IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF INDIANA

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, CIGNA HEALTH AND LIFE INSURANCE COMPANY **PLAINTIFFS,** **V.** **NORTHWEST REGIONAL SURGERY CENTER, LLC, ADVANCED REGIONAL SURGERY CENTER LLC, CARMEL SPECIALTY SURGERY CENTER LLC, COLUMBUS SPECIALTY SURGERY CENTER LLC, INDIANA SPECIALTY SURGERY CENTER LLC, METRO SPECIALTY SURGERY CENTER LLC, MIDWEST SPECIALTY SURGERY CENTER LLC, MUNSTER SPECIALTY SURGERY CENTER LLC, RIVERVIEW SURGERY CENTER LLC, SOUTH BEND SPECIALTY SURGERY CENTER LLC, SYCAMORE SPRINGS SURGERY CENTER LLC, SURGICAL CENTER DEVELOPMENT, INC. D/B/A SURGCENTER DEVELOPMENT, SURGICAL CENTER DEVELOPMENT #3 LLC** **DEFENDANTS.**	**Civil Action No.:** ______________

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PLAINTIFFS' ORIGINAL COMPLAINT

Plaintiffs Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (collectively "Cigna") file this Original Complaint against Defendants Northwest Regional Surgery Center LLC, Advanced Regional Surgery Center LLC, Carmel Specialty Surgery Center LLC, Columbus Specialty Surgery Center LLC, Indiana Specialty Surgery Center LLC, Metro Specialty Surgery Center LLC, Midwest Specialty Surgery Center LLC, Munster Specialty Surgery Center LLC, Riverview Surgery Center LLC, South Bend Specialty Surgery Center LLC, Sycamore Springs Surgery Center LLC (collectively, the "ambulatory surgery centers" or "ASCs"), Surgical Center Development, Inc. d/b/a SurgCenter Development, and Surgical Center Development #3 LLC (collectively, "SurgCenter," and together with the ASCs, "Defendants") and allege as follows:

INTRODUCTION

1. SurgCenter has entered into separate conspiracies with each of the Defendant ASCs. SurgCenter conspired with each of the ASCs to engage in fraudulent "dual pricing" and "fee forgiving" schemes, whereby the ASCs charge their patients little or nothing for out-of-network medical services while charging exorbitant rates to the patients' health insurance plans administered through Cigna.

2. Cigna is a Connecticut managed care company that administers employee health and welfare benefit plans (including, but not limited to, plans insured by Cigna). It is part of Cigna's responsibilities to those plans to control overall healthcare costs. One way Cigna discharges that responsibility is by entering into agreements with networks of healthcare providers, under which the providers agree to accept fixed rates for services in consideration of other benefits, including access to plan members. In the plans at issue here, plan members remain

free to use providers outside these networks, but their plans provide them incentives to remain in the network, and thereby to lower costs for the plan as a whole.

3. One such incentive involves requiring plan members to bear a portion of the cost (either through co-payment, co-insurance or deductible obligations) of treatment by out-of-network providers, who generally charge higher rates than doctors in the network. Without this obligation, out-of-network providers could submit charges to healthcare plans which have no relation either to the provider's actual costs or to the actual market for medical services, and members would have no incentive to avoid those providers.

4. The ASCs are "out-of-network" or "non-participating" providers, meaning they do not have contracts with Cigna.

5. Each ASC—with significant support and assistance from SurgCenter—undermined the above-mentioned safeguards by means of a fraudulent "fee forgiving" scheme. The ASCs lure patients from health plans that are administered and/or insured by Cigna by misrepresenting those patients' responsibilities under the plans, by promising not to collect the patients' required co-payment, co-insurance or deductible obligations, and by further promising not to seek reimbursement from the patient for any other portion of its bill that the plan does not cover.

6. Specifically, the ASCs lured Cigna's plan members in as patients by offering to bill and collect for surgical procedures at the plan members' "in-network" or lower benefits levels, even though the ASCs knew that, because they are out-of-network facilities, the plan members' out-of-network benefits levels should apply.

