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**CERTIFIED FOR PUBLICATION**

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION THREE

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| VHS LIQUIDATING TRUST,<br>Plaintiff and Appellant,<br>v.<br>MULTIPLAN CORPORATION et al.,<br>Defendants and Respondents. | A171914<br><br>(City & County of San Francisco Super. Ct. No. CGC-21-594966) |

Plaintiff VHS Liquidating Trust (VHS), the bankruptcy liquidator for a collection of not-for-profit healthcare providers, brought price-fixing and other antitrust claims against MultiPlan, a company that uses proprietary algorithms to suggest the reimbursement rates insurers and other third-party payors should pay to medical providers for out-of-network medical services. The trial court sustained MultiPlan's demurrer without leave to amend, concluding as a matter of law that reimbursements for out-of-network services are not subject to price fixing or tampering within the meaning of the Cartwright Act (Bus. & Prof. Code, § 16700 et seq.; undesignated statutory references are to this code). We see no basis for exempting this category of payments from the broad reach of the Cartright Act. Even under federal antitrust law, which protects competition less assertively than does the Cartright Act, we would find that insurers' reimbursements to providers are

prices that, if fixed or tampered with, may give rise to antitrust liability. Accordingly, we reverse the judgment.

## I.

### A.

We accept as true the following factual allegations of the operative first amended complaint (complaint). (*Villarroel v. Recology, Inc.* (2023) 97 Cal.App.5th 762, 768 (*Villarroel*).)

***Parties***

VHS Liquidating Trust is the bankruptcy liquidator for the former not-for-profit healthcare system Verity Health System of California, Inc. (Verity). Verity operated six not-for-profit hospitals, several associated medical foundations, and other affiliates serving the San Francisco, Los Angeles, and San Jose metropolitan areas. According to the complaint, Verity "serv[ed] its patients and communities for many years with needed care and diligence to the best of its abilities before going bankrupt" in 2018.

MultiPlan Corporation, now known as Claritev Corporation, "is a provider of healthcare data and analytics." The corporation "markets itself as using algorithms and data analytics to provide repricing and other services to health insurers." It also operates several preferred provider organization (PPO) health insurance networks, which compete with other payors' networks. The wholly owned subsidiaries (direct and indirect) of Claritev Corporation include defendants MultiPlan, Inc., Viant, Inc., Viant Payment Systems, Inc., and National Care Network, LLP. VHS's complaint refers collectively to these entities, including Claritev Corporation, as "MultiPlan." We will do the same.

***Payment for Medical Services***

Verity and other healthcare providers receive payment for their services from various sources, including patients, private insurers, and government payors such as Medicare and Medi-Cal.[1] The complaint describes a system in which private insurers pay providers directly; it alleges insurers " 'participate in the market for the purchase of goods and services from healthcare providers.' "

How much a provider receives for a given service varies by payor. The complaint alleges Medicare and Medi-Cal often do not cover California hospitals' costs for providing service; for example, a hospital may spend $1,000 to provide an urgent, life-saving procedure but receive only $500 in reimbursement. Many hospitals in California (including formerly Verity) serve primarily patients whose care is paid for by Medicare or Medi-Cal, and these hospitals cannot sustain their operations by caring only for patients covered by these public programs. They must serve a sufficient number of commercially insured patients to support their basic operations.

Commercial insurers typically pay at least enough to cover providers' costs, though the amount varies based on whether the provider has contracted to provide a particular service as part of the insurer's network. Being "in-network" affords a provider better access to an insurer's subscribers; in exchange, the provider agrees to reduced reimbursement rates. Contracts between providers and insurers specify the services for

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[1] VHS does not allege government payors were involved in the alleged Cartwright Act violations; its mention of these payors is limited to providing context for its claims.

VHS's complaint also includes self-funded payors, which typically are large employers that choose to self-insure and contract with insurers and MultiPlan to administer their plans. For simplicity, we use the term "insurers" to refer collectively to private insurers and self-funded payors.

which the provider has agreed to accept lower rates as "in-network services." The remaining services are commonly described as "out-of-network" (OON) services. Many hospital contracts with commercial insurers, including many of Verity's contracts, do not address, let alone provide payment terms for, OON services. Insurers nonetheless market their plans to employers and individuals based on assurances the insurers will cover some portion of the cost of OON services, and VHS alleges that hospitals provide OON services in reliance on these assurances.

In the absence of an agreement on OON rates, providers submit claims to insurers, and insurers reimburse providers at a rate typically based on the "usual, customary, and reasonable" (UCR) rate for that geographic area. Insurers have a financial incentive to minimize OON reimbursements, and providers often accept reimbursements at rates lower than the billed price, believing it to be more efficient than to haggle over every claim.

At the same time, VHS alleges that insurers are subject to countervailing competitive forces that prevent OON rates from dropping too low. Specifically, insurers compete to sign up hospitals to their networks, as larger networks are more attractive to employers and subscribers. Insurers also compete for subscribers on the strength of their OON coverage. An insurer offering unreasonably low OON rates reduces providers' willingness to join that insurer's network or to provide OON services to the insurer's subscribers. This makes the insurer less attractive to employers and potential subscribers, the complaint alleges.

In some cases, providers may bill patients for the shortfall between their billed price and the reimbursement amount. This practice is known as "balance billing", and it can leave patients with large, unexpected medical bills. California law prohibits balance billing in some circumstances,

including emergency medical care. (See *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 502.) Where balance billing is prohibited, reimbursement from the insurer is the only payment the provider receives.

