2024 WL 1533677 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division.
Essex County

GARRICK COX, MD LLC, a/k/a North Jersey Ortho. Gr.; Kayal Ortho. Ctr., P.C.; and Advanced Women's Healthcare, P.A., a/k/a Dr. Ulas Bozdogan, Plaintiffs,
v.
AETNA, INC.; Aetna Life Ins. Co.; Aetna Health & Life Ins. Co.; Aetna Health, Inc.; Aetna Health Ins. Co.; Multiplan, Inc., a/k/a Data iSight and/or Viant; National Care Network, LLC, d/b/a Data iSight; Astrazeneca Pharms. L.P.; P.O.Y. Holdings, LLC; Jpmorgan Chase, N.A.; Bayer Healthcare, LLC; Bayer Corp.; Guggenheim Capital, LLC; Acuative Corp.; The Hartz Mt. Corp.; Pearson Educ., Inc.; Teamster W. Reg. & Local 177, a/k/a Teamsters W. Reg. & N.J. Health Care Plan; Village Super Mkts., Inc., d/b/a ShopRite; Symrise, Inc.; and ABC Corps. 1- 100, Defendants.

No. ESX-L-3306-22.
April 2, 2024.

Order

Calcagni & Kanefsky LLP, Mariellen Dugan, Esq. (042881991), Kevin J. Musiakiewicz, Esq. (035181997), Martin B. Gandelman, Esq. (015592011), One Newark Center, 1085 Raymond Blvd., 14th Floor, Newark, New Jersey 07102, T: (862) 397-1796, E: mdugan@ck-litigation.com, Robins Kaplan LLP, Gregory S. Voshell (016872008), 1325 Avenue of the Americas, Suite 2601, New York, New York 10019, T: (212) 980-7407, E: gvoshell@robinskaplan.com, Attorneys for Defendants, Aetna, Inc., Aetna Life Ins. Co., Aetna Health & Life Ins. Co, Aetna Health, Inc., Aetna Health Ins. Co., AstraZeneca Pharms, L.p., P.O.Y. Holdings, LLC, Bayer Healthcare, LLC, Bayer Corp., Guggenheim Capital, LLC, Acuative Corp., the Hartz Mt. Corp., Pearson Educ., Inc., Teamster W. Reg. & Local 177, Village Super Mkts., Inc., and Symrise, Inc.

Hon. Keith E. Lynott, J.S.C.

***1** CBLP ACTION

THIS MATTER having come before the Court by Defendants, Defendants, Aetna, Inc., Aetna Life Ins. Co., Aetna Health & Life Ins. Co, Aetna Health, Inc., Aetna Health Ins. Co., AstraZeneca Pharms, L.P., P.O.Y. Holdings, LLC, Bayer Healthcare, LLC, Bayer Corp., Guggenheim Capital, LLC, Acuative Corp., The Hartz Mt. Corp., Pearson Educ., Inc., Teamster W. Reg. & Local 177, Village Super Mkts., Inc., and Symrise, Inc. (collectively, "Defendants"), through their counsel, Calcagni & Kanefsky LLP, on notice to counsel for Plaintiffs, Garrick Cox, MD LLC, a/k/a North Jersey Ortho. Gr. Kayal Ortho. Ctr., P.C., and Advanced Women's Healthcare, P.A., a/k/a Dr. Ulas Bozdogan ("Plaintiffs"), for an Order, pursuant to Rule 4:6-2(e), to dismiss Plaintiffs' Complaint with prejudice; and the Court having reviewed the papers submitted; and for good cause shown;

IT IS on this 28 day of March 2024;

ORDERED that Defendants' motion for dismissal of the Complaint as to movants is **DENIED;** and it is further

ORDERED that a copy of this Order shall be deemed served on the date of its entry on all counsel of record via eCourts.

<<signature>>

HON. KEITH E. LYNOTT, J.S.C.

[X] Opposed

[ ] Unopposed

See the Order and Statement of Reasons entered contemporaneously herewith.

ORDER

This matter, having been opened by the Court by Finazzo Cossolini O'Leary Meola & Hager, LLC, attorneys for Defendants, MultiPlan, Inc. ("MPI"), and National Care Network, LLC ("NCN") (collectively "MultiPlan" or the "MultiPlan Defendants"), upon notice to all counsel of record, for an Order pursuant to Rule 4:6-2(e) dismissing with prejudice Plaintiffs' Complaint against the MultiPlan Defendants, for failure to state a claim against them upon which relief can be granted, and the Court having reviewed the moving papers and any opposition and reply papers, and for good cause shown:

IT IS ON THIS 2 day of April 2024,

ORDERED that Defendants, MultiPlan, Inc., and National Care Network, LLC's Motion to Dismiss Plaintiffs' Complaint is hereby **GRANTED in part and denied in part;** and it is further

ORDERED that the claims asserted in Counts Four, Six, Seven, and Ten of the Complaint against Defendants, Multiplan, Inc., and National Care Network, LLC, are hereby dismissed without prejudice to a right to re-plead within 20 days of posting hereof or to seek leave to amend at a later time; and it is further

ORDERED that, except as set forth in the proceeding paragraph, the motion is denied.

ORDERED that service of this Order shall be deemed effectuated upon all parties upon its upload to eCourts. Pursuant to Rule 1:5-1(a), movant shall serve a copy of this Order on all parties not served electronically within seven (7) days of the date of this Order.

<<signature>>

HON. KEITH E. LYNOTT, J.S.C.

X Opposed

___ Unopposed

Statement of Reasons

In this action brought by a medical practice against numerous Defendants alleging underpayment for medical services rendered to patients, the Defendants move to dismiss, in whole or in part, the Complaint and Jury Demand (the "Complaint") of the Plaintiffs Garrick Cox, MD LLC a/k/a North Jersey Orthopedic Group ("Cox"), Kayal Orthopaedic Center, P.C. ("Kayal"), and Advanced Women's Healthcare, P.A. a/k/a Dr. Ulas Bozdogan ("Advanced") pursuant to R. 4:6-2(e) for failure to state a claim. Specifically, the Defendants Aetna, Inc., Aetna Life Ins. Co., Aetna Health & Life Ins. Co., Aetna Health, Inc. and Aetna Health Ins. Co. (collectively, the "Aetna Defendants"), along with the Defendants AstraZeneca Pharms. LP, P.O.Y. Holdings, LLC, JP Morgan Chase, N.A., Bayer Healthcare LLC, Bayer Corp., Guggenheim Capital, LLC, Acuative Corp., The Hartz Mountain Corp., Pearson Education, Inc., Teamsters Western Region & Local 177, Village Super Markets, Inc. and Symrise, Inc. (collectively the "Payor Defendants") move to dismiss the Complaint in part. Via a separate motion, the Defendants Multiplan, Inc a/k/a Data iSight and/or Viant and National Care Network, LLC d/b/a Data iSight (collectively, "Multiplan") move to dismiss the Plaintiffs' Complaint as against them in its entirety.

***2** For the reasons set forth herein, the Court grants in part and denies in part these motions. It finds, under the liberal standards applicable to assessing the legal sufficiency of pleadings, that the Complaint states viable claims for relief. However, it also dismisses certain claims subject to a right to re-plead.

I

As these are motions to dismiss, the Court is required to examine the Complaint through a generous and hospitable lens that favors the Plaintiffs. It accepts as true the factual averments of the Complaint and confers on the Plaintiffs the benefit of all reasonable inferences. At the same time, the Court is not required to accept as true mere legal conclusions asserted as facts.

The Court is not concerned at this stage of the case with the Plaintiffs' ability to prove their allegations. Instead, its function is to scrutinize the Complaint rigorously to determine its legal sufficiency - that is, if it is possible to discern the "fundament" of a cause of action from even an "obscure statement" of the claim. Printing Mart-Morristown, Inc. v. Sharp Elecs. Corp., 116 N.J. 739, 746 (1989). Put differently, the Court must determine if a viable claim or claims is/are suggested by the facts alleged.

Ordinarily, the Court determines the legal sufficiency of a complaint without reference to or reliance upon facts or materials de hors the pleading itself. An exception exists for materials attached to the Complaint, facts of public record, or documents or factual material that are integral to a plaintiff's claims. Banco Popular of N. Am. v. Gandi, 184 N. J. 161 (2005).

The Rules of Court impose a heightened standard for pleading of claims sounding in fraud or misrepresentation. Pursuant to R. 4:5-8, "[i]n all allegations of misrepresentation, fraud, ... particulars of the wrong, with dates and times if necessary, shall be stated insofar as practicable." However, "[m]alice, intent knowledge, and other conditions of mind of a person may be alleged generally." Id.

New Jersey courts grant motions to dismiss only in rare instances. When they do so, the dismissal is normally without prejudice to the right to re-plead to allege additional facts that address a deficiency identified by the Court. However, where the Complaint is "palpably insufficient", the Court will dismiss the same. Rieder v. State, Dep't of Transp., 221 N. J. Super. 547, 552 (App. Div. 1987).

II

The facts, drawn from the Plaintiffs' Complaint and accepted as true, for purposes of adjudicating these motions only, are as follows:

Cox and Kayal are medical service providers specializing in orthopedic surgery and treatment. Advanced is a medical practice specializing in obstetrics and gynecology. At all times, the Plaintiffs were out-of-network providers with respect to the Aetna and Payor Defendants and provided "pre-authorized and/or emergent, medically necessary" services to patients who were members or beneficiaries of health care plans sponsored, funded, controlled, administered or insured by the Aetna Defendants and the Payor Defendants.

The Aetna Defendants are insurance companies or affiliates that "sponsored, funded, operated, controlled, administered and/or underwrote health plans" for the patients whose treatment - and the claimed underpayment for the same - are the subject of this action. The Payor Defendants likewise "sponsored, funded, operated, controlled, and/or administered a health plan" for the patients identified in the Complaint by their initials.

***3** The Defendants Multiplan, Inc., doing business as Data iSight and Viant, and National Care Network, LLC, doing business as Data iSight ("DiS"), are part of the Multiplan family of companies that at all relevant times provided cost

management services to the healthcare industry, including healthcare "repricing" services, marketing DiS as one of its repricing services. Repricing refers to "programs of health care insurers, payors and administrators to reduce standard fee-for-service rates of out-of- network healthcare providers", including by "controversial back-end negotiations (after services rendered, unilateral discounting rate)."

The Complaint alleges that the Aetna Defendants are alter egos and/or agents of one another, with common ownership and financial interdependence, and hold themselves out to the public as a single economic entity. It asserts that the Aetna Defendants consented to Multiplan acting on their behalf and subject to their control and/or that Aetna conferred apparent authority on Multiplan to act on their behalf, in relation to the claims at issue.

The Complaint alleges that the Payor Defendants consented to the Aetna Defendants acting on their behalf and subject to their control, or conferred apparent authority to act on their behalf, in relation to all the matters asserted in the Complaint. In addition, according to the Complaint, Multiplan was an agent of the Aetna Defendants.

The Complaint alleges that Aetna and the Payor Defendants issued "oral pre-authorizations to Plaintiffs" for the treatment of the patients identified on a list - the Disputed Claims List or "DCL". The DCL, in turn, identifies, by initials, each such patient, an ID Number, the date of service, the amount billed for the services and the amount ultimately paid. The Complaint specifically identifies, for each patient, the Payor Defendant that sponsored, funded, operated, controlled, or administered the health care plan for that patient.

The DCL further sets forth the date on which an individual identified by first name advised the relevant Plaintiff that the services to be provided were authorized or that pre-authorization was not needed in respect of each patient and alleges a representation by such individual that the services to be provided to such patient would be paid for at a specific percentage - ranging from 80% to 100 % - of "UCR". A "UCR" charge or fee - the usual, customary and reasonable fee -is the amount that out-of-network providers normally charge to patients for medical services in the free market, based on the usual charge for a particular service by providers with similar training and experience in the same geographic area.

