employing prohibited acts and practices in connection with the sale or advertisement of out-of-network healthcare services, which qualify as "merchandise."

326. Acts and practices are unfair under the ACFA when they cause or are likely to cause injury to consumers, are not reasonably avoidable by consumers, and are not outweighed by any countervailing benefit to consumers or competition.

327. Defendants' conduct described throughout this Complaint constitutes unfair acts or practices prohibited by the Arizona Consumer Fraud Act. It causes or is likely to cause injury to consumers in that, *inter alia* it increases out-of-pocket costs for out-of-network healthcare goods and services; restricts access and renders unaffordable out-of-network healthcare goods and services; restricts competition in the market for out-of-network healthcare goods and services; unreasonably limits consumer choice in the market for healthcare goods and services; and subjects consumers to an anticompetitive market for out-of-network healthcare goods and services.

328. Defendants' conduct described throughout this Complaint is not avoidable by consumers because, *inter alia*, all major insurers operating in Arizona participate in the scheme, which deprives consumers of other options, and Defendants do not disclose their

scheme to consumers such that consumers might learn their reimbursement amounts for individual claims until after those claims have been processed.

329. Defendants' conduct described throughout this Complaint is not outweighed by any countervailing benefit to consumers or competition because it actually harms consumers (as described above), restricts prices to unreasonably low rates, eliminates competition in the market for coverage for out-of-network healthcare goods and services, and concentrates and distributes the profits derived from the scheme within the cartel.

330. The significant harm Defendants' scheme inflicts on Arizona residents, entities, and the public health is not outweighed by any potential utility to the State or its healthcare system. The only parties who benefit from Defendants' illegal practices are Defendants themselves; Defendants' repricing scheme injures Arizona patients, providers, and employers, with no accompanying benefit, and reaps enormous profits for MultiPlan and the Insurer Defendants. All told, Defendants' repricing scheme has had a significant negative effect on Arizona commerce.

331. Defendants knew or should have known that the unfair acts and practices in which they engaged were of the nature prohibited by the ACFA.

332. Defendants' conduct described above also constitutes unlawful deceptive practices in violation of the ACFA, and Defendants intentionally devised or willfully participated in the scheme.

333. MultiPlan misrepresented that it "improve[s] affordability, transparency, and quality in and across the U.S. healthcare system" and claimed to "[i]dentify and negotiate fair reimbursements for out-of-network claims." As described throughout this complaint, MultiPlan's repricing tools and agreements with its co-conspirators make out-of-network healthcare less affordable to patients who already pay elevated premiums; encourage a lack of transparency both in negotiations with healthcare providers and when communicating patient outcomes; and reduce the quality of care available to patients throughout the United States, including in Arizona.

334. The Insurer Defendants, in turn, misrepresent to employers and patients that paying higher premiums for PPO plans will allow them "flexibility," "savings," "freedom," and "choice" in their access to out-of-network care. These representations are false or substantially misleading. The Insurer Defendants' PPO plans do not provide greater consumer flexibility, savings, or choice because many patients who pay up front or are balance billed for out-of-networks services are left with unreasonable amounts owed for purportedly covered out-of-network services, making the purported flexibility and choice of access to out-of-network providers illusory and the savings effectively *de minimis* if not non-existent.

335. The Insurer Defendants' misrepresent that out-of-network claims will be covered and that the client-insurer will cover such claims at a "fair" or reasonable rate and that healthcare providers can negotiate reimbursement rates. This is false. Some providers accept patients with client-payor insurance and render services, believing those services are covered when they are effectively not covered. And when the healthcare provider seeks to negotiate to receive a reasonable fee, their reality is that MultiPlan is unlikely to allow meaningful negotiations.

336. The Insurer Defendants misrepresent to Arizona employers with ASO plans that they will generate cost savings through shared savings arrangements. Ultimately, however, employers pay exorbitant shared-savings fees generated by MultiPlan's repricing algorithm, which can drive an employer's fees higher than the cost of the healthcare service the plan member received. When taken as a whole, employers do not experience the costs savings touted by the Insurer Defendants.

337. The Insurer Defendants' conduct described above also constitutes unlawful concealment, suppression, or omission in violation of the ACFA.