7. The ASCs then each followed an undisclosed dual pricing scheme developed in coordination with SurgCenter. Under this scheme, the ASCs calculated their patients' cost-

sharing responsibility by applying a 150% multiplier to Medicare rates for services performed by the ASC, and then discounting those rates by the portion that the patients would have paid had they seen an in-network provider. When calculating how much to charge Cigna for those same services, however, the ASCs did not apply this same 150% multiplier to Medicare rates, and instead applied an 800% multiplier to Medicare rates—resulting in charges to Cigna that were as much as tens of thousands of dollars higher than the rates they used to calculate their patients' responsibility. The ASCs did not disclose to Cigna that they calculated how much they would collect from their patients based on the 150% of Medicare rate formula. The ASCs also did not disclose to their patients that they charged Cigna based on the much higher 800% of Medicare rate formula for those same services. In short, the ASCs never disclosed that they charged Cigna and their patients different prices for the same services. Cigna did not learn of the details of the ASCs' dual-pricing scheme until after Cigna was induced into overpaying for the ASCs' claims, and until after Cigna conducted its own investigation and analysis of the ASCs' claims.

8. As is the case with all of their patients covered by Cigna plans, the ASCs excuse the patients from paying anything more than the small amounts that the patients paid to the ASCs pursuant to this dual pricing scheme.

9. Put simply, the inflated "charges" that the ASCs submitted to Cigna are fraudulent, as these "charges" bear no relation to the amounts the ASCs actually charged their patients. Indeed, courts have referred to the charges submitted by fee-forgiving providers like the ASCs as "phantom" charges.

10. "Fee forgiving" of this kind has long been recognized as a variety of medical billing fraud. More than two decades ago, the American Medical Association advised its members: "[P]hysicians should be aware that . . . [r]outine forgiveness of waiver or copayments

may constitute fraud under state and federal law." *See* AMA Ethics Advisory Opinion 6.12 – Forgiveness or Waiver of Insurance Copayments (June 1993) (*available at* http:/www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion612.page). In the context of the federal Medicare program, the Department of Health and Human Services reached the same conclusion: "Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in . . . false claims . . . [and] excessive utilization of items and services paid for by Medicare." HHS OIG Special Fraud Alerts (Dec. 19, 1994) (*available at* https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html).

11. Likewise, courts have consistently found that these types of billing practices are improper and have affirmed healthcare plans' right not to cover the artificial inflated "charges" that providers like the ASCs submit. Indeed, courts, state legislatures, and other governmental bodies have recognized that these schemes victimize health care benefits plans and the clients who sponsor them, members of these plans, and managed care companies like Cigna, by exponentially increasing healthcare costs for employers and employees.

12. At least two states, Colorado and Florida, have already declared these types of schemes illegal and have enacted statutes to stop them. *See* Colo. Rev. Stat. Ann. § 18-13-119; Fla. Stat. Ann. § 817.234(7).

13. Cigna was only able to confirm the ASCs' fraudulent billing practices through a special investigation of the ASCs, after which Cigna began reducing or denying payment for claims submitted by the ASCs.

14. The net effect of the Defendants' schemes was, among other things, to mislead Cigna plan members into believing that the ASCs could offer services at Cigna's in-network

benefits levels when, in fact, the ASCs could not, which artificially increased the cost of healthcare to Cigna and its clients.

15. SurgCenter-affiliated ASCs in Indiana alone have fraudulently induced Cigna into paying millions of dollars to the ASCs as a result of their fee-forgiving schemes.

16. In this action, Cigna seeks to recover the payments made to the ASCs and to prevent SurgCenter and the ASCs from continuing their fraudulent billing schemes against Cigna. By bringing this action, Cigna is ensuring that its clients and plan members are charged only appropriate amounts for services rendered, and thereby helping to maintain the affordability of healthcare coverage for individuals and employers.

PARTIES

17. Plaintiff Connecticut General Life Insurance Company is a company organized under the laws of the State of Connecticut, with its principal place of business in Bloomfield, Connecticut.

18. Plaintiff Cigna Health and Life Insurance Company is a company organized under the laws of the State of Connecticut, with its principal place of business in Bloomfield, Connecticut.

19. Defendant Northwest Regional Surgery Center LLC is an Indiana limited liability company with its principal place of business in Merrillville, Indiana.

20. Defendant Advanced Regional Surgery Center LLC is an Indiana limited liability company with its principal place of business in Jeffersonville, Indiana.