The Complaint avers that the Plaintiffs "relied on and [were] induced to render services with the expectation to be compensated consistent with the statements, representations, and course of conduct/conduct of defendant(s), including payment based on market rates, that is, UCR." It asserts that, in performing its repricing services, described elsewhere in the Complaint, Multiplan knew or should have known that the claims for payment it was processing involved pre-authorized medical services.

The Complaint avers that the "defendants" thereafter grossly underpaid the Plaintiffs for their medical services, paying less than three cents on the dollar. It avers there is an outstanding balance of $1,964,841.92, exclusive of interest (and reserves the right to add additional patients and/or dates of service as the case proceeds).

The Plaintiffs allege that, in or around 2008, Aetna was the subject of an investigation by the Attorney General of New York relating to the use of a UCR database known as Ingenix. It asserts the Attorney General determined that Aetna employed this database in a manner as to manipulate UCR rates downward "through faulty data practices and procedures." The Complaint asserts that "Aetna has a track record "of routing out-of-network claims to a facially independent company to 'serve as a conduit of rigged data' of UCR" with the intention of steering patients to in-network providers.

***4** The Complaint avers that, as part of a settlement with the New York Attorney General, Aetna funded a new, independent entity for purposes of ascertaining UCR rates called FAIR Health. The Complaint alleges that FAIR Health holds itself out as an independent nonprofit that collects data and manages a database of privately billed health insurance claims for the purpose of making available "'trusted claims data resources that are used to promote sound decision making by all participants in the healthcare system."' The Complaint states that FAIR Health holds itself out as engaging health care data analysts, statisticians, and clinical experts to apply extensive experience in developing and implementing "healthcare data analytic processes and statistical quality review that assess the validity and integrity of the data."

The Complaint alleges that Aetna represents to New Jersey members of health care plans that Aetna obtains its data as to UCR rates from the FAIR Health database and not the specific terms of the plans themselves. Indeed, according to the Complaint, Aetna states that members can consult the FAIR Health website for the estimated cost of out-of-network services.

However, according to the Complaint, in or around 2019, Aetna implemented an initiative with Multiplan that it called the "National Advantage Program" or "NAP", the stated purpose of which was to facilitate discounts for out-of-network care for patients to ensure they would not be balance billed for such care. (Balance billing is the practice of billing a patient for the net amount of the cost of care charged by the provider and not paid or reimbursed by the payor).

According to the Complaint, the real objective of the NAP was to reduce UCR payments to providers "artificially (and fraudulently)." Aetna "structured the NAP's Multiplan scheme in a manner that incentivized it to reduce UCR reimbursement as low as possible", as it previously did through the Ingenix program, with the savings achieved between the correct UCR amounts and the amounts paid to the providers after repricing - the "NAP" fees - retained as "kickbacks."

According to the Complaint, the payors paid the NAP fees to Aetna with the understanding that patients would not be balance billed. Although the program as represented contemplated ad hoc negotiations with providers to resolve disputes over fees, Aetna did not undertake any negotiations. "Following the Ingenix model, Aetna designed a program so that the artificially low UCR determinations would be made by a facially independent company, codefendant Multiplan, so that Aetna could claim independence and maintain plausible deniability."

The Complaint avers that, by adopting the NAP, Aetna ceased using the FAIR Health database or similar databases to determine the UCR rate for particular services. In lieu of reimbursing out-of-network providers at "historical UCR rates", Aetna resumed the prior practice of "using a supposedly independent company to manipulate and understate UCR in order to enrich itself, and Multiplan, by diverting the Payor Defendants' funds from payment to physicians under the guise of a savings plan. "Aetna's NAP repricing program was developed, rooted and dictated as a corporate policy and practice and is not rooted in or originate from [sic] any patients' health plan."

The Complaint alleges that "Aetna conspired with Multiplan to skew UCR through a 'repricing' program - called the Data iSight Methodology ('DiS')." This methodology was originally developed by the Defendant National Care Network, LLC as a market alternative to Ingenix - "in other words a vehicle to manipulate and understate UCR as Ingenix had until shuttered by the N. Y. Attorney General." Multiplan acquired National Care Network, LLC in 2011 and transitioned its business model from forming supplementary networks of in-network providers into an "'analytics' business."

***5** Aetna engages Multiplan to price claims under a threshold established by Aetna. The process contemplates that, where a provider balance bills the patient for the difference between the amount billed and the amount priced via DiS, Multiplan will provide an advocate to negotiate for the patient on a mutually agreeable payment. However, "[c]ontrary to Aetna's representations and course of dealings, DiS is neither a UCR calculation, nor a 'fair and reasonable' reimbursement pricing methodology, nor was there any genuine commercially reasonable negotiation process."

The Complaint avers that Multiplan markets its DiS methodology as a method that pays less than UCR. "Thus, while defendants' pre-authorizations represented payment at UCR rates, plaintiff's claims were unilaterally diverted to MultiPlan to 're-price' them using a DiS method that marketed itself as an 'optimal' alternative to a UCR calculation."

The Complaint avers that DiS employs a "cost plus methodology", pursuant to which Multiplan estimates costs for hospitals, and not medical practices, from Medicare data and adds a fair profit margin. The Plaintiffs assert that "Defendants' determination of the 'margin factor' is inaccurate, arbitrary, and designed to enrich defendants." They assert that, as a result of the use of the DiS methodolgy, healthcare providers have reported a precipitous drop in UCR reimbursements. And for the claims in issue in this case, "defendants paid far less than the UCR amounts (including, for example, FAIR Health) that defendants had represented during the pre-authorizations", representing a small fraction of the Plaintiffs' actual charges.

The Plaintiffs assert that "DiS is outcome driven; it is based on Medicare rates and data applied to reach a predetermined 'target reimbursement amount"'. The methodology relies upon a DRG coding system used for hospital reimbursements and based on a fixed payment for a particular diagnosis, when independent physicians are generally reimbursed based on a CPT system that provides payment for each separate procedure rendered by a physician. "The Defendants' reliance on Medicare data, hospital rates (DRGs) and target pricing (rather than commercial data and CPTs) demonstrates the DiS is designed not to make actual UCR calculations, and it lacks the data or abilities to do so."

Unlike commercial UCR rates, Medicare rates (according to the Complaint) reflect "federal policy and budgetary decisions." As a result, there is no relationship between the Medicare fee schedule and UCR fees. Such a reimbursement model does not produce rates established based on the services provided by similar providers in the same geographic area.

The Complaint asserts that "DiS is also flawed and arbitrary because - as disclosed by the DiS patent - its reimbursement rate is not based on the usual payment to similar providers for similar services, but rather DiS involves an outcome-driven 'target reimbursement' method, as well as a profit 'margin' that defendants unilaterally and arbitrarily determine to be 'fair.'" According to the Complaint, "defendants' secret predetermined 'target' rate scheme, and self-serving determination of a 'fair' profit margin for providers, ultimately drives DiS reimbursement. Aetna and MultiPlan know, or should have known, that DiS rates are not based on historical payments to similar provider [sic] for the subject medical service in the same geographic area." The policy and practice is to "pay providers as low a rate as they are able to get away with to enrich themselves" and without review or consideration of a health plan's terms.

***6** The Complaint alleges that Multiplan's compensation is a percentage of the difference between the provider's billed charges and the amount that application of the DiS methodology produces, with the funds of the Payor Defendants used to pay Multiplan on the basis of such savings. "Unbeknownst to the Payor Defendants, Multiplan slips a portion of its commission as a kickback to Aetna."

Aetna and Multiplan represent to the Payor Defendants that, by employing the DiS methodology, they are reducing the cost of medical services and still paying a fair and agreeable reimbursement rate. However, DiS is actually replacing FAIR Health. "What actually happens is that Aetna and Multiplan - under the guise of administrative fees (i.e., NAP fee) - divert monies that should pay for essential medical care to themselves, and then leave patients exposed to be directly filled by doctors (i.e., balance billing). For example, a publicly-available contract indicates Aetna grabs 30% of the 'savings' and Multiplan takes 7.5%."

The Complaint avers that a surgeon who performs a complex surgery can be paid less for such services than Multiplan and Aetna receive for processing the claim. It notes that the treatment of Patient K.P., listed on the DCL, resulted in billed charges of $142,000, but payment of $1,691.85. The percentage of savings achieved by Aetna and Multiplan in respect of this patient would, so the Complaint alleges, result in payments to them in excess of the amount paid to the physician.

The Plaintiffs allege that, after rendering services to the patients listed on the DCL, they filed timely claims with the "defendants" in accordance with New Jersey law and "defendants' corporate-wide administrative policies." They submitted supporting documents to substantiate the requests for payment. The Plaintiffs contend that "[a]s a matter of routine business practice", they engaged in regular communications with the Defendants and/or their agents "regarding coverage, reimbursement and other issues." It asserts that "[t]hroughout the parties' course of dealings and numerous forms of communication and interaction, defendants and/or their agents voluntarily and freely engaged with and dealt directly with Plaintiffs" and Plaintiffs "relied in good faith on defendants' conduct and the parties' course of dealings."

The Complaint states that "[e]ven though the services rendered by Plaintiffs were pre-approved and/or emergent, medically necessary care, defendants systematically failed to issue proper reimbursement for the services rendered by Plaintiffs to defendants' insureds identified in the DCL." The Defendants also failed to provide payment in accordance with New Jersey "prompt pay" laws and regulations, resulting in an obligation to pay interest charges of 12% for claims not correctly paid in a timely manner. The Plaintiffs allege that they undertook administrative appeals of the underpayments, but the process was futile.

The Plaintiffs aver that Multiplan's representation that the DiS methodology is defensible, market tested and transparent is false. When the Plaintiffs sought to appeal payment determinations, Plaintiffs received "boilerplate, perfunctory responses affirming Aetna' s original position with little to no explanation." The "defendants" were not responsive to the Plaintiffs' efforts to engage them regarding the claims at issue to avoid balance billing of the patients.

***7** The Complaint avers that the "defendants intentionally and deliberately administer the [health] plans in a self-serving manner to lower the reimbursement for out-of-network services in order (i) to increase defendants' profits, because defendants and/or their agents have a financial incentive and are compensated based on reduced reimbursement rates to out-of-network providers, like Plaintiffs; and/or (ii) to discourage the insured-patients from seeking out-of-network treatment

from the healthcare provider of their choice." The Defendants undertake such efforts, according to the Complaint, even though the patients "are entitled to access the out-of-network provider of their choice, and are promised by defendants access to such providers, which in turn, is intended to put out-of-network providers out of business."

The Plaintiffs allege that all of their claims arise from state common, statutory and regulatory law and are not predicated on any federal right, law or statute, including the Employee Retirement Income Security Act ("ERISA"). The Plaintiffs are asserting "their own direct claims and causes of action, rather than derivative claims predicated on an Assignment of Benefits from a patient." They aver that "the Aetna and Payor Defendants did not transmit any plans, plan terms or language to MultiPlan and/or DiS during repricing, upon information and belief." They assert that Muliplan and/or DiS's repricing of claims "is independent of the terms of any patients' plans, and MultiPlan and/or DiS's pricing of claims and so-called negotiation with providers is conducted on a systematic basis by MultiPlan and/or DiS employees who lack knowledge of the terms and conditions of a particular patient's health plan." The internal corporate practices and policies employed by the Defendants are independent of the terms of any plan, including any ERISA plan.

The Complaint sets forth eleven separate Counts for relief. These Counts purport to state claims for Conspiracy (First Count), Breach of Implied Contract (Second Count), Breach of the Covenant of Good Faith and Fair Dealing (Third Count), Quantum Meruit (Fourth Count), Promissory Estoppel (Fifth Count), Negligent Misrepresentation (Sixth Count), Fraud (Seventh Count), Negligence (Eighth Count), Tortious Interference with Economic Advantage (Ninth Count), Conversion (Tenth Count) and Violation of the New Jersey Civil RICO Statute (Eleventh Count). The headings to certain of these Counts state that such Count is directed to specific Defendants only. However, the prayers for relief in all Counts demand judgment against all Defendants. In each Count, the Plaintiffs claim entitlement to compensatory damages, interest and attorneys' fees and, in connection with some Counts, to punitive and exemplary damages as well.