***The Ingenix Precursor Scheme***

VHS alleges that in 2009, the New York Attorney General brought an enforcement action against Ingenix, then a subsidiary of insurer UnitedHealthcare, for helping insurers coordinate reimbursement rates for OON services. The core conduct under investigation included commercial insurers' " 'use of schedules compiled by Ingenix . . . in determining reimbursement rates for OON care. Ingenix gather[ed] billing data from the largest health insurers in the country . . . and then sen[t] back schedules to these health insurers and others, based on the pooled data, which the insurers use[d] . . . to set their reimbursement rates.' " The Ingenix schedules allegedly understated market rates by up to 28 percent, leading to artificially suppressed reimbursement rates. Insurers settled related class-action claims for more than $2 billion, and the New York Attorney General forced UnitedHealthcare to shut down Ingenix. The settlement required insurers to fund in its stead the creation of an independent price-reference database called FAIR. VHS alleges that rather than use the FAIR database, major insurers soon "continued essentially the same conduct through MultiPlan."

***The Alleged MultiPlan Scheme***

VHS alleges that MultiPlan offers insurers "repricing" services, which operate as follows: Insurers send their OON claims to MultiPlan, which uses a proprietary algorithm based on a database of one billion claims to suggest how much the insurer should pay the provider for that claim. MultiPlan's database contains claims data from more than 700 insurers, making it

" 'much, much larger and more diverse than what any single pay[o]r has within their systems.' " MultiPlan's recommended prices allegedly are "far lower than the payor would otherwise pay on the claim," consistent across insurers, and consistent across geographic regions. On behalf of the insurer, MultiPlan "imposes the new price on the healthcare provider, giving the provider just days to respond to the 'repriced' claim. As a condition of accepting the repriced claim, providers may be unable to seek reimbursement from any other source—effectively locking in the harm caused by the collusive underpayment." MultiPlan charges insurers a fee of about five to seven percent of the difference between the original and repriced claim amounts.

By 2020, MultiPlan was repricing 370,000 OON claims per day. VHS alleges that insurers pay MultiPlan's recommended repricing rates 87 percent of the time " 'without any human touch.' " With "human touch," the rate of insurer adherence to MultiPlan's recommendations rises to 95 percent. For inpatient care, MultiPlan has estimated that providers accept their repriced amounts for OON services 93 to 99.4 percent of the time.

More than 700 insurers use MultiPlan's repricing services, including " 'all of the top 15 insurers' in the country" as of January 2024. MultiPlan touts its universal adoption among the insurance industry's major players, both publicly and privately. For example, before its initial public offering, MultiPlan told analysts that "[t]he health insurance sector has consolidated to four top insurers" and "MultiPlan has 25+ year relationships with three of those top four and is deeply integrated and embedded with" and "the preferred partner of all four."

Privately, MultiPlan's executives make clear to insurers that the insurers' competitors use MultiPlan's repricing services. VHS alleges, for

example, that in 2016, "MultiPlan's former Chief Revenue Officer, Dale White, wrote an email to United executives, explaining that United's top competitors were using MultiPlan's repricing services. Mr. White encouraged United to do the same, writing: 'We believe implementation of these initiatives will go a long way to bringing United back into alignment with its primary competitor group [Blues, Cigna, Aetna] on managing out-of-network program costs.' " UnitedHealthcare's Vice President of Out-Of-Network Payment Strategy explained that a key factor in the decision to use MultiPlan's repricing services "was that the technology 'was widely used by our competitors.' "

Based on these alleged facts, VHS contends that MultiPlan conspired with its insurer clients to fix OON reimbursement rates below what the insurers would have paid, had they exercised independent judgment. VHS alleges that MultiPlan serves as the "[h]ub" in "a traditional 'hub, spoke, and rim' agreement" by soliciting insurers' competitively sensitive claims data, building its repricing algorithms based on this data, and communicating to insurers that their competitors all abide by MultiPlan's recommended OON rates. Indeed, VHS alleges that from MultiPlan's public statements alone, insurers know that all of their competitors "(a) are under long-term commercial OON repricing contracts with MultiPlan; (b) submit their competitively sensitive claims data to MultiPlan regularly; and (c) follow MultiPlan's specific granular prices for commercial OON reimbursements 93% to 99.4% of the time (most often without any human touch), such that they can rely on the assurances from MultiPlan that all of their significant would-be competitors are 'in on it' too."

VHS alleges that insurers would not use MultiPlan's recommended prices without "reasonably strong assurances like these that all of [their]

significant would-be competitors would do the same thing," as they otherwise would fear that competing insurers would offer more generous reimbursement rates, secure better access to providers, and ultimately win more subscribers. VHS contends that the insurers' actions are against their own economic interest, and are thus circumstantial evidence of the "rim" agreement among insurers. As further circumstantial evidence, it points to MultiPlan's monopoly in the market for repricing services, the highly consolidated nature of the markets for commercial insurance reimbursement, insurers' submission of sensitive claims data to MultiPlan, MultiPlan's public statements emphasizing that its interests in reducing OON reimbursement rates are aligned with insurers', and ample opportunities for participating insurers to communicate, including at industry conferences.