21. Defendant Carmel Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in Carmel, Indiana.

22. Defendant Columbus Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in Columbus, Indiana.

23. Defendant Indiana Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in Bloomington, Indiana.

24. Defendant Metro Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in Jeffersonville, Indiana.

25. Defendant Midwest Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in Indianapolis, Indiana.

26. Defendant Munster Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in Munster, Indiana.

27. Defendant Riverview Surgery Center LLC is an Indiana limited liability company with its principal place of business in Rockport, Indiana.

28. Defendant South Bend Specialty Surgery Center LLC is an Indiana limited liability company with its principal place of business in South Bend, Indiana.

29. Defendant Sycamore Springs Surgery Center LLC is an Indiana limited liability company with its principal place of business in Indianapolis, Indiana.

30. Defendant Surgical Center Development, Inc. is a Nevada corporation with its principal place of business in Pismo Beach, California. Upon information and belief, Surgical Center Development, Inc. takes an active role developing and managing each Defendant ASC, including assisting ASCs in their formation, advising each ASC regarding fees, billing and collections policies, and responses to inquiries regarding the ASCs' claims and services.

31. Defendant Surgical Center Development #3 LLC ("SurgCenter #3") is a Nevada limited liability company with its principal place of business in Carson City, Nevada. Upon

information and belief, SurgCenter #3 takes an active role developing and managing each Defendant ASC, including assisting ASCs in their formation, advising each ASC regarding fees, billing and collections policies, and taking an ownership interest in each ASC.

JURISDICTION AND VENUE

32. This Court has personal jurisdiction over the parties because the ASC Defendants are located in this State and because all Defendants systematically and continuously conduct business in this State and otherwise have minimum contacts with this State sufficient to establish personal jurisdiction. Further, this Court has personal jurisdiction over Defendants pursuant to the Racketeer Influenced and Corrupt Organizations Act ("RICO") 18 U.S.C. § 1965(a)-(b). In addition, this Court has personal jurisdiction over the Defendants pursuant to 29 U.S.C. § 1132(e)(2).

33. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because it arises under the Constitution, laws, or treaties of the United States. Specifically, Plaintiffs assert claims in this case that arise under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et. seq. and RICO 18 U.S.C. § 1962(c). The Court has jurisdiction over Cigna's remaining claims pursuant to 28 U.S.C. § 1367 because the state and common law claims alleged herein are so related to the federal claims that they form part of the same case or controversy.

34. In addition, the Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332, as there is complete diversity between Plaintiffs and Defendants, and the amount in controversy substantially exceeds $75,000. Plaintiffs are both citizens of Connecticut. The Defendant ASCs are citizens of Indiana and Defendant SurgCenter is a citizen of California and Nevada. With respect to all Defendants, absent injunctive relief, Cigna has suffered or will

suffer substantially in excess of $75,000 in damages as a result of Defendants' actions described herein.

35. Venue is proper in the Northern District of Indiana because certain of the ASCs may be found in this judicial district, and a substantial part of the events giving rise to the claims in this action occurred in this District. 29 U.S.C. §§ 1132(e)(2), 1391(b)(1), and 1391(b)(2). Specifically, many of the patients identified in the claims for reimbursement submitted by the ASCs reside in this District, the services provided to Cigna's customers for which certain ASCs obtained payments from Cigna were performed in this District, and the ASCs and SurgCenter conduct business within this District.

FACTUAL BACKGROUND

Relevant Facts Regarding Managed Care and Cigna-Administered Plans.

36. Cigna, among other things, insures and administers employee health and welfare benefit plans.

37. The majority of Cigna-administered plans are Administrative Services Only ("ASO") plans funded by the employers who sponsor them. Cigna is a fiduciary for these plans in its role as the plans' claims administrator.

38. Some of the employers who have been victimized by paying the ASCs' exorbitant, fraudulent "charges" are government entities. Thus, some of the funds paid to fraudulent providers like the ASCs are ultimately paid with taxpayer dollars.

39. Certain Cigna entities also offer fully-insured plans, which are funded by Cigna. Cigna also serves as the plans' claims administrator for fully-insured plans.