In the First Count - explicitly lodged against all Defendants - the Plaintiffs assert the Aetna Defendants and Multiplan "acted in concert to commit an unlawful act and/or to commit an unlawful act by unlawful means." They contend the Payor Defendants are "also liable by agency for the conspirator [sic] acts of the Aetna Defendants."

This Count asserts that the "defendants conspired and entered into an agreement(s) and a clandestine repricing scheme to understate UCR for out-of-network surgical facilities, which they knew would injure and wrong Plaintiffs, especially after a pre-authorization representing that payment would be based on UCR." The Complaint alleges that all Defendants "shared and accepted the conspiratorial objective, and their acts furthered the conspiratorial objective explicitly and implicitly."

The objective, according to the Complaint, of the "defendants' agreement(s) and secret repricing scheme" was for the Defendants to "enrich themselves at the expense of Plaintiffs, and similarly situated providers, by luring Plaintiffs to render services through their representations, and course of conduct and dealings, but then only provided arbitrary and nominal reimbursement far below UCR rates." The Defendants knew, so the Complaint avers, that when they induced the Plaintiffs to perform medical services, many of the Plaintiffs' claims for reimbursement would not be paid at the rates represented at pre-authorization or according to industry custom, but nevertheless represented that the claims would be reimbursed at UCR rates. The "Defendants' representations regarding the manner in which Plaintiff's claims would be/were adjudicated and/or paid were designed to mislead, induce and deceive Plaintiffs." The Defendants "undertook overt and material acts to coordinate, implement and further the repricing scheme, including by and through negligent misrepresentations, intentional misrepresentations, tortious interference and fraud."

***8** The Complaint alleges that the Aetna and the Payor Defendants falsely represent to the public, including to providers, that "MultiPlan and/or DiS maintain(s) an extensive database" to determine UCR in northern New Jersey, when in fact, contrary to such statements, omissions and conduct, and rather than maintaining an accurate database, Multiplan and/or DiS "pays" inconsistent and arbitrary amounts that are "a percentage of Medicare rates as modified by a target pricing scheme." Multiplan and/or DiS "(conspiring with codefendants) calculated and recommended payments well below market rates because they incur a direct benefit (e.g., 'commissions' on the percentage of savings) that correlates with the degree to which a providers reimbursement is underpaid." The Aetna Defendants knew and/or should have known that Multiplan and/or DiS did not "maintain an adequate, valid database and/or utilized other policies and practices in order to undermine the reasonable payment rate for similar providers within plaintiffs' geographical region."

The Second Count - stated to be lodged against the Aetna and Payor Defendants only - alleges that the "Defendants"

indicated "by a course of conduct, dealings and the circumstances surrounding the relationship, and/or by trade usage, to Plaintiffs that defendants would properly pay for surgical and medical expenses provided." The "defendants", according to the Complaint, represented that payment for pre-authorized services would be made regardless of the Plaintiffs' out-of-network status, and/or that pre-authorization is not required when Plaintiff renders emergent services. According to the Complaint, the "defendants were paid additional sums by the Patients for access to out-of-network providers, and the services of Plaintiffs were necessary to satisfy the surgical and medical needs of defendants' insureds."

The Complaint alleges that the "Defendants" indicated "by course of conduct, course of dealings, industry custom and/or the circumstances surrounding the relationship, to Plaintiffs that defendants would hold their insureds harmless after a patient reached his/her maximum annual patient responsibility, and thus timely pay Plaintiffs UCR amounts based upon what other healthcare providers of the same specialty in the same geographic area were paid for the services rendered by Plaintiffs." The "Defendants" indicated "by a course of conduct, dealings, and the circumstances surrounding their relationship, and/or trade usage to Plaintiffs that they would honor" their representations that the services were pre-authorized or pre-certified, their representations as to payment verifications and/or their representations that pre-authorization was not required in order to be reimbursed.

The Complaint alleges that Aetna's knowledge and intent is demonstrated by "its creation and operation of undisclosed programs" through which "it will ultimately make correct, or nearly correct, UCR payments (e.g., FAIR Health 80%) to a provider if it receives persistent complaints and objections to Aetna's underpayment schemes." It avers that Aetna operates "clandestine programs to pacify and quiet the 'squeaky wheel,' so that Aetna and Multiplan can continue with their repricing scheme and profiting from the underpayment of the vast majority of providers and patients who lack the ability, resources, knowledge or persistence to access Aetna's hidden programs to pay at UCR rates."

The Plaintiffs contend they rendered medically necessary surgical and other services to the Patients identified on the DCL and expected "defendants" to "properly compensate Plaintiffs." It avers a reasonable person in the position of the "defendants" would know, or reasonably should have known, that the Plaintiffs were performing services expecting that "defendants" would pay for them appropriately. They assert that, "[d]espite indicating to Plaintiffs by a course of conduct, course of dealings, industry custom, and/or the circumstances surrounding the relationship, that defendants would properly and timely reimburse Plaintiffs for either their actual charges as an out-of-network provider (emergent services) or their UCR rates (non-emergent services)", the "defendants" failed to do so. Such failure, according to the Complaint "constitutes breach of the implied contract between defendants and Plaintiffs."

***9** The Third Count - also said to be lodged against the Aetna and Payor Defendants only - avers that the contract "between Plaintiffs and defendants" contains an implied covenant of good faith and fair dealing. It asserts that the "Defendants" acted with "improper motive" and injured the Plaintiffs' "rights and benefits under the contract", and "breached the contract through acts of commission or omission described herein that are wrongful and without justification."

The Fourth Count - explicitly lodged as to all Defendants - alleges that the "Plaintiffs performed and rendered medical services relating to the Patients on the DCL in good faith." It asserts that the Plaintiffs reasonably expected compensation for their services "in accordance with pre-authorizations, the respective courses of conduct, dealings and/or industry custom." They assert that the Plaintiffs' services were "accepted by the person to whom they were rendered and Defendants pre-approved services and/or indicated pre-approval was not necessary for reimbursement."

The Plaintiffs aver that the "Defendants have profited themselves unfairly at the expense of Plaintiffs' efforts and services." The "defendants" refused to pay Plaintiffs "correctly for the medical services provided to patients identified on the DCL - contrary to New Jersey common law, statutory and regulatory obligations of defendant(s)."

The Fourth Count alleges that Aetna and Multiplan "colluded to understate the UCR rate for out-of-network providers and the difference between the amount that should have been paid and the amount that was paid is approximately $2 million. The Plaintiffs assert that the amounts not paid to Plaintiffs have been "unjustly retained by defendants, and it is used to pay kickbacks ('commissions') to MultiPlan and/or DiS as well as to the Aetna Defendants for so-called 'savings.'" The Plaintiffs state that the "Defendants have a financial incentive to understate the true UCR rate, including for example, by paying flat rates that do not account for geographical factors." They contend that "defendants have been conferred a benefit by diverting payment that should have been paid to Plaintiffs to pay themselves, returning only a portion back to the Payor Defendants."

The Complaint asserts that the "Defendants were compensated and obligated to provide access to the pre-authorized medical services without regard to the network status of a provider, and 'defendants" were equitably obligated to reimburse providers for such services." It avers that, "[t]o satisfy defendants" legal obligations (including network adequacy obligations), defendants required the services of Plaintiffs to render the surgical and medical services" the Plaintiffs rendered to the Patients.

The Defendants, according to the Complaint, received a benefit because of "Plaintiffs rendering services that remain grossly underpaid." The Defendants, the Complaint avers, have been enriched through use of funds that should have been paid "in a timely and appropriate manner" to the Plaintiffs.

The Plaintiff directs the Fifth Count only against the Aetna and Payor Defendants. This Count alleges that the "Defendants made promises to Plaintiffs that proper reimbursement for medical services would be afforded to the Patients identified on the DCL, including by pre-authorizing, advising the pre-authorization was not necessary, and/or verifying payment terms, then refusing proper payment when the bills were submitted by Plaintiffs." This Count avers that the "defendants were contacted to confirm whether there would be reimbursement for the medical services the Patient needed and/or to verify payment terms." and "Defendants indicated or conveyed that Plaintiffs would be properly reimbursed for the subject medical services needed by the Patients."

***10** The Plaintiffs allege that the "Defendants expected, or reasonably should have expected, that the pre-authorizations and payment verifications would be relied upon by Plaintiffs in agreeing to go forward with rendering the medical services needed by the Patients." They contend that that the Aetna and Payor Defendants "did not advise or disclose to Plaintiffs that after it rendered the pre-approved services, all or most surgical facility claims would be unilaterally redirected to a third-party, MultiPlan and/or DiS, for so-called 'repricing."'

The Plaintiffs assert they reasonably relied on the pre-authorizations and payment verifications of defendants, and were induced to render services. They claim that the "defendants"' conduct violates applicable state law barring retroactive withdrawal of pre-authorization in the absence of material misrepresentations of the provider to obtain such pre-authorization.

The Fifth Count avers that the Plaintiffs' reliance on the promise of the Defendants caused them a substantial detriment. They contend that "[c]ontrary to defendants' statements, MultiPlan and/or DiS unilaterally imposes an extremely low rate of payment, and does so after Plaintiffs had been induced to render services, including by defendants' statement and conduct relating to pre-authorization."

The Sixth Count - explicitly advanced against all Defendants - avers that the "Defendants negligently represented that they would provide proper reimbursement to the Plaintiffs with respect to the Patients identified on the DCL, including by way of pre-authorization, advising that pre-authorization was not necessary, and/or payment verification, but then refusing proper payment when the bills were submitted by Plaintiffs." This Count alleges that Multiplan made "false and/or misleading representations to the public, including providers, and to Aetna regarding the DiS program, including for example and without limitation, that it operates a 'fair and reasonable reimbursement' pricing methodology, that its data and methods are properly 'validated' and its practices are 'completely transparent' to all parties."

The Plaintiffs allege that these representations were false in that "[d]efendants materially misrepresented to Plaintiffs that they would be reimbursed at the usual, customary and reasonable rate, or a percentage thereof." However, "after the services were rendered - and contrary to the pre-authorizations, pre-certifications and/or payment verifications provided by defendants - defendants engaged in a bait-and-switch by improperly underpaying for the services rendered."

This Count alleges that the Plaintiffs relied on such representations and the course of conduct and dealings between the parties to their detriment. It avers that the "defendants' conduct" also violates applicable law barring retroactive withdrawal of pre-authorization unless the provider engaged in misrepresentation to secure the authorization."

The Seventh Count - also directed to all Defendants - avers that the "Defendants intentionally misrepresented, by acts of commission and omission: (a) that Plaintiffs would be paid a UCR rate for rendering services to the patients identified on the

DCL; (b) the amount initially determined by Multiplan was a negotiated or a mutually agreed amount; (c) by failing to disclose that the initial payment amount was actually a lowball offer as part of defendants' covert negotiation process; (d) that MultiPlan's and/or DiS's repricing is based on a valid, objective determination of a 'fair and reasonable' amount for providers of similar training and experience in northern New Jersey; and/or (e) by misstating patient responsibility where patients had reached their maximum annual amount, triggering full responsibility of defendants." This Count asserts that MultiPlan and/or DiS "intentionally colluded with the Aetna Defendants (and thus the Payor Defendants), who sanctioned these repricing practices, which resulted in arbitrary payments well below UCR rates.".