As a variant on this theme, VHS also alleges MultiPlan's conduct constitutes unlawful horizontal price fixing between MultiPlan's PPO networks and the insurers. Without MultiPlan's collusive agreements with its insurer customers, MultiPlan's PPO networks "would have acted as a meaningful competitive check on commercial health plans . . . by competing against them to recruit, credential, and compensate healthcare providers for their services," the complaint alleges.

Further, VHS alleges that MultiPlan's actions "not only impacted pricing for OON services, but also impacted the market of reimbursement rates for in-network services." "This is because providers generally agree to set lower in-network rates with insurers in return for favoring those providers with greater access to their insureds, increased volume, and/or quicker access to payment from those insurers . . . . If the reimbursement rates for OON services were the same or less than those for in-network services, insurers would have no incentive to give such favorable treatment to

those providers. As a result, in-network rates are necessarily lower than rates for OON services . . . thus a lower OON rate will result in an even lower in-network rate."

**B.**

VHS filed this suit against MultiPlan and a number of insurers in September 2021. After the trial court granted the insurers' motions to compel arbitration, VHS filed a petition for writ of mandate, which this court denied. The Supreme Court, in turn, denied VHS's petition for review.

VHS then filed the operative complaint against MultiPlan without naming the insurers as defendants. This complaint asserts five counts under the Cartwright Act: horizontal price fixing through a hub-and-spoke agreement, with MultiPlan as the hub (count I); horizontal price fixing based on MultiPlan's PPO networks (count II); horizontal price tampering, including by suppressing rates for in-network services (count III); unlawful horizontal exchange of competitively sensitive business information (count IV); and unlawful vertical exchange of competitively sensitive business information (count V). The complaint also includes a single count under the Unfair Competition Law (count VI), premised on the same conduct as the Cartwright Act claims.

MultiPlan demurred to the complaint. The trial court heard argument, then sustained the demurrer without leave to amend. As to counts I through III, the trial court ruled that reimbursement for OON services is "part and parcel of a health insurance policy rather than a standalone product or service." Without a standalone product or service, the court ruled there was no price that could be fixed or tampered with, within the meaning of the Cartwright Act. As to the claims for unlawful exchange of competitively sensitive information (counts IV and V), the trial court treated these as

derivative of the price-fixing and -tampering claims and concluded that VHS "likewise [had] not sufficiently allege[d]" them because it had not adequately alleged price fixing or tampering. Last, because VHS had conceded that its UCL claim (count VI) rose or fell with the Cartwright Act claims, the trial court sustained the demurrer as to the UCL claim as well. The order did not explain why no leave to amend was afforded.

The trial court entered final judgment, and VHS timely appealed.

A parallel multi-district litigation asserting similar claims against MultiPlan and a number of insurers is pending in federal court in the Northern District of Illinois. After the opening brief in this appeal was filed, the district court in that case denied a motion to dismiss the providers' federal and state antitrust claims and state consumer protection claims. (*In re MultiPlan Health Insurance Provider Litig.* (N.D.Ill. 2025) 789 F.Supp.3d 614, 647–648 (*MultiPlan*).) VHS filed in our court a notice of supplemental authority, and the parties addressed the new decision in their subsequent briefs.[2]

**II.**

When reviewing a demurrer, " '[t]he trial court examines the pleading to determine whether it alleges facts sufficient to state a cause of action under any legal theory, with the facts being assumed true for purposes of this inquiry.' " (*Sproul v. Vallee* (2025) 116 Cal.App.5th 285, 292.) "On appeal, '[o]ur review is de novo.' " (*Id.* at p. 293.) "We construe the allegations of the complaint liberally, giving them a reasonable interpretation and treating the demurrer as admitting all properly pleaded facts." (*Ibid.*)

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[2] VHS requests that we take judicial notice of the Statement of Interest filed by the Department of Justice in *MultiPlan*, *supra*, 789 F.Supp.3d 614. Although MultiPlan has not opposed the request, we deny it as unnecessary to the resolution of the issue before us.

Applying this standard, we first address the Cartwright Act directly. Then, because we find no case law addressing the Cartwright Act's application to insurers' reimbursement payments, we also look for guidance to federal antitrust cases. Both sources of law point in the same direction, leading us to conclude that an insurer's payment for OON services is a transaction subject to the protection of our antitrust laws.

**A.**

"The Cartwright Act (Bus. & Prof. Code, § 16700 et seq.), like the Sherman Antitrust Act (15 U.S.C. § 1 et seq.), was enacted to promote free market competition and to prevent conspiracies or agreements in restraint or monopolization of trade." (*Exxon Corp. v. Superior Court* (1997) 51 Cal.App.4th 1672, 1680.) "Broadly speaking, the Cartwright Act is premised on the notion that competition yields efficient resource allocation, lower prices, higher quality, and greater social welfare." (*Ahn v. Stewart Title Guaranty Co.* (2023) 93 Cal.App.5th 168, 178–179 (*Ahn*); see also *Cianci v. Superior Court* (1985) 40 Cal.3d 903, 918–919 (*Cianci*).)

The Cartwright Act " 'generally outlaws any combinations or agreements which restrain trade or competition or which fix or control prices.' " (*Pacific Gas & Electric Co. v. County of Stanislaus* (1997) 16 Cal.4th 1143, 1147.) "The primary substantive provision of the Cartwright Act is found in section 16720," which defines a "trust" as " 'a combination of capital, skill, or acts by two or more persons' for such purposes as price-fixing, exclusive dealing, or restraints on trade or commerce or competition." (*Ahn*, *supra*, 93 Cal.App.5th at p. 179; § 16720.) In one of several paragraphs addressing price-fixing, section 16720 includes the act of "[a]gree[ing] in any manner to keep the price of [an] article, commodity or transportation at a fixed or graduated figure." (§ 16720, subd. (e)(2); see also subds. (d) & (e)(3).)