40. Regardless of the type of plan funding, Cigna is a fiduciary of each of the plans at issue, as it exercises discretionary authority over plan assets and plan administration in its

capacity as a claims administrator, by, among other things, making benefits determinations and paying benefit claims. In this fiduciary capacity as a claims administrator, Cigna has processed claims and/or addressed appeals on behalf of all of the plans at issue. The plans at issue explicitly provide Cigna with the discretionary authority to calculate benefits and administer the plans. *See, e.g.*, Ex. 1 at 43 ("**Calculation of Covered Expenses:** [Cigna], in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings . . ."); *id.* at 56 ("**Discretionary Authority:** The Plan Administrator delegates to [Cigna] the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to [Cigna] the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.").

41. Regardless of the type of plan funding, all of the plans at issue authorize Cigna to recover any overpayments made by the plans on the plans' behalves. *See, e.g.*, Ex. 1 at 43 ("Recovery of Overpayment: When an overpayment has been made by [Cigna], [Cigna] will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment."). Indeed, Cigna's ASO Agreements with ASO plans require Cigna to recover overpayments made on the plans' behalf—stating that, "[i]n the event that [Cigna] overpays a claim for Plan Benefits

or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayment," including the potential of litigation.

42. The overpayment recovery provisions in these plans specifically identify a particular fund, distinct from the recipient's general assets—*i.e.*, payments made by Cigna or the plans to the recipient. These provisions also specifically identify a particular share of that particular fund to which Cigna is entitled—*i.e.*, the amount of the overpayment. Accordingly, these overpayment recovery provisions create an equitable lien by agreement over any overpayments made by Cigna or the plans. The provision puts plan members (and providers, as explained below) on notice that any overpayment made by Cigna will be recoverable (*i.e.*, subject to a lien) as soon as the overpayment is made.

43. The overpayment plan provisions discussed above apply equally to providers when a plan member assigns his or her claim for reimbursement to the provider. The plans generally allow a member to assign his or her claim for reimbursement to a provider, with Cigna's consent. *See, e.g.*, Ex. 1 at 43. When the provider in turn submits a claim to Cigna, it indicates that the claim for benefits has been assigned. *See, e.g.*, Ex. 2 (representative claim record submitted by ASC indicating benefits have been assigned). When a member assigns a claim to a provider, the provider stands in the shoes of the member and is eligible for reimbursement only to the extent the member would have been in the absence of an assignment. Moreover, the provider is on notice of the provisions governing reimbursement—including cost-share requirements, the exclusions for amounts that would not have been charged in the absence of insurance or that members are not obligated to pay—and the recovery of overpayments. Upon information and belief, each of the ASCs patients have assigned their claims for reimbursement

to the respective ASC, as indicated on the claim submission forms that the ASCs submit to Cigna for reimbursement. *See, e.g.*, Ex. 2.

44. Accordingly, when the ASC accepts assignment of a plan member's claim for imbursement without charging or collecting the member's cost-share requirements, the ASC is not entitled to reimbursement for the claim, just as a plan member would not be entitled to reimbursement if she submitted the claim herself without having satisfied her cost-share obligation.

45. The majority of the plans under which the ASCs sought benefits are governed by ERISA. Some of the plans at issue are not governed by ERISA, because, for example, they are sponsored by governmental or church employers. The spreadsheets attached as Exs. 3A-3K indicates whether each plan is governed by ERISA. Most of the plans at issue here offer members the choice of receiving services either from health care providers that contract with Cigna to participate in Cigna's provider network or from providers outside of that network.

46. Cigna-administered health plans reimburse their members for certain healthcare costs, defined in the plans as "covered expenses," which are expenses incurred by the member for services that are covered under the plan and are medically necessary. When a Cigna plan member receives medical services, Cigna determines what part of the provider's billed charges is considered for coverage by the plan, known as the "allowed amount."

47. There are different types of member responsibility, including deductibles, benefit limits, co-payments, and co-insurance.

48. These member cost-sharing responsibility amounts are calculated as a percentage or portion of the allowed amount.

49. If a member receives a service from a provider that contracts to be part of Cigna's network (an "in-network" or "participating" provider), the plan pays the provider the amount that the provider agreed to accept—its contracted network rate. The member pays any applicable co-insurance, co-payments, and deductibles toward the allowed amount based on the coverage for in-network services specified in the member's plan, and the plan pays the balance of the allowed amount.

50. In exchange for agreeing to accept fixed, network rates for their services, participating providers receive certain benefits, including access to members of Cigna-administered plans as a source of patients.