***11** This Count avers that Multiplan and/or DiS and the Aetna Defendants received compensation from the Payor Defendants as a direct result of the intentional misrepresentations." The Plaintiffs aver that they "reasonably believed, to their substantial detriment" that they would be compensated at UCR rates for the surgical and related medical services rendered to the Patients and justifiably relied on what turned out to be defendants' intentional misrepresentations to the contrary."

The Eighth Count - advanced against the Aetna Defendants and Multiplan - asserts that the "Defendants owed a duty of care to Plaintiffs." It alleges that Aetna violated duties of care to all persons "in its vetting, retention, promotion, oversight and continuing relationship of MutliPlan to use the DiS pricing, as MultiPlan's methodology, practices and data are flawed and grossly understate the lawful payment amount - especially where Aetna on information and belief received numerous complaints from providers regarding DiS and had the ability to oversee, scrutinize and terminate or modify diverting out-of-network provider claims to Multiplan's DiS program."

The Ninth Count - asserted against all Defendants - alleges that Plaintiffs had a reasonable expectation of economic advantage or benefit. It asserts that the Defendants were aware of the Plaintiffs' expectancy of advantage and wrongfully interfered with it. The Plaintiffs aver that, but for such wrongful interference, they would have realized the expected economic advantage or benefit.

The Tenth Count - alleged against the Aetna Defendants and Mutliplan - asserts that Mutiplan and/or DiS and the Aetna Defendants "have undertaken acts of control in denial of Plaintiffs' rights to a UCR payment, or inconsistent with Plaintiffs' right(s)." It alleges that, having performed services based on a pre-authorization and upon timely submission of a claim, the Plaintiffs had a right to "immediate issuance and possession of a UCR payment" and the "Defendants" wrongfully interfered with such right by "diverting Plaintiffs claims to flawed repricing, and the resulting gross underpayment, and keeping a portion of the amount due to Plaintiffs as their 'commission' for creating the illusion of 'savings' for the Payor Defendants."

The Eleventh Count - lodged against the Aetna Defendants and Multiplan - alleges that these Defendants violated New Jersey's Racketeer Influenced Corrupt Organizations Act, N.J.S.A. 2C-41-1, et seq. (the "Civil RICO" statute). This Count asserts that the Aetna Defendants and Multiplan and DiS engaged in an "enterprise". It alleges that the Defendants "entered into an agreement to conduct or participate in the conduct of the affairs of the enterprise and specifically in an agreement for the commission of at least two "predicate acts." This Count asserts that the enterprise engaged in or affected trade or commerce in New Jersey.

The Plaintiffs allege that these Defendants participated in the affairs of the enterprise through a "pattern of racketeering activity." They contend that the Defendants committed at least two predicate acts, and "the incidents of racketeering activity embrace unlawful conduct that has the same or similar purposes, results, participants or victims, and/or the methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents."

The Complaint alleges the racketeering activities include "fraud (including wire and mail fraud); theft (including theft by deception);deceptive business practices, e.g., making false or misleading statements in any advertisement to the public to promote a service; and use of a 'false measure or any other device' to determine a quantity (N.J.S.A. 2C-21-7); failure to act disinterestedly (N.J.S.A. 2C-21-10); and/or misapplication of entrusted property (N.J.S.A. 2C-21-15)." The Plaintiffs assert that the Defendants functioned as an unlawful "'corporate hub"' of a "'hub, spoke and rim' type agreement" among the various insurance company clients and repricer to "'fix' the amounts that would be reimbursed to healthcare providers on out-of-network claims."

III

***12** On these motions, all Defendants contend that the Complaint is unsustainable because the Plaintiffs have impermissibly alleged conduct, actions, omissions and/or representations by all named Defendants without adequately specifying which of the Defendants engaged in the alleged conduct, acts, omissions, or representations. The movants assert the pleading practice of lumping together all Defendants when alleging unlawful conduct without identifying specific conduct of each such Defendant renders the Complaint legally deficient. They contend that conclusory allegations that the Aetna Defendants and Multiplan were agents of the Payor Defendants, and/or in the case of Multiplan, that it was also an agent of the Aetna Defendants, do not cure the deficiency.

The movants point out that the DCL refers to first names only of the individuals who allegedly pre-authorized the services of the Plaintiff, advised that no pre-authorization was required and/or verified payment amounts as a percentage of UCR rates. According to the movants, the Plaintiffs have failed to identify such individuals by last name or affiliation with one or more of the Defendants or even to identify the entity or entities with which the Plaintiffs believed they were communicating. The movants assert that this lack of specificity as to who provided the alleged assurances and/or on whose behalf the same were provided undermines the pleading as a basis for then asserting the various causes of action.

The movants specifically challenge the legal validity of the First Count. They contend that, due to the impermissible grouping of the named parties under the heading "Defendants" without differentiating among them or identifying which parties undertook which actions, the Complaint fails to state a viable claim for civil conspiracy.

Multiplan further contends that the Plaintiff's claim for civil conspiracy fails as the Complaint does not sufficiently allege that the claimed conspirators committed a tort, which they point out is the essential underpinning of an actionable civil conspiracy. It also asserts there are no facts set forth in the pleading establishing a basis for a claim that it knew of a plan to deprive the Plaintiffs of proper payment or that Multiplan knowingly performed any action(s) in furtherance of such plan. Multiplan asserts the allegations of the Plaintiffs as to the existence of a conspiracy are impermissibly conclusory and that the Court is not required to accept as true such conclusory allegations.

The movants challenge the legal sufficiency of the Eleventh Count alleging violation of the Civil RICO statute. They allege the Plaintiffs have lodged conclusory allegations without adequate factual support. They assert the Plaintiffs lack standing to assert a Civil RICO claim because they did not suffer an injury that was proximately caused by the claimed unlawful conduct. Instead, according to the movants, any injury suffered was the result of the failure of patients to pay the balance owed for the services. They note that federal courts have dismissed Civil RICO claims in similar cases based on failure to establish standing or proximate cause.

The Defendants contend that the Plaintiffs have failed to allege facts establishing the requisite elements of "enterprise" or "pattern of racketeering activity." They assert the allegations of mail or wire fraud are insufficient as they lack the specificity required for allegations of fraud. They contend the Plaintiffs are seeking to fill a round hole with a square peg with the allegations of violations pertaining to theft by deception, deceptive business practices, or misapplication of entrusted property. They argue the facts alleged, even when examined liberally in their favor, do not establish that the Defendants committed any of these predicate acts.

***13** The Aetna and Payor Defendants contend that all of the tort claims lodged against them fail as a matter of law by reason of the economic loss doctrine. They point out that the Plaintiffs allege the existence of an implied contract or contracts as between each of the Plaintiff providers and these Defendants. They assert that, in such circumstances, claims sounding in tort and seeking economic damages are untenable, as the terms and conditions of the parties' contract controls to establish duties, obligations and rights of the contracting parties, as well as the allocation of risk and the measure of damages.

Although these Defendants do not specifically challenge at this time the sufficiency of the claim for breach of implied contract lodged in the Second Count, they seek dismissal of the claim lodged in the Third Count for breach of the implied covenant of good faith and fair dealing. They assert the Complaint fails to allege adequately an improper motive or conduct by them that is different in any way from what they assert is conduct that breached the implied contracts themselves.

All the movants assert that the claim alleging quantum merit is untenable as a matter of law. They contend that the Plaintiff has not alleged with any meaningful specificity that the Plaintiffs conferred any benefit on them the retention of which would

be unjust. They argue that the only beneficiaries of the Plaintiffs' medical services were the patients. Multiplan asserts that, in all events, even presuming some benefit was realized by the co-Defendants, it did not receive any benefit from the services rendered by the Plaintiffs.

The Defendants argue that the claims sounding in fraud and/or negligent misrepresentation are unsustainable as the Complaint fails to plead these causes of action with requisite particularity. They assert that the Complaint does not set forth what false representations were made and/or the "who, when, what and where" facts required to state a viable claim for fraud or misrepresentation. The Payor and Aetna Defendants assert the Complaint fails to allege misrepresentations of fact, but merely asserts, at most, a failure by them to honor promises of future conduct. Multiplan asserts the Plaintiffs have not satisfied the obligation to plead reliance on any conduct of Multiplan, including reliance on its alleged misconduct in holding itself out as an entity that objectively determines the UCR for a medical provider's services.

The movants contend the claim asserting tortious interference fails as the Plaintiffs have not alleged facts establishing the element of malice. They assert that the Complaint merely alleges that the Defendants pursued their own economic self-interests, which is not unlawful.

The Defendants challenges the legal sufficiency of the claim for conversion. They argue that the Plaintiffs are simply alleging an unpaid debt and not the improper exercise of dominion over property in derogation of the Plaintiffs' right to the same. Finally, Multiplan contends the Plaintiffs' claim for negligence is not legally viable as the pleading does not establish a duty of care owed by Multiplan to any of the Plaintiffs.

IV

This Court concludes that, insofar as the Complaint refers to the Payor and Aetna Defendants, it does not indiscriminately or otherwise inappropriately lump together such parties in a manner that prevents them from understanding the conduct they allegedly engaged in or the basis of the claims asserted against them. To the contrary, the Complaint alleges these Defendants either sponsored, controlled, administered, or underwrote the various plans of which the subject patients were members or beneficiaries.

***14** The Complaint asserts that the Aetna Defendants, in their capacities as plan administrators, were agents of the Payor Defendants. It alleges that the Payor Defendants or the Aetna Defendants, acting as agents or as principals, pre-authorized the medical services the Plaintiff performed on an out-of-network basis in relation to the specific patients on the DCL or advised that pre-certification was not necessary. It avers that in each case these entities represented to the relevant Plaintiff that the services would be compensated at a specified percentage of the UCR rates.

The Complaint alleges that the assurances of payment given in respect of the patients named on the DCL (and other patients) established a course of dealing or practice that created an implied contract for payment for medical services based upon specified percentages of the UCR.

The Complaint avers that the Defendants then breached the contract(s) in the cases of the patients identified on the DCL by grossly underpaying the Plaintiff, employing Mutiplan as a means to justify the underpayments through a contrived determination of the UCR. The Complaint asserts that that the Payor and Aetna Defendants acted in concert, along with Multiplan, to grossly underpay the Plaintiffs for the services. According to the Complaint, the Payor and Aetna Defendants accomplished this result by first giving false assurances of payment based on the UCR rates and then engaging Multiplan to perform repricing of the claims. The Complaint alleges that Multiplan, acting for the Aetna Defendants, purported to engage in good faith negotiations of the UCR for various services provided by the Plaintiffs, based on an objective determination of UCR grounded in a proprietary database, but in fact arbitrarily employed targeted reimbursement amounts established by corporate policies of the Payor and Aetna Defendants. Through this process, according to the Complaint, the conspiring Defendants coerced providers into accepting the underpayments. The Complaint alleges that the Payor Defendants then compensated the Aetna Defendants and Multiplan - or enabled them to compensate themselves - based on the levels of underpayment achieved.

The pleading at issue here differs materially from that involved in Four Seasons at North Caldwell Condominium Association, Inc v. K. Hovnanian at North Caldwell III, LLC, 2019 WL 2996574 (N.J. Super. Law Div.), a non-precedential decision (of this Court) on which the Defendants rely for their contention that the pleading impermissibly groups the Defendants together and fails to differentiate among them and thus fails to sufficiently allege facts as to who did what and when. Four Seasons was a construction defect case in which the plaintiff condominium association sued a developer and numerous affiliates within a large corporate organization. The plaintiff alleged that the developer and all members of the corporate family were individually liable for breach of contract, fraud, consumer fraud and negligence, among other claims, even though it was readily apparent that only the developer entered the contracts (for the most part), issued the disclosure statement to unit purchasers and undertook the actual project development work.

Indeed, the complaint at issue in Four Seasons explicitly alleged that the affiliates of the developer entity were vicariously liable for the obligations of the developer on the theory of piercing the corporate veil. The Plaintiff lodged very specific allegations as to the corporate relationships of the entities within the corporate family at issue as a result of a trial in a nearly identical case involving the same group of affiliates that explored such relationships in detail.