And although this language does not mention services, case law has long recognized that the Cartwright Act reaches services as well. (See, e.g., *Marin County Bd. of Realtors, Inc. v. Palsson* (1976) 16 Cal.3d 920, 925–928 (*Marin County*).) "Except as otherwise provided by statute, 'every trust is unlawful, against public policy and void.' " (*Ahn*, at p. 179, quoting § 16726.)

Although the statute is phrased in absolute terms, "[o]nly unreasonable restraints of trade are prohibited, so the 'rule of reason' generally asks whether the challenged conduct on balance promotes or suppresses competition." (*Ahn*, *supra*, 93 Cal.App.5th at p. 179.) Some violations of antitrust law, " ' "because of their pernicious effect on competition and lack of any redeeming virtue[,] are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." ' " (*Flagship Theatres of Palm Desert, LLC v. Century Theatres, Inc.* (2011) 198 Cal.App.4th 1366, 1374, quoting *Marin County*, *supra*, 16 Cal.3d at pp. 930–931.) "Among these [per se violations] are price fixing." (*Mailand v. Burckle* (1978) 20 Cal.3d 367, 376 (*Mailand*); see also *Oakland-Alameda County Builders' Exchange v. F.P. Lathrop Constr. Co.* (1971) 4 Cal.3d 354, 363.) On that basis, it is generally understood that " '[a]ny combination which tampers with price structures is engaged in an unlawful activity,' " regardless of the reasonableness of the prices or whether the parties have market power. (*Mailand*, at p. 376, quoting *U.S. v. Socony-Vacuum Oil Co.* (1940) 310 U.S. 150, 218; see also *Mailand*, at p. 377.)

Some element of "combination" is, however, required. (*Mailand*, *supra*, 20 Cal.3d at p. 376.) A trade association that gathers and disseminates industry pricing information among its members does not offend antitrust law when its members use that information " ' "in the management and

control of their individual businesses." ' " (*In re Automobile Antitrust Cases I & II* (2016) 1 Cal.App.5th 127, 154, italics omitted; see also p. 153.) " 'Only when [the recipients of pricing data] take concerted action to restrain trade based on such information do they act illegally.' " (*Id.* at p. 154, italics omitted.)[3]

Importantly for our case, purchasers can be liable for fixing prices, just as sellers can. Antitrust law " ' "does not confine its protection to consumers, or to purchasers, or to competitors, or to sellers. Nor does it immunize the outlawed acts because they are done by any of these." ' " (*Cellular Plus, Inc. v. Superior Court* (1993) 14 Cal.App.4th 1224, 1233 (*Cellular Plus*), italics omitted.)

Here, VHS alleges that MultiPlan and its insurer clients have conspired to fix prices for OON services. The amount an insurer pays a provider like Verity for the services rendered is the price in question. The complaint alleges these amounts are set when MultiPlan "reprices" a claim for OON services, so that prices are mostly fixed by MultiPlan acting in concert with the insurers, rather than being freely negotiated between the insurers and the providers under competitive market conditions. The

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[3] After the conduct at issue in this case, the Legislature amended the Business and Professions Code to add section 16729, which states it is "unlawful for a person to use or distribute a common pricing algorithm as part of a contract, combination in the form of a trust, or conspiracy to restrain trade or commerce in violation of this chapter." According to the California Attorney General, the law "makes it clear that using common pricing algorithms to fix prices among competitors is just as illegal as traditional price fixing methods under the [Cartwright] Act." (Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 325 (2025–2026 Reg. Sess.) as amended Sept. 2, 2025, p. 9.) The parties do not contend that this section applies retroactively, so we do not address it further.

Cartwright Act indisputably applies to protect competition in the market for medical services. (*Cianci*, *supra*, 40 Cal.3d at p. 916 [overturning precedent to so hold].) And it generally prohibits the fixing of prices by buyers, as well as sellers. (*Cellular Plus*, *supra*, 14 Cal.App.4th at p. 1233.) Thus, we fail to see why the insurers' purchases of the medical services at issue here would be exempt from antitrust scrutiny for price fixing. Nothing in the language of the statute suggests such a carve-out. And, as the *Cianci* court made clear, "there is a heavy presumption against implicit exemptions." (*Cianci*, at p. 921.)

The trial court reached a different conclusion on the theory that a reimbursement transaction is merely an insurer's fulfillment of an obligation already owed to its subscriber, rather than a "standalone" purchase of OON services. That is, the trial court took the view, as MultiPlan argues here, that because coverage for OON services cannot be purchased independently of a patient's health insurance plan, there is no discrete price that is subject to fixing. We think this view ignores that economic actors often function in multiple markets simultaneously, and that the obligations they owe participants in one market do not erode antitrust protections in a different market. Consider, for example, a building contractor who contracts with a client to construct a home for a certain price, then hires subcontractors to handle the required plumbing and electrical work. The fact that the general contractor's obligations to the homeowner are what compels the contractor to purchase subcontractors' services does not remove the transactions with the subcontractors from the protection of antitrust law. Similarly, we see no reason why the insurers' contractual obligations to their subscribers to pay for OON services should insulate from antitrust scrutiny their negotiations with medical providers over the reimbursement rates for these services.