51. Just as they benefit participating providers, Cigna's network arrangements benefit employers and plan members by controlling overall health care costs and increasing the quality of medical care. In addition, members benefit from obtaining services from a participating provider because participating providers agree not to bill members for the difference between the allowed amount and the provider's billed charges.

52. In contrast, if a member receives a service from a provider who does not contract to be part of Cigna's provider network (an "out-of-network" or "non-participating" provider), the provider can charge whatever it likes for its services—and out-of-network rates generally are higher than contracted rates—and the provider may "balance bill" the member for the difference between the allowed amount and the provider's billed charges.

53. With respect to out-of-network claims, Cigna's plans limit reimbursement to the "Maximum Reimbursable Charge" (MRC) for "covered expenses." The MRC is the lesser of (a) the provider's normal charge for a similar service, or (b) either a specified percentile of charges made by other providers of such services in the region or a specified percentile of the

reimbursement rate that Medicare provides for such services, in the same geographic area. *See, e.g.*, Ex. 1 (example of Cigna-administered plan). For a variety of reasons, the billed amount is relevant and material to the determination of the "allowed amount," which is the amount that Cigna determines to be covered by its plan, and which forms the basis for determining Cigna's reimbursement payment and the plan member's cost-share responsibility.

54. To make out-of-network benefits an affordable option for the employers sponsoring them, Cigna's plans contain various financial incentives for members to choose participating providers, by requiring them to share the increased costs associated with obtaining out-of-network services. Most significantly, Cigna's plans require members to pay a higher portion of the cost of out-of-network services through higher cost-share obligations, including deductibles and coinsurance payments. A "deductible" is an amount that must be paid by the member for Covered Expense each calendar year before the plan begins paying its percentage of Covered Expenses. *See* Ex. 1 at 12-22 (examples of deductibles under a representative Cigna plan). "Coinsurance" is a percentage of the allowed amount that the member is required to pay towards the cost of that service. *See id.* at 11. The deductible and co-insurance amounts that members must pay towards out-of-network services are usually much higher than the deductible and co-insurance they must pay (if any) towards in-network services.

55. The deductible and co-insurance requirement underlies the entire concept of out-of-network benefits. It sensitizes members to the true costs of out-of-network services—ensuring that if members receive such a service, they are willing to pay a greater portion of that expense out of their own pockets. If members did not share in these costs, then they would have no financial incentive to moderate their demand for out-of-network services or to consider the higher costs of any particular out-of-network provider, leading to increased costs for the plan.

56. Similarly, without deductible and co-insurance requirements, out-of-network providers would lack any incentive to not charge the plan astronomical rates, because the patients who choose to see the providers would not bear any portion of the inflated cost.

57. Cigna's plans have several mechanisms to ensure that members receiving out-of-network services pay their required deductible and co-insurance and that non-participating providers do not waive it.

58. For example, Cigna's plans do not automatically cover or reimburse a member for every "charge" the provider submits to Cigna. Rather, for a benefit to be payable, the charge must be a "Covered Expense," which satisfies all terms and condition of the plan, including that the expense is "incurred" by or for a covered person (*i.e.*, a plan member or the member's dependent), that the expense is medically necessary, and that it is included on the list of covered expenses appearing in the summary plan description and is not excluded from coverage. *See, e.g.*, Ex. 1 at 24. Cigna's obligation to reimburse a plan member is therefore limited to the expenses actually incurred by the member. If the member has no obligation to pay, then Cigna has no obligation to pay.

59. These Covered Expenses are in turn subject to the applicable cost-share requirements of the plan, including deductible and coinsurance, as described above. Cigna-administered plans define deductible as "expenses to be paid by you or your Dependent . . . [that] are in addition to any Coinsurance," and define co-insurance as "the percentage of charges for Covered Expenses that an insured person is ***required*** to pay under the plan." *See* Ex. 1 at 11 (emphasis added). Thus, Cigna-administered plans expressly require members to satisfy their cost-sharing responsibility (*i.e.*, co-insurance, co-payments, and deductibles) in order for charges

to be covered under the plans. Indeed, the plan's obligation to reimburse for its share of covered expenses does not even arise until the member has satisfied their full, out-of-network deductible.