***15** It was in this context that the Court found the pleading legally deficient. The Court determined in the circumstances that it was impermissible for the plaintiff to allege that all of the affiliates had engaged in breach of contract, misrepresentation or other tortious conduct without specifically delineating how entities other than the developer itself could also have done so. The Court found in the particular circumstances that a pleading alleging that all such defendants entered into and breached contracts, misrepresented the quality of the construction or failed to ensure proper construction of the project was manifestly unsustainable unless additional facts to such effect were alleged.

In this case, the pleading does allege the role played by the Payor Defendants and the Aetna Defendants in effectuating the claimed underpayments with sufficient specificity to apprise them of the basis of the claims asserted. In contrast to the matters addressed in Four Seasons, the Payor Defendants and the Aetna Defendants are similarly-situated in relation to the allegations of this Complaint. Without a reasonable opportunity for discovery, the Plaintiffs cannot be expected to plead with any greater precision than they have the activities undertaken by specific named Payor or Aetna Defendants.

The Court is aware that the Complaint alleges that the Plaintiffs obtained pre-authorizations or assurances that the same were not required and the payment verifications from individuals who are only partially-named, and without pleading a specific affiliation to a Payor and/or Aetna Defendant. But it is readily apparent that the Plaintiffs allege these individuals were acting directly for or on behalf of one of the Payor Defendants and/or the Aetna Defendants and in the latter case, as either a principal (i.e., an insurer) of the relevant plan or as an agent of the plan sponsor. The Plaintiffs are entitled in the circumstances to develop a more complete identification of the individuals and their affiliations via discovery.

The Court concludes the pleading adequately identifies the factual predicates for the claims stated. It sufficiently informs the Aetna and Payor Defendants of the actions allegedly undertaken by them or for which they may bear legal responsibility that form the essential underpinning of the various legal theories pleaded by the Plaintiffs. (As discussed infra, the Court reaches a somewhat different conclusion as to Multiplan).

The Court determines that it is not appropriate to address the applicability vel non of the economic loss doctrine on a motion to dismiss. Although it is true that the Plaintiffs assert the existence of implied contracts as between themselves and the Aetna and Payor Defendants, it is also true that the latter dispute the existence of such contracts. In such circumstances, the Plaintiffs are, at minimum, entitled to plead tort theories in the alternative. Moreover, without a completed record following opportunity for discovery, it is not possible to determine whether any or all of the tort theories lodged by the Plaintiffs are predicated on independent duties assumed or undertaken by the movants such that claims sounding in tort would co-exist with breach of contract claims.

The Court finds that, contrary to the contentions of the Payor and Aetna Defendants, the Plaintiffs have pleaded facts that would establish not only a breach of the alleged implied contracts that they and the Payor and Aetna Defendants allegedly entered, but also a breach of the implied covenant of good faith and fair dealing that would perforce exist in such contracts. The Complaint alleges the adoption by the Payor and Aetna Defendants of a practice of repricing the Plaintiffs' claims for reimbursement using a means that was intended to appear to be independent and legitimate, but that in actuality enabled the pricing to be predicated on targeted amounts substantially below market rates. The alleged purpose of the practice was to

deprive the Plaintiffs of market derived rates of compensation promised to them by the Payor and Aetna Defendants. Such facts would establish an improper motive, an effort to deprive the Plaintiffs of the benefit of their alleged bargain and discretionary conduct by the Payor and Aetna Defendants in the implementation of the parties' agreements that was arbitrary and capricious.

***16** The Plaintiffs have pleaded sufficient facts to establish a viable claim for civil conspiracy as against the Payor and Aetna Defendants, as well as Multiplan. As the parties agree, an actionable civil conspiracy arises from an agreement to perform an unlawful act or a lawful act by unlawful means. Banco Popular N. Am. v. Gandi, 181 N.J. 164, 177 (2005). It is not an independent cause of action, but a means by which to hold multiple parties accountable in damages for participating jointly in an underlying tort. The participants must be aware of and share in the essential objectives of the alleged conspiracy and undertake some act to advance the same. "It is enough [for liability] if you understand the general objectives of the scheme, accept them, and agree, either explicitly or implicitly, to do your part to further them." Ibid. (internal quotation marks omitted).

Here, the Complaint alleges that all Defendants, including Multiplan, knew of the authorizations and assurances of payment given to the Plaintiffs for the medical services and participated in a scheme to underpay the Plaintiff via the re-pricing activities of Multiplan. The Complaint alleges that the Payor and Aetna Defendants adopted Multiplan's determinations of UCR, knowing the same were not the product of objective analysis as represented, but of arbitrary assignments of UCR amounts in order to keep the payments under a predetermined target amount. The Complaint avers that the Payor Defendants compensated the Aetna Defendants and Multiplan through commissions, characterized by the Plaintiffs as kickbacks, in the form of increasing portions of the savings achieved.

The Complaint alleges the ultimate purpose of the concerted action among the Defendants was to undermine the ability of out-of-network providers to provide services to plan beneficiaries and force the latter to refrain from using such providers. It asserts this practice is at odds with the fact that the Payor Defendants charged and accepted additional premiums for affording the beneficiaries the right to engage out-of-network providers in certain circumstances.

The Complaint adequately alleges that the participants in the conspiracy were aware of this objective of the undertaking and subscribed to the same. It sets forth a specific division of labor among the Payor Defendants, the Aetna Defendants and Multiplan, as well as the respective roles performed and the overt acts undertaken by each of them in connection with the concerted effort to reduce the payments to the Plaintiffs.

The Payor Defendants point out that certain allegations of the Complaint appear to allege that the Aetna Defendants and Multiplan undertook actions without the knowledge or assent of the Payor Defendants, having falsely assured the latter that their repricing methods would not result in balance billing of patients. Certain averments suggest that the Aetna Defendants misappropriated to themselves funds of the plans sponsored by the Payor Defendants for purposes of paying their commissions or kickbacks.

It is possible to read certain allegations of the Complaint to allege that the Payor Defendants were not aware of the activities of the Aetna Defendants and Multiplan in relation to their repricing of provider claims for reimbursement and/or that the Aetna Defendants advised that the repricing activities of Multiplan would be undertaken in a manner as to avoid balance billing of patients and subscribers to the Payor Defendants' health care plans. However, other allegations establish a basis for contending that the Payor Defendants knowingly participated in a conspiracy to wrongfully underpay the Plaintiffs for their services. Not only do the Plaintiffs allege that the Aetna Defendants were agents of the Payor Defendants acting with authority in relation to repricing, but the Complaint, read (as it must be) generously in favor of the Plaintiffs, asserts the Payor Defendants knew of, assented to and participated in a plan to significantly reduce payments for the Plaintiffs' services by engaging Multiplan to employ its DiS methodology as a basis for repricing the services at rates far below the promised percentage of UCR. And, according to the Complaint, this occurred by cloaking such repricing process falsely in the mantle of an objectively based, data driven determination of UCR.

***17** Whether the Plaintiffs can or will prove these allegations is, of course, not a matter that the Court can or must determine at this juncture. But examination of the Complaint, particularly under the liberal standard of Printing Mart, belies the contention that the pleading does not sufficiently allege a civil conspiracy because it impermissibly lumps together the Defendants without identifying the conduct undertaken by each of them to support the claims asserted against them. Insofar

as the claim of a civil conspiracy is concerned, this assertion overlooks the various allegations that establish the requisites for a claim sounding in civil conspiracy - the claimed orchestration of the same by the Payor and Aetna Defendants, the assurances of payment allegedly given to the Plaintiffs by representatives of the Payor and Aetna Defendants with an intention not to honor the same, and the use of the repricing process performed by Multiplan as a means of effecting a gross underpayment under the guise of a proper determination of the UCR. Such averments establish both an underlying tort and a knowing agreement of the Defendants to participate in committing it.

The Payor and Aetna Defendants contend that the Plaintiffs have failed to state a viable claim against them sounding in quantum meruit. A claim for quantum meruit hinges on allegations that the Plaintiffs performed a service for the Defendants for which they reasonably expected remuneration.

The Aetna and Payor Defendants contend that such a claim requires the Plaintiffs to plead (and prove) that they conferred a benefit on the Plaintiffs and the Defendants would be unjustly enriched if the Plaintiffs were not remunerated. They assert that the Plaintiffs have failed to plead facts establishing such a benefit and contend they cannot do so, as the medical services they provided inured solely to the benefit of the various patients and not the Payor and Aetna Defendants. The Plaintiffs rejoin that these elements are applicable only to clams for unjust enrichment; that they have asserted claims sounding in quantum meruit only; and they have adequately alleged facts establishing the elements of this claim.

It is certainly true that many courts in New Jersey and elsewhere have discussed quantum meruit and unjust enrichment interchangeably or as in essence two sides of the same coin with similar if not identical elements. However, this Court does not understand the claim for quantum meruit to necessarily require the pleading of a benefit conferred on the defendant, save to the extent that the performance of a service for which a plaintiff reasonably expected remuneration certainly may be viewed as such a benefit. But it is also not necessary at this stage of the case for the Court to delve deeply into such matters in the context of this case, as the Plaintiffs have, in all events, pleaded facts that establish such a benefit.

The Court finds the benefit conferred on the Payor and Aetna Defendants was the satisfaction or discharge of the obligations of the respective plan sponsors or insurers to cover the patient participants for out-of-network services. Absent the willingness of providers such as the Plaintiffs to provide services to patients on an out-of-network basis (with the concomitant risk of disputes over payment such as occurred here), the Payor Defendants and their administrative agents would not be in a position to satisfy their contractual obligations to afford their members with access to such services for which commitment they received (according to the Complaint) additional premiums. See, e. g., Plastic Surgery Center, PA. v. Aetna Life Insurance Co., 967 F. 3d 218, 241 n. 26 (3d Cir.2020); El Paso Healthcare Sys. v. Molina Healthcare of N. M., Inc., 683 F. Supp. 2nd 454, 461 (W.D. Tex. 2016).

The Payor and Aetna Defendants contend the claims asserted for fraud and negligent misrepresentation fail as the Plaintiffs have failed to plead facts supporting such claims with the requisite particularity as required by R.4:5-8. They contend the allegations of fraud are unsustainable as an (alleged) promise of future payment cannot constitute an actionable fraud.

***18** A claim for fraud or misrepresentation requires allegations of misrepresentation of fact or omission of material information, together with reliance. To establish common-law fraud, a plaintiff must prove: (1) a material misrepresentation of a presently existing or past fact; (2) knowledge or belief by the defendant of its falsity; (3) an intention that the other person rely on it; (4) reasonable reliance thereon by the other person; and (5) resulting damages. Gennari v. Weichert Co. Realtors, 148 N.J. 582, 610 (1997).

The Court finds the Plaintiffs have alleged fraud or misrepresentation as to the Payor and Aetna Defendants with the required particularity. The pleading provides sufficient factual detail to enable these Defendants to understand the nature of the claim for fraud and/or negligent misrepresentation lodged against them.

The Complaint alleges specifically that, as to each of the Patients listed on the DCL, a representative of the Payor and Aetna Defendants gave specific assurances that the relevant Plaintiff would be paid for the services to be provided on the basis of UCR rates. The Complaint provides the date and content of the assurance and partially identifies the individual who provided it. No more can reasonably be expected of the Plaintiffs in the circumstances. Although the New Jersey Rule does impose a heightened standard of pleading in a case alleging fraud or misrepresentation, it also requires more specific pleading where practicable. The Court finds the pleading here satisfies this requirement to the extent practicable.