338. The Insurer Defendants conceal, suppress, and omit that they pay healthcare providers at rates well below UCR rates. This is material because some patients choose PPO plans to continue seeing a preferred out-of-network healthcare provider, and would

likely choose another payor if they knew their preferred healthcare provider was being unfairly compensated while healthcare premiums continue to increase unabated.

339. Defendants' concealments, suppressions, and omissions of material facts were carried out with the intent that consumers, providers, and employers would rely upon them in connection with the purchase of merchandise.

340. Defendants knew or should have known that the deceptive practices, misrepresentations, and omissions described above were of the nature prohibited by the ACFA and Defendants intentionally devised or willfully participated in the scheme.

341. As a direct and proximate result of Defendants' deceptive and unfair repricing scheme, Arizona consumers have overpaid for out-of-network healthcare goods and services and the elevated premiums associated with their PPO plans.

342. As a direct and proximate result of the unfair or deceptive acts or practices described herein, Defendants have received, and will continue to receive, income, profits, and other benefits that they would not have received had they not engaged in violations of the Arizona Consumer Fraud Act.

343. The State seeks all legal and equitable relief as allowed by law, including, *inter alia*, injunctive relief for Defendants' violations of the Arizona Consumer Fraud Act, as authorized by A.R.S. § 44-1528(A). Specifically, the State seeks an injunction requiring Defendants to cease the unfair or deceptive acts or practices described herein.

344. The Attorney General has reason to believe, based on the facts alleged herein, that Defendants' unfair and deceptive acts or practices have violated, and will continue to violate, the Arizona Consumer Fraud Act, absent the grant of an injunction.

345. While engaging in the unlawful practices alleged in this Complaint, Defendants have at all times acted "willfully" as defined by A.R.S. § 44-1531: Defendants knew or should have known that their conduct was of the nature prohibited by the Arizona Consumer Fraud Act. This Court, therefore, should impose on Defendants an appropriate civil penalty for each violation of the Arizona Consumer Fraud Act.

346. Restitution is appropriate to "[r]estore to any person in interest any moneys . . . which may have been acquired" by Defendants' unlawful practices, which here includes the amounts that Arizona consumers overpaid for out-of-network healthcare services, employers overpaid in fees, and providers were underpaid compared to UCR. A.R.S. § 44-1528(A)(2); A.R.S. § 44-1531.02(B).

347. Disgorgement of "any profits, gain, gross receipts or other benefit obtained" by unlawful practices should be "paid to the state for deposition in the consumer remediation subaccount of the consumer restitution and remediation revolving fund established by § 44-1531.01." A.R.S. § 44-1528(A)(3). Disgorgement here should include the gross receipts that Defendants received through their illegal practices.

348. Accordingly, the State seeks all legal and equitable relief as allowed by law, including restitution, disgorgement, injunctive relief, attorneys' fees and costs of investigation and prosecution of this action, all appropriate civil penalties and fees, and any other relief to which the State may be entitled.

PRAYER FOR RELIEF

WHEREFORE, the State demands that judgment be entered in its favor and against Defendants. Specifically, the State seeks an order and judgment from the Court:

(a) Awarding restitution of all amounts that may have been acquired from those subjected to Defendants' unlawful practices, which here includes the amounts that Arizona patients and employers overpaid, and amounts providers were underpaid, for out-of-network healthcare goods and services and related fees;

(b) Disgorging Defendants' ill-gotten gains obtained as a result of their illegal practices;

(c) Requiring Defendants pay pre- and post-judgment interest on such monetary

relief;

(d) Imposing a civil penalty of not more than one hundred fifty thousand dollars for each of Defendants' violations of the Arizona Uniform State Antitrust Act, pursuant to A.R.S. § 44-1407;

(e) Imposing a civil penalty of not more than ten thousand dollars for each of Defendants' violations of the Arizona Consumer Fraud Act, pursuant to A.R.S. § 44-1531;

(f) Enjoining Defendants from continuing to participate in the MultiPlan cartel and requiring each to independently establish a method for calculating out-of-network rates;

(g) Awarding attorneys' fees and costs arising from the investigation and prosecution of this action; and

(h) Awarding and all other relief to which the State is entitled as a matter of law or equity.

JURY DEMAND

Plaintiff demands trial by jury on all issues so triable.

DATED this 1st day of June, 2026

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