60. Similarly, Cigna-administered plans state that they do not cover "charges which you [the member] are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan." Ex. 1 at 37. The language is representative of the language found in Cigna-administered plans. As a recent version of Cigna's plans explains, "[s]ome providers forgive or waive the [patient's] cost share obligation . . . that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan." Ex. 4 at 13; *see also id.* at 36 (explaining that "charges which you are not obligated to pay" include the "charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefit level or some other benefits level not otherwise applicable to the services received.").

61. Here, for example, if an ASC submits "charges" of $10,000 to Cigna, but does not bill or require the patient to pay their applicable cost-sharing responsibility, the plan excludes coverage for this phantom charge.

62. In addition, Cigna-administered plans generally limit reimbursement for out-of-network services to the "Maximum Reimbursable Charge" for "covered services," which can be no more than the "provider's normal charge for a similar service or supply," and explicitly exclude from coverage providers' charges "to the extent that they are more than Maximum Reimbursable Charges."

63. Here, the inflated "charges" submitted to Cigna by the ASCs were not their "normal charge" for the services at issue, because these were not the charges that the ASCs actually charged to their patients. Rather, the "charges" submitted to Cigna were "phantom"

charges, as some courts have referred to the charges submitted by fee-forgiving providers. Cigna was not aware that the ASCs' billed charges were not their "normal charges" until after Cigna conducted its own internal investigation of the ASCs' claims, because the ASCs never disclosed to Cigna that they were engaged in a dual pricing scheme—*i.e.*, charging Cigna and their patients different rates for the same services. As described below, at the time of service, the ASCs did not quote patients the "charges" submitted to Cigna. Instead, the ASCs based the amounts that they collected as cost-share from their patients on much lower amounts that had no relationship to the amounts that they charged Cigna for the same services.

64. Moreover, by promising Cigna plan members that in-network benefits would apply and that they would incur no additional out-of-pocket expenses above and beyond the ASCs' artificial cost share liability quoted to Cigna plan members, the ASCs foreclosed themselves from billing and collecting any additional amount of money.

65. Courts have repeatedly held in the context of "fee forgiving" or "dual pricing schemes" that healthcare plans do not cover a provider's "charges" when that provider does not collect the patient's applicable cost-sharing responsibilities. *See, e.g.*, *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701 (7th Cir. 1991); *Biomed Pharms., Inc. v. Oxford Health Plans (NY), Inc.*, 522 F. App'x 81, 81-82 (2d Cir. 2013).

66. Any other interpretation would run contrary to the purpose of health insurance, which is to reimburse members for payments they actually make to providers, not to provide windfall payments to providers.

SurgCenter and the ASCs' Fraudulent Dual Pricing and Fee Forgiving Schemes

67. SurgCenter has developed a business model designed to game the healthcare system by submitting grossly inflated, phantom "charges" to Cigna that do not reflect the actual

amounts the ASCs bill patients. SurgCenter implements this fraudulent scheme through each of the ASCs with which it partners.

68. According to its website, SurgCenter "partners with local surgeons to create physician-owned and operated ambulatory surgical centers (ASC)."

69. SurgCenter assists surgeons in forming the LLC and in the design and construction of the ambulatory surgical centers, including, upon information and belief, the Defendant ASCs here.

70. SurgCenter then provides no-fee management and consulting services in managing and running the ambulatory surgical centers, including, upon information and belief, the Defendant ASCs here.

71. According to its website, SurgCenter becomes "a vested partner that purchases 35% ownership" in each ambulatory surgical center, including, upon information and belief, the Defendant ASCs here.

72. SurgCenter has an ownership interest in more than 100 ambulatory surgery centers throughout the United States, including the eleven Defendant ASCs.

73. The Defendant ASCs have not joined Cigna's provider network, and thus are known as "out-of-network" or "non-participating" providers.

74. The Defendant ASCs all employ "fee forgiving" and "dual pricing" schemes. In other words, they entice members to their out-of-network facilities by billing them small amounts (and sometimes collecting nothing at all from members), but charge the members' plans exorbitant, fraudulent amounts that bear no relation to the amounts the patients are charged.

75. Each ASC then waives, or forgives, the proportion of the charges that the member owes based on the inflated charge that the ASC submits to the member's plan. None of the ASCs

disclose to Cigna that they charged Cigna and their patients significantly different prices for the same services.

76. Upon information and belief, all aspects of the fraudulent fee forgiving and dual pricing schemes used by each ASC were designed and implemented at the direction of SurgCenter.