The Complaint, read liberally in favor of the Plaintiffs, alleges that the Payor and Aetna Defendants assured the Plaintiffs of payment at UCR rates with a present intention not to fulfill that assurance. Indeed, the Complaint alleges that these parties had in place an elaborate scheme to deny the Plaintiffs payment at the UCR rates promised while making it appear they were paying on the basis of an objectively derived determination of UCR in each instance. The Plaintiffs satisfy the reliance element by pleading that they provided the services based on the assurances of payment at UCR rates that they assert they received.

Whether or not they are able to prove such claims is, of course, for another day. But the Complaint adequately sates viable claims for fraud and/or negligent representation as to the Payor and Aetna Defendants.

The Payor and Aetna Defendants contend the claim for tortious inference with prospective advantage fails as the Plaintiffs have not sufficiently alleged the element of malice. They assert a cause for tortious interference is untenable in circumstances in which the alleged tortfeasor(s) was/were simply pursuing its/their own economic self-interest. They assert this is precisely what they were doing in relation to the handling of the Plaintiffs' claims for payment.

A claim for tortious interference with prospective economic advantage arises when the plaintiff has a reasonable prospect of economic advantage with which the defendant knowingly and maliciously interfered, proximately resulting in damages. Printing Mart, 116 N.J. at 750. The element of malice is not limited to actual ill will, but it is established by conduct undertaken without justification.

The Complaint adequately states facts that, if proved, would establish a claim for tortious interference with prospective economic advantage. The Plaintiffs assert the existence of an elaborate scheme among the Defendants to deprive the Plaintiffs of promised payment for medical services. The Complaint alleges the repricing program the Payor and Aetna Defendants put in place with the assistance of Multiplan has as its principal purpose facilitating a substantial reduction in the amounts paid for the services while falsely presenting the process of repricing as producing an objectively derived determination of the UCR rates. The Complaint alleges the DiS method of pricing the services the parties employed was designed to achieve or justify a targeted price for services that would at once be substantially lower than the UCR rate, but that would be presented to the provider as representing the result of a valid, data driven ascertainment of the UCR rate.

***19** The Complaint alleges the Defendants engaged in this contrived process either after having promised to compensate at the UCR rates - in the case of the Payor and Aetna Defendants - or with the knowledge that such assurances had been given - in the case of Multiplan. An alleged purpose of the conduct was to discourage patients from employing out-of-network providers such as the Plaintiffs even though their health care benefits plans permitted them to do so in appropriate cases.

The law of tortious interference with prospective economic advantage requires commercial parties to operate in the marketplace according to a reasonable code of conduct that assures good faith and fair dealing and a level playing field for commercial intercourse. The allegations of the Complaint, if proved, would establish that the Defendants did not merely seek to advance or promote their own economic interests with the repricing program they undertook, but knowingly operated outside the rules of the road to the detriment of the Plaintiffs.

As noted, the Aetna Defendants challenge the viability of claim sounding in conversion lodged in the Tenth Count of the Complaint. They assert the facts alleged by the Plaintiffs amount, at most, to a dispute between a creditor and an alleged debtor over payment of a commercial debt. They contend the Plaintiffs have improperly attempted to shoehorn such facts into the elements for the tort of conversion.

Conversion is the unlawful exercise of dominion over the property of another without a claim of right. Commercial Insurance Co. of Newark v. Apgar, 376 N. J. Super. 153 (App. Div. 2005). The allegations of the Complaint, examined through a lens that favors the Plaintiffs, establishes a relationship between them and the Aetna Defendants that could permit a conclusion that the withholding of promised payments by the latter constituted a conversion of funds in which the Plaintiff had a property right.

The Complaint avers that the Aetna Defendants, with the knowledge and assent of the Payor Defendants, assured the Plaintiffs of payment from the various health care plans covering the medical expenses of the Patients listed on the DCL at

the UCR rates for the services provided. It avers that, by a contrived process of repricing the Plaintiffs' legitimate claims for reimbursement, the Aetna Defendants used the funds of the various health plans they would have paid to the Plaintiffs to compensate themselves and/or Multiplan for the alleged savings they had achieved via such repricing. Such averments set forth the "fundament" of a cause of action for conversion based on the claim of a property right in the funds wrongfully retained by the Aetna Defendants. Printing Mart, 116 N.J. 739, 746.

Turning to the assertion of Multiplan that the Complaint improperly lumps them together with the Payor and Aetna Defendants, the Court arrives at a somewhat different conclusion than it did in relation to the same contentions of the latter. It is true that the Complaint contains many averments against the "Defendants" collectively when it is readily apparent, based on the alleged role of Multiplan in the matters that issue, that Multiplan did not undertake and could not have undertaken or participated in the conduct. In this respect, the Complaint does impermissibly conflate various Defendants in a manner akin to the pleading deficiencies identified in Four Seasons.

Most glaringly, although the Second and Third Counts of the Amended Complaint state in the headings that the Count asserts contract related claims against the Payor and Aetna Defendants only, the specific allegations of these Counts tell a different story. Paragraph 126 alleges the Defendants - defined elsewhere in the Complaint to include Multiplan - "indicated by a course of conduct, course of dealings, industry custom, and the circumstances surrounding the relationship, to Plaintiffs that defendants would properly pay for surgical and medical services provided." Paragraph 127 alleges that the "defendants represented that payment for pre-authorized services would be made regardless of Plaintiffs' out-of-network status, and/or that pre-authorization is not required when Plaintiff renders [SIC] emergent medical services." Paragraph 128 avers that the "defendants" were "paid additional sums by the Patients for access to out-of-network providers, and the services of Plaintiffs were necessary to satisfy the surgical and medical needs of defendants' insureds." Both the Second and Third Counts set forth a prayer for relief for breach of contract against all Defendants.

***20** Such allegations and claims are thus fundamentally at odds with the factual averments concerning the role of Multiplan in relation to the matters at issue. Although the Complaint alleges that Multiplan was aware of the pre-authorizations given to the Plaintiffs, it is readily apparent from examination of the Complaint that Multiplan did not itself provide the pre-authorizations. Nor did it represent that payment would be made regardless of the patients' out-of-network status, receive premiums, or insure the patients.

Indeed, Multiplan was not involved in the relationship among the parties until after the services were provided and the alleged implied contract was already formed. Presumably, this explains why the Plaintiffs state in the headings of the Second and Third Counts that only the Payor and Aetna Defendants are the targets of such Counts, even if the same can be read to state otherwise.

The Court accepts that the Complaint does not actually lodge a claim for breach of contract or breach of the implied covenant of good faith and fair dealing against Multiplan as a result of the headings to the Counts inserted by the Plaintiffs. But the lack of differentiation among the Payor and Aetna Defendants, on the one hand, and Multiplan, on the other hand, does appear to the Court to result in certain claims being asserted against Multiplan that are not tenable, at least on the facts currently alleged. In this regard, the Court notes that, during this motion practice and following the rendering of a decision of this Court in another case involving similar claims to those advanced here, the Plaintiffs advised the Court they were withdrawing, without prejudice, the claims against Multiplan asserting quantum meruit, negligent misrepresentation, and conversion. As a result, the Court need not address the arguments of the parties as to these claims in relation to Multiplan.

Although the Plaintiffs have withdrawn their claim for negligent misrepresentation as against Multiplan, they press the claim for fraud interposed in the Seventh Count. They continue to assert as to Multiplan the claims lodged in the Complaint sounding in negligence and tortious interference asserted in the Eighth and Ninth Counts.

The Court finds the claim for fraud asserted by the Plaintiffs assist Multiplan is legally deficient. The essential misrepresentations on which the Plaintiffs' claim is predicated are the pre-authorization/assurances that such pre-authorizations were not required and the assurances of payment according to the UCR given to the Plaintiffs prior to performing the medical services for each patient listed on the DCL. Based on the facts presently alleged, Multiplan did not participate in such assurances. Indeed, its alleged role in the claimed underpayments did not even occur until after the assurances of payment had already been given.

One can certainly also read the Complaint to assert that Multiplan misrepresented to the public and to providers in general the nature and purpose of its services and function by falsely stating that its repricing services were based on an objective assessment of the UCR rates for the various components of services provided by providers such as the Plaintiffs. But even granting that Multiplan offered such representations to the Plaintiffs - as opposed to the Payor and Aetna Defendants - the repricing services provided by Multiplan followed, as noted, the alleged assurances of full payment undertaken by the representatives of the Payor and/or Aetna Defendants and the performance of medical care by the Plaintiffs. Given the sequence of events as detailed in the Complaint, it is difficult, without more, to conceive of how the Plaintiffs relied on the claimed misrepresentations by Multiplan in undertaking to perform the services for the patients. The present Complaint simply does not provide facts establishing a basis for a determination of reliance by the Plaintiffs on any claimed misrepresentations by Multiplan.

***21** The Court finds that, on the facts as presently alleged, Multiplan participated with the Payor and Aetna Defendants in a conspiracy to perpetrate a fraud on the Plaintiffs, by undertaking its repricing services with the intention of generating results that artificially reduced the payments for their services, while knowing that higher payments based on UCR rates were promised to them. But the facts pleaded in the Complaint do not establish that Multiplan itself independently committed the fraud asserted by the Plaintiffs.

The Court agrees with the Plaintiffs that the Complaint asserts a viable claim for tortious interference with prospective advantage. Here, the Complaint alleges that Multiplan joined a scheme to deprive the Plaintiffs of the full economic benefit of their medical services rendered to the patients by fraudulently re-pricing the reimbursement claims of the Plaintiffs for the benefit of both the Payor and Aetna Defendants and Multiplan. Put differently, according to the Complaint, the Plaintiffs allege that Multiplan knowingly and wrongfully supplied the specific means and method by which the Payor and Aetna Defendants achieved and legitimized substantial underpayments. Such averments establish conduct undertaken not merely in the exercise of economic self-interest by Multiplan, but an intentional interference with expected economic benefits without justification.

The Court finds that the Plaintiffs have alleged sufficient facts to state viable claims against Multiplan for negligence, alleged in the Eighth Count. The Complaint asserts facts that, if proved, could support a conclusion that Multiplan assumed a duty of reasonable care as to the Plaintiffs. By undertaking, allegedly under false pretenses, to reprice the reimbursement claims of the Plaintiffs and support the payment determinations of the Payor and Aetna Defendants, while knowing that the latter had promised the Plaintiffs reimbursements at UCR rates, one could conclude in the circumstances that Multiplan assumed a duty to perform such repricing based on an accurate, objective determination of UCR, but failed actually to do so.

This leaves the claims asserted by the Plaintiffs as to the Aetna Defendants and Multiplan under the Civil RICO statute asserted in the Eleventh Count. The gravamen of a Civil RICO statute violation is involvement in the affairs of an "enterprise" through a "pattern of racketeering activity." Specifically, the RICO statute provides:

> c. It shall be unlawful for any person employed by or associated with any enterprise engaged in or activities of which affect trade or commerce to conduct or participate, directly or indirectly, in the conduct of the enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.
>
> d. It shall be unlawful for any person to conspire as defined in N.J.S. 2C:5-2, to violate any of the provisions of this section.
>
> [N.J.S.A. 2C:41-2]

The statute affords a civil remedy for treble damages, attorneys' fees and costs of suit to anyone damaged in his business or property by reason of a violation of the foregoing provisions. N.J.S.A. 2C:41-4(c).

It is apparent form this text, that to state a viable claim for civil relief under the statute, a plaintiff must establish (1) conduct; (2) of an enterprise; (3) through a pattern; (4) of racketeering activity. As a claim under the Civil RICO statute sounds in fraud, the plaintiff must plead the elements with particularity pursuant to R. 4:5-8.