In the language of the complaint, the economic relationships between commercial health insurers and their subscribers "occur in different markets than those that are the focus of this Complaint." The complaint focuses on a " 'market for the purchase of goods and services from healthcare providers.' " Specifically, the complaint defines the relevant market as "the provider-side market for reimbursement from commercial insurers . . . for OON and in-network general acute care inpatient hospital services and outpatient hospital services." The complaint alleges that Verity was a " 'direct seller[]' "—the "mirror image equivalent of 'direct purchaser[]' "—to insurers in this market, which it calls the Reimbursement Market. The complaint further alleges that, but for MultiPlan's illegal scheme, insurers would be competing in this market to offer competitive (i.e., higher) prices on reimbursements.

MultiPlan disputes VHS's framing of the market at issue. It argues, based on VHS's market definition, that the product at issue is a " 'reimbursement' " and is "exactly the same as, and nothing other than, the insurance benefit arising under contracts or 'assurances' between payors and subscribers."[4] But two things can be true at once. The "reimbursement" at

[4] During oral argument, MultiPlan contended VHS's complaint focused on OON *reimbursements* and disclaimed any theory based on payment for OON *services*, citing paragraph 18 of the complaint. According to MultiPlan, that allegation distinguishes this case from *MultiPlan*. We disagree. Paragraph 18 alleges the economic relationships between providers and their patients, on one hand, and between insurers and their subscribers, on the other, occur in different markets than the transactions at issue here. And elsewhere the complaint makes clear the market at issue includes reimbursements, or payments, *for OON services*. (See, e.g., complaint, ¶ 214 ["relevant service markets include the provider-side market for reimbursement from commercial insurers and SFPs *for OON* and in-network . . . *hospital services*"], italics added.)

issue here may be both a price for medical services that is being unlawfully dictated by MultiPlan *and* an insurance benefit that the insurer is contractually obligated to pay. The complaint focuses on the first of these dual attributes, not on the second. It describes the market in which insurers sell coverage to subscribers or employers only for the purpose of setting forth the broader context of the industry.

The law requires us to give the complaint "a reasonable interpretation, reading it as a whole and its parts in their context." (*Blank v. Kirwan* (1985) 39 Cal.3d 311, 318.) Reading the complaint in this manner, we conclude that it alleges price fixing in a market where providers seek payment from insurers for medical services rendered. We express no opinion on the merits of the claim, other than to conclude the claim is not exempt from scrutiny under the Cartwright Act by virtue of the insurers having separate contractual obligations to their subscribers. (See, e.g., *In re Zelis Repricing Antitrust Litigation* (D.Mass. Mar. 30, 2026, No. 25-10734-BEM) 2026 U.S.Dist.Lexis 67369, at p. *26 (*Zelis*) [declining to resolve factual disputes about market definition at pleading stage].)

We reach this conclusion based on the broad language of the Cartwright Act and general principles in our case law about its application. But because we have not identified any California case law directly addressing whether the Cartwright Act applies to OON reimbursements, we next consider federal cases for their potential persuasive value.

**B.**

Interpretations of federal antitrust law can be instructive when construing the Cartwright Act, though they are not conclusive, "given that the Cartwright Act was modeled not on federal antitrust statutes but instead on statutes enacted by California's sister states around the turn of the 20th

century." (See *Aryeh v. Canon Business Solutions, Inc.* (2013) 55 Cal.4th 1185, 1195.) Our Supreme Court has explained that "the Cartwright Act is broader in range and deeper in reach than the Sherman Act." (*Cianci*, *supra*, 40 Cal.3d at p. 920.) And on this basis appellate courts have sometimes declined to follow Sherman Act cases, concluding the Cartwright Act is more protective of competition. (See, e.g., *Cellular Plus*, *supra*, 14 Cal.App.4th at p. 1242.) Here, our analysis of Sherman Act cases leads us to conclude that, even under federal law, the demurrer was erroneously sustained.

We begin with the three federal district court decisions upon which the trial court relied. These cases dismissed patients' and/or providers' antitrust challenges to OON reimbursement rates on the basis of an argument similar to the one MultiPlan makes here. We find these cases distinguishable, and we disagree with the lesson the trial court drew from them—that transactions between insurers and providers must be viewed through the lens of the benefits an insurer owes its subscriber. We are instead persuaded by the decision of the court overseeing the *MultiPlan* multi-district litigation that OON reimbursement rates are "prices" that can be fixed within the meaning of antitrust law. (*MultiPlan*, *supra*, 789 F.Supp.3d at pp. 631–632.)

Our broader review of federal precedent also supports this conclusion. U.S. Supreme Court and federal appellate cases have recognized that insurer-provider transactions are legally distinct from an insurer's obligations to its subscribers, and the transactions are subject to antitrust scrutiny. So, too, are the transactions here.

**1.**

We find the trio of district court cases relied on by the trial court unpersuasive, at least as to these claims brought by medical providers. Two of the cases dealt with claims by subscribers, not providers, and the third

offered no explanation for why the subscriber-based reasoning would apply to claims brought by providers. More persuasive than these cases is the analysis in *MultiPlan* that the trial court had no opportunity to consider.