The statute provides a definition of the term "enterprise" as follows:

> ***22** c. "Enterprise" includes any individual, sole proprietorship, partnership, corporation, business or charitable trust, association, or other legal entity, any union or group of individuals associated in fact although not a legal entity, and it includes illicit as well as licit enterprises and governmental as well as other entities.
>
> [N.J.S.A. 2C:41-1(c)]

A "pattern of racketeering activity," according to N.J.S.A. 2C:41-1(d), requires:

> (1) Engaging in at least two incidents of racketeering conduct one of which shall have occurred after the effective date of this act and the last of which shall have occurred within 10 years (excluding any period of imprisonment) after a prior incident of racketeering activity; and
>
> (2) A showing that the incidents of racketeering activity embrace criminal conduct that has either the same or similar purposes, results, participants or victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.
>
> [N.J.S.A. 2C:41-1(d)]

In State v. Ball, 141 N.J. 142 (1995), the Supreme Court discussed at considerable length the proof requirements for a case brought under the New Jersey RICO statute, including the requirements for establishing an "enterprise" and a "pattern of racketeering activity." The case involved a criminal prosecution against a number of participants in an alleged scheme to facilitate dumping of solid waste generated in New York at unauthorized sites in New Jersey. Although the case arose from a criminal prosecution under the New Jersey RICO statute, the Court finds the Supreme Court's discussion of the statutory elements to be of relevance in the circumstances here involving, of course, a private civil action.

Among other rulings, the Supreme Court affirmed the conviction, concluding that the trial court had properly instructed the jury on the standards for finding that there was a pattern of racketeering activity and that the defendants participated in the unlawful activities of an enterprise. The court also found the evidence supported the jury's finding as to each of the elements. At the same time, however, the Supreme Court's reasoning as to the statutory requisites for a "pattern of racketeering activity" differed from that of the Appellate Division.

The court concluded that the New Jersey definition "descends from the briefer federal definition of 'pattern of racketeering activity.'" Id. at 163. It pointed out that in Sedima v. Imrex Co., 473 U.S. 479 (1985), the United States Supreme Court had noted in a footnote that the definition of "pattern of racketeering activity" differs from the other definitions of the federal RICO statute "in that it states that a pattern *requires* at least two predicate acts, not that it *means* two such acts." Ibid. (citing Sedima, 473 U.S. at 496 n.14) (emphasis in original). The Ball court stated that "[o]bserving that two of anything rarely forms a 'pattern,' the [Sedima] Court stated that the statute implied that although two acts are necessary, they may not be sufficient." Id. at 164.

The Ball court then acknowledged that, in H.J. Inc. v. Northwestern Bell Tel. Co., 492 U.S. 229 (1989), the Supreme Court had determined that the statutory definition of "pattern of racketeering activity," by using the term "requires," placed a broad "outer limit" on the concept of two predicate acts. Ibid. (citing H.J. Inc., 492 U.S. at 237). The Ball court noted that "[f]rom the legislative history, the [H.J. Inc.] Court deduced that '"[i]t is th[e] factor *of continuity plus relationship* which combines to produce a pattern."' Ibid. (quoting H.J. Inc., 492 U.S. at 239 (quoting 116 Cong. Rec., at 18940 (1970)) (emphasis in original). Thus, according to H.J. Inc., "proof of a pattern required a showing that the predicate acts 'are related, *and* that they amount to or pose a threat of continued criminal activity.'" Ball, 141 N.J. at 164 (quoting H.J. Inc., 492 U.S. at 239) (emphasis in original).

***23** The Ball court noted that, under H.J. Inc., the relatedness requirement covers "'criminal acts that have the same or

similar purposes, results, participants, victims, or methods of commission, or otherwise are interrelated by distinguishing characteristics and are not isolated events.'" Ibid. (quoting H.J. Inc., 492 U.S. at 240 (quoting and deriving its definition from the Dangerous Special Offender Act, 18 U.S.C.A. § 3575(e), enacted in conjunction with RICO)). "Continuity," according to the H.J. Inc. court, is "both a closed- and open-ended concept, referring either to a closed period of repeated conduct, or to past conduct that by its nature projects into the future with a threat of repetition. It is, in either case, centrally a temporal concept." Id. at 241-42, (citation omitted). The Ball court noted that the H.J. Inc. court had concluded that, although relatedness and continuity make up two distinct prongs of the "pattern" requirement, proof of the two "'will often overlap.'" Ball, 141 N.J. at 164 (quoting H.J. Inc., 492 U.S. at 239).

The Ball court observed that "New Jersey is the only state that provides that the pattern consists of at least two 'incidents,' as opposed to 'acts.'" Id. at 165-166. It found that the statute "also *requires* that at least two of the 'incidents' of racketeering be related to each other." Id. at 166 (emphasis in original).

In ascertaining the meaning of "pattern of racketeering activity," the Appellate Division had concluded that the New Jersey statute required relatedness but not continuity. Ibid. It had determined that "'to establish a 'pattern[,]' it need * * * be shown [only that] the predicate acts are related. It is not necessary to show continuity as required under Federal RICO.'" Ibid. (quoting State v. Ball, 268 N.J. Super. 72, 144 (App. Div. 1993)). The Supreme Court noted that, in reaching that conclusion, the Appellate Division "found explicit support in the statute itself for the relatedness requirement, *see* N.J.S.A. 2C:41-1d(2), but none for a requirement of continuity." Ibid.

The Supreme Court stated that the Appellate Division "reasonably found in the statute and its legislative history an intent on the part of the Legislature not to require 'continuity' as an element of 'pattern of racketeering activity,' at least not in any strong or distinctive sense of the term." Id. at 167. However, the Supreme Court determined that "'continuity' is [not] irrelevant to demonstrating a 'pattern of racketeering activity.'" Ibid. Instead, "in discussing the definition of 'pattern of racketeering activity,' the Assembly Committee observed that the new version 'substituted "incident" for "act" because "act" is a somewhat restrictive term ... whereas an incident more aptly represents--a circumstance or happening.'" Ibid. (quoting Committee Meeting at 7). The court inferred from the "preference" for the word "incident," with its perceived meaning of "happening" or "circumstance," that "the Legislature intended to cover a broader spectrum of behavior than is connoted by 'act.'" Ibid. "The pattern of racketeering activity and the activity criminalized under RICO should be, or threaten to be, ongoing." Ibid.

The court also determined that "the Legislature expressed its clear concern that the underlying incidents not be isolated events." Ibid. It found that "Chairman Herman remarked that criminal activity may have 'interruptions' without thereby defeating the 'pattern' element." Ibid. It noted that "[a] member of the Committee also commented that criminal activity 'doesn't have to be continuous, in other words. You can have interruptions.'" Ibid. Thus, according to the court, "the Committee recognized that there had to be some 'connective tissue among criminal incidents,' but that it need not be continuous in the sense of completely uninterrupted as long as the incidents are not isolated or disconnected." Ibid.

***24** The court concluded that "RICO was not designed to punish mere repeated offenses." Ibid. It found that "the Deputy Attorney General acknowledged that to be consistent with the Legislature's declaration of purpose the pattern must be more than just a string of two or more similarly-committed crimes." Id. at 167-168. It reasoned that "our statute expressly enjoins use of the RICO statute to cover isolated criminal incidents. N.J.S.A. 2C:41-1d(2)." Id. at 168. Accordingly, "'continuity,' understood as an antonym of the terms 'isolated' or 'sporadic,' points to 'incidents of criminal conduct' that exhibit some ongoing connection." Ibid. The court stated that it agreed with an amicus party "that the statute itself implies some ongoing connection or continuity also in its express specification that 'incidents of racketeering activity embrace criminal conduct that [is] ... otherwise *interrelated by* distinguishing characteristics ..." Ibid. (quoting amicus brief that was quoting N.J.S.A. 2C:41-1d(2)) (emphasis in original).

The court concluded that "some degree of continuity, or threat of continuity, is required and is inherent in the 'relatedness' element of the 'pattern of racketeering activity.'" Ibid. It stated that "[a]lthough we do not require 'continuity' as a distinctive subelement of 'pattern,' we find sound and persuasive the reasoning of those courts that use a 'totality of the circumstances' approach in applying the federal 'continuity plus relationship' test for determining the existence of a pattern of racketeering activity." Ibid.

The court next found that "the factor of 'continuity,' as acknowledged by the Supreme Court in H.J. Inc., may itself be established by evidence that overlaps the evidence establishing 'relatedness.'" Ibid. (citing H.J. Inc., 492 U.S. at 239). Citing to United States v. Zauber, 857 F. 2d 137, 149 (3d Cir. 1988), cert. denied, 489 U.S. 1066, (1989), the Ball court identified the factors to be examined in determining relatedness/continuity as follows:

> [a] combination of specific factors, "such as the number of unlawful acts, the length of time over which the acts were committed, the similarity of the acts, the number of victims, the number of perpetrators, and the character of the unlawful activity" could be considered in determining whether a pattern existed.
>
> [Id. at 168-169 (quoting Zauber, 857 F.2d at 149 (quoting and applying holding of Barticheck v. Fidelity Union Bank, 832 F.2d 36, 39 (3d Cir. 1987)).]

The court determined that "[a]n understanding of 'relatedness' based on a totality of circumstances is compatible with the statutory definition that enumerates several factors--purposes, results, participants, victims and methods and other characteristics--that may combine or be 'otherwise interrelated' to establish a pattern from the 'incidents of racketeering activity' that in any event may not be 'isolated.' N.J.S.A. 2C:41-1d(2)." Id. at 169.

The court observed that "[i]n the most likely setting, predicate incidents of racketeering conduct will occur sequentially over a period of time." Ibid. It found that "New Jersey's legislative discussions, unlike Congress', do not indicate a concern for reaching only long-term criminal activity." Ibid. But it determined that "short-term criminal activity, to be covered, must encompass incidents of criminal conduct that are not disconnected or isolated." Ibid. Indeed, "[i]ncidents of racketeering that occur sequentially, to overcome any inference that they are totally disconnected or isolated, must exhibit some temporal connection or continuity over time." Ibid.

Based on this analysis, the court held that "the primary criterion of New Jersey's 'pattern of racketeering activity' is 'relatedness.'" Ibid. That criterion "calls for the application of a broad standard involving the totality of all relevant circumstances, which may include 'continuity.'" Ibid.

The court also engaged in a similar disquisition as to the requirements for establishing the element of "enterprise." It made clear that, among the factors to be considered in determining if there was an unlawful "enterprise" is the frequency with which the association engaged in incidents or committed acts of racketeering activity. Id. at 162-163.

***25** The court pointed out that "the RICO statute itself in using the term 'enterprise' contains no express or implied requirement for a distinct ascertainable structure; rather, it is framed broadly to include any group of persons 'associated in fact.'" Id. at 160. It noted that "the legislative history shows that the term 'enterprise' was meant to be construed broadly." Id. at 161. It concluded that "[t]he drafters intended New Jersey RICO to encompass more than traditional organized-crime families, which commonly contain an internal command system or structure." Ibid. Instead, "the Legislature intended its statute to reach less organized and non-traditional criminal elements as well." Ibid. It found that the United States Supreme Court's discussion of enterprise in United States v. Turkette, 452 U.S. 576 (1981), "refers to organization, not structure, and fairly understood, required only an informal organization functioning as a continuing unit." Ibid.

The Ball court held that "under the RICO Act 'enterprise' is an element separate from the 'pattern of racketeering activity,' and that the State must prove the existence of both in order to establish a RICO violation." Id. at 161-162. It determined that the enterprise "is the association, and the pattern of racketeering activity consists of the predicate incidents." Id. at 162. It acknowledged that "evidence that serves to establish such an enterprise need not be distinct or different from the proof that establishes the pattern of racketeering activity." Ibid.

The court further held that "because the enterprise is distinct from the incidents constituting the pattern of activity, it must have an 'organization.'" Ibid. It found that the organization of an enterprise "need not feature an ascertainable structure or a structure with a particular configuration." Ibid. Instead, "[t]he hallmark of an enterprise's organization consists rather in those kinds of interactions that become necessary when a group, to accomplish its goal, divides among its members the tasks that are necessary to achieve a common purpose." Ibid.

The court reasoned that "[t]he division of labor and the separation of functions undertaken by the participants serve as the distinguishing marks of the 'enterprise' because when a group does so divide and assemble its labors in order to accomplish its criminal purposes, it must necessarily engage in a high degree of planning, cooperation and coordination, and thus, in effect, constitute itself as an 'organization.'" Ibid. The court determined that "[a]part from an organization's structure as such," the "focus" of the evidence "must be on the number of people involved and their knowledge of the objectives of their association, how the participants associated with each other, whether the participants each performed discrete roles in carrying out the scheme, the level of planning involved, how decisions were made, the coordination involved in implementing decisions, **and how frequently the group engaged in incidents or committed acts of racketeering activity,** and the length of time between them." Id. at 162-163 (emphasis added).

There can be no question that the Eleventh Count of the Complaint, viewed in isolation, is highly conclusory and does not, of itself, even remotely satisfy the pleading requirements for lodging a Civil Rico claim. But Printing Mart requires this Court to examine the pleading as a whole and rigorously in order to determine if the Plaintiffs have stated a viable claim. When the Court undertakes this exercise, as required, it finds the Plaintiffs have alleged facts that establish the required elements of a claim under the Civil Rico statute.

The facts alleged establish the existence of an "enterprise" as contemplated by the statute. As the discussion in Ball makes clear, an enterprise consists of an organization and a division of labor among participants seeking a common end, but this element does not require a specific structure. The Ball court made equally clear that, in considering whether a party has established the separate element of an "enterprise", a significant factor the Court must examine is how frequently the group engaged in acts of racketeering.

***26** Here, the Plaintiffs have pleaded facts that the Aetna Defendants and Multiplan established an enterprise - a joint, organized undertaking toward a common end, the repricing of the Plaintiffs' claims for reimbursements for medical services performed for Patients on the DCL List in a manner as to substantially and systematically reduce the payments well below UCR, while employing a methodology that would be represented as ascertaining UCR by reference to and employment of a valid and tested database of payments for medical services performed in the marketplace for such services. The Complaint alleges the parties employed their highly organized effort to limit provider reimbursement on multiple occasions, resulting as discussed further infra in numerous predicate acts. The pleading alleges that the participants in the enterprise benefitted from by their actions by sharing as putative commissions increasing percentages of the savings realized from reducing the amounts actually paid to resolve the reimbursement claims compared to the amounts sought by the Plaintiffs.

The Complaint establishes a division of labor among the participants to achieve the common objective. According to the Complaint, the actions undertaken by the participants directing the enterprise involved assurances given to the Plaintiffs of payment for services according to UCR rates, thus inducing the providers to provide medical services to the patients whose care is covered or insured by one of the plans sponsored by the Payor Defendants and/or insured or administered by the Aetna Defendants. Aetna provided these assurances and thereafter received and processed the resulting reimbursement claims.

At this point, according to the Complaint, Multiplan stepped in and employed its DiS methodology to reprice the reimbursement claims. The result, according to the Plaintiffs was a gross underpayment presented as the product of analysis of UCR undertaken by Multiplan via reference to a comprehensive database of payments for comparable services, but that was in reality a wholly contrived procedure intended to legitimize a payment determination at or below a targeted amount established by the Aetna or Payor Defendants. Multiplan also conducted, so the Plaintiffs claim, a bogus negotiation process when necessary to enable the end result to be represented as agreed between the provider and Aetna.

According to the Complaint, the Aetna Defendants and Multiplan thus carried out their scheme on multiple occasions over time with or through the active participation of both of them, carrying out separately delineated functions contributing to a common end. The Complaint adequately alleges that the Aetna Defendants and Multiplan conducted the enterprise jointly through the actions ascribed to them.

The Complaint, examined in its entirety and through a lens that favors the Plaintiffs, establishes multiple acts of wire and/or mail fraud committed in furtherance of the scheme. To establish wire and/or mail fraud. the plaintiff must show (1) a scheme

to defraud, (2) the use of the mails or wires to further the scheme, and (3) the specific intent to defraud.

Here, the facts alleged are sufficient to establish such a scheme implemented through the use of telephonic communications between the Plaintiffs and representatives of the Aetna or Payor Defendants. The Complaint alleges multiple acts of fraudulent assurances given by the latter that they would remit payment to the Plaintiffs for medical services to be rendered by these providers to insureds/subscribers of the medical plans of the Payor Defendants, in each case according to UCR rates.

The Complaint avers that the Aetna and Payor Defendants provided these assurances with the intention of never paying according to such promised rates, but of subjecting the resulting reimbursement claims to review according to the repricing methodology made available by Multiplan and of vastly understating the UCR charge for the services, resulting in payments to the Plaintiffs of cents on the dollar compared to what was due under a reasonable determination of UCR rates. The Payor and Aetna Defendants remitted payments and explanations of benefits as to the fraudulently processed claims through the mails or wires. Such allegations establish a scheme to defraud, use of the mails and/or wires on multiple specified occasions to carry out the fraud and a specific intent to perpetrate a fraud.

***27** The Court is dubious that the pleading under review alleges facts establishing any of the other claimed predicate offenses - theft, theft by deception, deceptive business practices (as defined) and/or misapplication of entrusted property. The facts as presently alleged do not appear to the Court to establish the required elements of these offenses. For example, it is difficult to conceive of the DiS methodology used to reprice the Plaintiffs reimbursement claims as a measure within the intendment of the statutory definition of deceptive business practices or that the Plaintiffs entrusted the Defendants with their property such that a criminal misapplication of entrusted property can be said to have occurred. But it is not necessary for the Court to render a definitive ruling on this point - and accordingly, it does not do so. As noted, the Complaint alleges sufficient facts to establish multiple acts or mail and wire fraud.

The Court concludes the Complaint also contains factual averments sufficient to establish a pattern of racketeering activity as defined by the statute and the Ball court. The facts alleged by the Plaintiffs establish the elements of relatedness and continuity as such concepts were discussed and described by the Ball court.

As noted, that court emphasized the Legislature's determination to impose a requirement for proof of multiple incidents of racketeering activity, as opposed to multiple acts, denoting an intention to ensure, before subjecting parties to the remedies provided, a "broader spectrum" of behavior and conduct that must be, or threatened to be, "ongoing." 141 N.J. at 166. Such incidents must be more than isolated events, and even if not continuous, must exhibit "'connective tissue"' and represent conduct "that [is] otherwise interrelated by distinguishing characteristics." Id. At 167. The court found the factor of continuity - in the sense of an antonym to isolated, unconnected events - requires an ongoing connection among the acts alleged even if not occurring continuously or over a long period of time.

The Ball court identified various factors to consider in determining whether the requisite pattern exists. These include the number of unlawful acts, the similarity of the acts, the character of the acts and the number of victims and perpetrators.

The Plaintiffs allege the existence of an enterprise that carried out its intended purpose of systematically underpaying provider reimbursement claims over time and in multiple instances. The Complaint alleges the enterprise dealt with the claims in similar if not identical fashion - first via false representations that the services to be rendered would be paid according to the UCR rate, followed by a implementation of a process of repricing that would generate contrived determinations of UCR in order to justify reimbursements at vastly lower amounts than required by adherence to actual UCR pricing, followed by, when necessary, entirely fictive negotiation of claims that were disputed. The Complaint refers to multiple victims and the facts alleged suggest a pattern of activity that is ongoing.

In R.J. v. Cigna Health & Life Ins. Co., 625 F.Supp. 3d 951 (N.D. Cal. 2022) and L.D. v. United Behavioral Health, 2021 U.S. Dist. Lexis 47067 (N.D. Cal. March 11, 2021), the District Courts denied motions of Multiplan to dismiss Civil RICO claims interposed by patients who claimed that the defendants unlawfully employed a repricing scheme to underpay for medical services they received from providers after the plan sponsor and/or administrator pre-authorized the services and verified payment according to UCR rates via phone calls prior to the medical procedures.. Although neither of these cases is controlling and both involved claims of patients, the Court finds the reasoning employed to be instructive here.

In particular, in R.J., the court determined (at the pleading stage) the pleading sufficiently alleged an intent to defraud, noting that the plaintiffs' argument to the contrary "overlooks Plaintiffs' allegation that the fraudulent scheme began with the VOB [verification of benefits] calls, when Cigna failed to disclose anything about MultiPlan or Viant's role in repricing claims." 625 F.Supp. 3d at 964.

***28** The court concluded the plaintiffs had adequately alleged an association-in-fact enterprise. It stated:

> Plaintiffs' [Complaint] includes allegations that ... support a plausible inference that Defendants engaged in a RICO enterprise.... The [Complaint], however, includes the requisite "significant level of factual specificity" from which to infer a RICO enterprises. Plaintiffs allege that Cigna sent MultiPlan an arbitrarily selected "target rate" for each claim at issue for repricing.Viant then repriced the claim based on nation-wide median rates charged by Medicare facilities, not amounts charged by intensive outpatient substance use providers in a given geographic area. When Viant did not have data for a certain service, its software engineers would select the service rate. MultiPlan actively offered the Viant methodology to Cigna as a product capable of underpaying claims with minimal provider pushback, and MultiPlan knew and explained to Cigna that the Viant methodology could provide the appearance of legitimacy and offer cover for the fraudulent underpayment of IOP claims.
>
> [Id. at 966 (citations to the pleading omitted).]

The R.J. court rejected Multiplan's argument that it had no responsibility for the alleged communications of Cigna to the plaintiffs at the beginning of the treatment process. The court found that "[t]he argument is unpersuasive because as already discussed above, Plaintiffs satisfactorily allege that Cigna and MultiPlan were co-participants in a RICO scheme that caused harm. Having pled a cognizable RICO scheme, the statements and acts of co-participants in a scheme to defraud [are] admissible against other participants." Id. at 968 (internal quotation marks omitted). Consequently, "[t]hat MultiPlan did not have a direct role in issuing the benefits plans and responding to the VOB calls is of no moment." Ibid.

The Defendants assert the Plaintiffs' claim for relief under the Civil Rico statute fails for lack of standing of these Plaintiffs and/or for failure to establish the element of proximate cause of the Plaintiffs' claimed damages. Whether styled as a failure to establish standing or proximate cause, the augment when distilled to its essentials posits that the damages claimed by the Plaintiffs are the proximate result of the failure of the Patients to pay the balance of the unpaid bills for medical services and not of the alleged conduct of the Defendants. The Payor and Aetna Defendants point out that federal courts have dismissed Civil RICO claims in cases involving allegations similar to the facts alleged here on this basis. See, e.g., Pac. Recovery Sols. v. United Behavioral Health, 508 F. Supp. 3d 606 (N.D. Cal. 2020) (holding the plaintiffs providers' claims were derivative of their patients' injuries and too remote to confer the providers with RICO standing).

This Court finds this contention is not a basis for dismissal of the Compliant for failure to state a claim under the liberal Printing Mart standard. The assertion of lack of standing/proximate cause overlooks the practical reality that providers are unlikely to secure the reimbursement to which they claim entitlement under a fair ascertainment of UCR rates from their (former) patients. In any event, the Court finds a more complete record is necessary concerning the claimed injuries and the cause of the same before taking up the question of whether the Plaintiffs can meet this element of their Civil RICO claim. The Court finds here only that the Plaintiffs have pleaded sufficient facts to establish a viable claim under the Civil RICO statute.

***29** For these reasons, the Court grants the motion of Multiplan and dismisses the claims as to this Defendant in the Fourth, Sixth, Seventh and Tenth Counts, either based on the Plaintiffs' voluntary withdrawal of such claims as to Multiplan during the motion practice or the findings set forth herein. Its dismissal is without prejudice to the right to replead if desired as to any or all such Counts to address the deficiencies noted herein or to seek leave to amend at a later time. The Court otherwise denies the Defendants' motions.

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