The first case the trial court relied upon, *Franco v. Connecticut General Life Insurance Co.*, featured allegations brought by medical providers (and associations of providers) that insurers had conspired with one another and Ingenix to fix prices for OON reimbursements. (*Franco v. Connecticut General Life Insurance Co.* (D.N.J. 2011) 818 F.Supp.2d 792, 802–804 (*Franco*), reversed in part on other grounds, *Franco v. Connecticut General Life Insurance Co.* (3d Cir. 2016) 647 Fed.Appx. 76.) Similar claims were also included on behalf of a set of subscriber plaintiffs. (*Franco*, 818 F.Supp.2d at pp. 802–803.) The district court first ruled that the *providers* lacked standing to pursue their claims for several reasons: Their allegations of direct injury were "superficial and underdeveloped," they could not pursue antitrust claims based on a third-party beneficiary theory, and the complaint did not allege that the providers had obtained express assignments of such claims from the insureds. (*Id.* at p. 812.) The association plaintiffs were likewise found to lack standing. (*Id*. at pp. 812–813.)

Then, in the portion of the opinion on which the trial court relied, the *Franco* court went on to analyze whether the *subscribers* had stated a price-fixing claim under the Sherman Act. (*Franco*, *supra*, 818 F.Supp.2d at pp. 829–834.) Concluding they had not, the court explained that the complaint "failed to articulate what product's or service's price has been manipulated," because "there is no indication in the complaints that coverage for [OON] services . . . is a discrete product available for purchase and sale apart from the rest of a subscriber's insurance policy, at its own price." (*Id.* at p. 832; see also *id.* at p. 834 [characterizing OON reimbursements as

"benefits paid by the insurance company to the insured pursuant to a health benefits plan"].) This analysis was from the perspective of the subscriber, the holder of the insurance policy. Subscribers may have had a stake in whether there was price "competition as to the premium charged" for the policy, but for them price-fixing with regard to reimbursements was merely a cost paid by someone else—the insurer—"in the provision of its product." (*Id.* at p. 833.) Because the provider plaintiffs had been dismissed for lack of standing, the *Franco* court never addressed the transaction from the providers' perspective. (See *id.* at pp. 812 [dismissing "all . . . antitrust claims asserted by Provider Plaintiffs" for lack of standing], 829–841 [analyzing subscribers' antitrust claims], 839 [referring separately to subscribers' role in market and "the now-dismissed Provider Plaintiffs"].)

The second case the trial court relied on, *In re Aetna UCR Litigation*, ruled that plaintiffs had not stated a Sherman Act claim because they had not plausibly alleged the existence of a conspiracy. (*In re Aetna UCR Litigation* (D.N.J. June 30, 2015, No. 07-3541) 2015 U.S.Dist.Lexis 84600 at pp. *58–*71 (*Aetna UCR*).) As a secondary ground for dismissal, the court then adopted *Franco*'s reasoning and found the subscriber plaintiffs had not alleged "that the price of any product or service has been fixed or restrained." (*Aetna UCR*, at p. *73.) The complaint characterized OON reimbursements as simply a contractual benefit owed under the subscriber's insurance policy. (*Ibid.*) The court noted that "the price of health insurance is the premium," and "plaintiffs do not allege that the premium charged for their health insurance plans has been fixed." (*Id.* at pp. *73–*74.) On this reasoning the court concluded, "the connection between defendants' alleged conduct and the premium charged is too attenuated to support a finding of price-fixing." (*Id.*

at p. *77.) But like *Franco*, *Aetna UCR* did not examine the transaction between providers and insurers from the perspective of providers.

The third case the trial court invoked, *Pacific Recovery Solutions v. Cigna Behavioral Health, Inc.*, dismissed providers' Sherman Act claim for lack of antitrust standing. (*Pacific Recovery Solutions v. Cigna Behavioral Health, Inc.* (N.D. Cal. Mar. 29, 2021, No. 5:20-cv-02251-EJD) 2021 U.S.Dist.Lexis 59779, at pp. *34–*36 (*Pacific Recovery*).) As one of several alternate grounds for dismissal, the court then followed *Franco* and *Aetna UCR* to find the complaint did not plausibly allege a service capable of being price-fixed, but it did not explain why the reasoning of those cases, brought by subscribers, would govern the claims by providers in the case before it. (*Pacific Recovery*, at pp. *35–*36.)

As we noted, after VHS filed its opening brief a fourth district court decision was issued, this time by the court overseeing the multi-district litigation against MultiPlan and a range of insurers. (*MultiPlan*, *supra*, 789 F.Supp.3d 614.) Defendants there raised the same argument MultiPlan advances here (among others): The complaint failed to identify a discrete product or service with a price that could be fixed because the real product at issue is a subscriber's insurance policy, and subscribers cannot separately purchase coverage for OON services. (*Id.* at p. 631.) The court rejected this argument as a "sleight of hand" that analyzed the wrong market—the market for insurance policies. The *MultiPlan* court instead analyzed the market alleged in the complaint—the market for OON services for purchase by third-party commercial payors. (*Id.* at pp. 630–631.)

The *MultiPlan* court noted that other federal courts have characterized insurers as buyers of healthcare services. Following them, *MultiPlan* characterized any distinction between an insurer's purchase of healthcare

services and an insurer's reimbursement for those services as " ' irrelevant for antitrust purposes.' " (*MultiPlan*, *supra*, 789 F.Supp.3d at p. 631, quoting *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic* (W.D.Wis. 1994) 881 F.Supp. 1309, 1317.) The court then distinguished *Franco* and *Aetna UCR* as involving claims brought by subscribers not providers, and it respectfully disagreed with *Pacific Recovery* and the trial court's decision in this case as overly reliant on *Franco* and *Aetna UCR* despite different factual allegations. (*MultiPlan*, at p. 632.) We agree with the reasoning in *MultiPlan*, and we reach a similar conclusion here.

**2.**

*MultiPlan* is consistent with a broad range of federal antitrust precedent, which regularly recognizes that insurers (and other third-party payors) purchase healthcare services from providers. Federal courts and treatises acknowledge that the prices providers charge insurers can be fixed within the meaning of antitrust law. The same logic applies with equal force to the prices insurers actually pay providers for those same services.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, for example, the U.S. Supreme Court considered pharmacies' price-fixing claims against an insurer, Blue Shield, and three pharmacies that entered contracts related to reimbursements for prescription drugs. (*Group Life & Health Insurance Co. v. Royal Drug Co.* (1979) 440 U.S. 205 (*Royal Drug*).) Under these agreements, "a participating pharmacy agrees to furnish prescription drugs to Blue Shield's policyholders at $2 for each prescription, and Blue Shield agrees to reimburse the pharmacy for the pharmacy's cost of acquiring the amount of the drug prescribed." (*Id.* at p. 209.) At non-participating pharmacies, policyholders paid the pharmacy the full price of the

prescription, and the insurer reimbursed the policyholder 75 percent of the difference between that price and $2. (*Ibid.*)

The Supreme Court considered whether these pharmacy agreements were "the 'business of insurance,' " in which case they would be shielded from antitrust scrutiny by the McCarran-Ferguson Act, and held they were not. (*Royal Drug*, *supra*, 440 U.S. at pp. 210, 233.) While the McCarran-Ferguson Act is not at issue here, the underlying question is similar: Is there an analytically distinct economic relationship between providers and insurers, or is that relationship subsumed within the insurance contract between insurers and subscribers?

The Supreme Court began by defining the business of insurance as involving the spreading and underwriting of a policyholder's risk. (*Royal Drug*, *supra*, 440 U.S. at p. 211.) It then made clear that "the obligations of Blue Shield under its insurance policies" were distinct from the pharmacy agreements at issue, which were "merely arrangements *for the purchase of goods and services by Blue Shield*." (*Id.* at pp. 213–214, italics added.) It explained: "The benefit promised to Blue Shield policyholders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies." (*Ibid.*) The Court also explained that the pharmacy agreements were "legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low." (*Id.* at p. 215.) By contrast, "the 'business of insurance' " involved contracts between insurers and policyholders, which the pharmacy agreements were not. (*Ibid.*) "They [we]re separate contractual

arrangements between Blue Shield and pharmacies engaged in the sale and distribution of goods and services other than insurance." (*Id.* at p. 216.)

*Royal Drug* thus said clearly that an insurer's purchase of goods and services from a provider—even one where those purchases are framed as reimbursements pursuant to an insurance policy—is distinct from the coverage benefit provided to the subscriber. (*Royal Drug*, *supra*, 440 U.S. at pp. 210–216; see also *Ocean State Physicians Health Plan*, *Inc. v. Blue Cross & Blue Shield of Rhode Island* (1st Cir. 1989) 883 F.2d 1101, 1108 [noting *Royal Drug* Court "took care to distinguish Blue Shield's provider contracts from its subscriber contracts"].)

The First Circuit's opinion in *Kartell v. Blue Shield of Massachusetts*, *Inc.* is equally instructive. (*Kartell v. Blue Shield of Massachusetts*, *Inc.* (1st Cir. 1984) 749 F.2d 922 (*Kartell*).) There, the court considered whether an insurer's ban on providers balance billing patients was an unreasonable restraint on trade. It first reasoned that there was no "restraint" because the insurer was not a " 'third force' " preventing buyers and sellers from reaching independent bargains; instead, it was "itself the purchaser of the doctors' services." (*Id.* at p. 924.) The First Circuit cited a handful of federal appellate antitrust decisions holding that an insurer's reimbursement "amounts to purchasing, albeit for the account of others." (*Id.* at p. 925 [citing cases].) The court also explained that any distinction between " 'purchasing' " and " 'insurance reimbursement' " was "irrelevant for antitrust purposes." (*Id.*at p. 926.) "The relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge." (*Ibid.*) *Kartell* therefore reinforces the lesson we draw from *Royal Drug*: An insurer's reimbursement to a provider amounts to a purchase and is

analytically distinct from the contractual relationship between an insurer and its subscriber.

Other federal courts have reached similar conclusions, including to allow providers' price-fixing claims against insurers to proceed past the pleading stage. (See, e.g., *West Penn Allegheny Health System, Inc. v. UPMC* (3d Cir. 2010) 627 F.3d 85, 105 [insurer's alleged abuse of buyer-side market dominance (monopsony power) to set artificially low reimbursement rates caused antitrust injury to hospital]; *Zelis*, *supra*, 2026 U.S.Dist.Lexis at pp. *7, *31 [denying motion to dismiss providers' claims that insurers and repricing service provider conspired to suppress OON payments to providers]; *In re Delta Dental Antitrust Litigation* (N.D.Ill. 2020) 484 F.Supp.3d 627, 638 [denying motion to dismiss claims alleging insurer and other defendants collectively determined, and with monopsony power imposed, below-market reimbursement rates for providers]; *In re Wellpoint Out-of-Network "UCR" Rates Litig.* (C.D.Cal. 2011) 865 F.Supp.2d 1002, 1015, 1025–1030 [denying motion to dismiss providers' and subscribers' antitrust claims alleging a conspiracy to fix OON reimbursements using Ingenix's manipulated UCR data]; *American Medical Association v. United Healthcare Corp.* (S.D.N.Y. 2008) 588 F.Supp.2d 432, 438, 446–449 [denying motion to dismiss providers' and subscribers' antitrust claims alleging insurers had manipulated UCR data to under-reimburse them].)

Courts and treatises likewise recognize that providers are susceptible to antitrust liability if providers fix the prices they charge insurers—indeed, insurers have been plaintiffs in such cases. (See *Arizona v. Maricopa County Medical Society* (1982) 457 U.S. 332, 335–336 (*Maricopa County*) [plaintiff stated claim based on alleged conspiracy among doctors to fix maximum prices]; *North Texas Specialty Physicians v. Federal Trade Commission* (5th

Cir. 2008) 528 F.3d 346, 370 [affirming in relevant part FTC's finding that providers engaged in horizontal price-fixing of prices charged to payors]; *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic* (7th Cir. 1995) 65 F.3d 1406, 1414 [insurer that paid provider directly had antitrust standing to challenge alleged overcharges by providers]; Ralph C. Hofer et al., Cal. Antitrust & Unfair Competition Law (rev. ed. 2025) § 21.02 [gathering cases involving alleged price-fixing by providers].) It would be illogical to conclude that providers' bills to insurers involve prices that can be fixed, but insurers' payments of those same bills do not. (See *Cellular Plus*, *supra*, 14 Cal.App.4th at p. 1233 [antitrust law does not immunize outlawed acts based on status as purchaser or seller]; John J. Miles, 2 Health Care and Antitrust Law (rev. ed. 2026) § 19:2 ["It is just as unlawful for competing health plans to agree on the prices they pay their participating providers as it is for competing providers to agree on the prices they will accept from health plans"].)

In sum, federal case law establishes that the obligations an insurer owes a subscriber are legally distinct from the insurer's transactions with providers, whether on an in-network or OON basis. (*Royal Drug*, *supra*, 440 U.S. at pp. 210–216; see also *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, *supra*, 881 F.Supp. at p. 1414.) It is "irrelevant for antitrust purposes" whether the transaction between insurer and provider is framed as a purchase or as a reimbursement. (*Kartell*, *supra*, 749 F.2d at p. 926.) Either way, it is unlawful for insurers to agree to fix the price of OON reimbursements, just as it is unlawful for providers to do so. (See, e.g., *Maricopa County*, *supra*, 457 U.S. at pp. 342–348 [agreements among competing physicians setting maximum fees payable by insurers unlawful notwithstanding asserted cost containment justification]; *Mandeville Island*

*Farms, Inc. v. American Crystal Sugar Co.* (1948) 334 U.S. 219, 236 [Sherman Act applies to purchasers and sellers].) We see no reason to reach a different conclusion under the Cartwright Act, which is broader than its federal counterpart. (See *Cianci*, *supra*, 40 Cal.3d at p. 920.)

**III.**

We conclude the demurrer should not have been sustained based on the theory that OON reimbursements are not subject to antitrust scrutiny for price fixing or tampering.[5] Because the trial court sustained MultiPlan's demurrer to all claims on this ground without leave to amend, the court did not reach other arguments MultiPlan advanced in its demurrer. Because the parties also did not brief these alternative arguments before us, we will remand for the trial court to address them in the first instance. (See *Villarroel*, *supra*, 97 Cal.App.5th at p.781; *Linear Technology Corp. v. Applied Materials*, *Inc.* (2007) 152 Cal.App.4th 115, 130–131.)

The judgment is reversed. The matter is remanded for further proceedings. Appellant shall recover its costs on appeal.

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[5] In light of our conclusion, we need not reach the parties' additional arguments on the Knox-Keene Act or policy considerations. But while we decline to rest our decision on policy considerations, we note with concern that the trial court's ruling would appear to exempt a significant portion of the healthcare industry from antitrust scrutiny, particularly when coupled with courts' repeated refusal to allow subscribers to challenge similar conduct. (See *Franco*, *supra*, 818 F.Supp.2d at pp. 812–814, 829–841; *Aetna UCR*, *supra*, 2015 U.S.Dist.Lexis, at pp. *39–*40, *57–*78.) Such an exemption would be at odds with the Cartwright Act's "strong public policy . . . encouraging free and open competition and competitively established prices." (*Cellular Plus*, *supra*, 14 Cal.App.4th at pp. 1242–1243.)

TUCHER, P.J.

WE CONCUR:

FUJISAKI, J.

PETROU, J.

*VHS Liquidating Trust v. MultiPlan Corporation et al.* (A171914)

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| Trial Court: | City and County of San Francisco Superior Court |
| Trial Judge: | Hon. Anne-Christine Massullo |
| Counsel: | Bartko Pavia, Patrick M. Ryan, Chad E. DeVeaux, Marisa Livesay and Brittany N. DeJong for Plaintiff and Appellant |
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