77. For instance, upon information and belief, SurgCenter provided each of the ASCs with a "Coding, Billing and Collections" manual, which, among other things, sets forth SurgCenter's fee-waiving policy, which was followed by the ASCs:

> Patients accessing out-of-network benefits at your Facility are not charged their out-of-network benefit levels for services performed. Patient liability at your Facility should never exceed the amount they would owe at an in-network facility. Deductible amounts are waived and in-network co-insurance are charged. (Ex. 5 at 25.)

78. The following is a summary of the fee forgiving and dual pricing schemes used by SurgCenter and each of the ASCs.

79. First, each ASC promises patients that they will only be billed rates similar to what they would pay at an in-network facility, even though the ASCs are out-of-network facilities. An example of a notice that one of the ASCs provides to patients is attached hereto as Ex. 6. The ASC then begins by calculating the rates for the services they will provide the patient at 150% of Medicare.

80. Second, each ASC calculates the Cigna plan members' cost-sharing responsibility (e.g., co-payments, co-insurance, and deductibles) by applying the Cigna plan members' ***in-network*** benefits level to those 150% Medicare rates, even though the ASCs are out-of-network providers. According to SurgCenter's "Coding, Billing and Collections" manual, each ASC waives the deductible, thereby negating any obligation by the plans to reimburse for any portion of covered expenses.

81. Upon information and belief, SurgCenter created "Insurance Verification" and "Calculation of Patient Responsibility" templates used by the ASCs to calculate the patient's responsibility under the dual pricing scheme, as well as the claim forms submitted to Cigna by the ASCs. These documents are created by SurgCenter and provided to the ASCs as part of the scheme to defraud insurers such as Cigna. An example of a Calculation of Patient Responsibility form used by a non-party SurgCenter-affiliated facility is attached hereto as Ex. 7. Upon information and belief, all SurgCenter-affiliated facilities (including the Defendant ASCs here) use this or a similar Calculation of Patient Responsibility form. Here, in the attached example, the SurgCenter-affiliated facility charged the patient only $431.88 (*id.*)—a small fraction of the patient's cost-sharing responsibility under the plan—but submitted a charge of $28,606.88 to Cigna for those same services.

82. Third, each ASC promises Cigna plan members that they will not have to bear any additional out-of-pocket expenses beyond what the ASCs have calculated as the members' cost share liability based on the members' in-network benefits level using 150% of Medicare rates. As a result, each ASC waives the applicable out-of-network co-insurance, co-payment, and deductible amounts that Cigna plan members must pay out-of-network providers like the ASCs under Cigna-administered health benefit plans.

83. Fourth, each ASC submits claim forms to Cigna based on a separate fee schedule that is calculated based on 800% of Medicare rates. These charges are fraudulently inflated by as much as tens of thousands of dollars per claim over the 150% Medicare rates that the ASCs used to determine the amounts they collected from the Cigna plan members. The "charges" submitted to Cigna by the ASCs are phantom charges, as the ASCs do not collect, and never

intend to collect, the full amounts that they put on the forms. Instead, they intend to collect much less—if anything at all.

84. Through the scheme described above, each ASC misrepresented its actual charges for the services rendered to Cigna affirmatively and through omission. As a result, Cigna relied on the amount that the ASCs billed to Cigna in their claim forms when processing and paying the ASCs' claims.

85. The purpose of this scheme was to entice Cigna plan members to use the ASCs' out-of-network surgical centers so that Cigna would reimburse the ASCs for their grossly inflated rates. Given their exorbitant charges, the ASCs and SurgCenter recognized that Cigna's plan members would not use, and likely could not afford to use, the ASCs' facilities if the ASCs billed and collected the applicable out-of-network cost share responsibility from Cigna plan members, which would have required out-of-pocket payments from Cigna plan members that totaled thousands, if not tens of thousands, of dollars. Therefore, the ASCs waived the required out-of-network co-insurance, co-payment, and deductible amounts members were obligated to pay under their plans.

86. Further, each ASC knowingly misrepresented to patients that the patients could use their "in-network" benefits at the ASCs even though the ASCs were out-of-network facilities. If Cigna patients had known that the ASCs and SurgCenter in fact have no authority to waive the out-of-network co-insurance, co-payment, and deductible amounts required by the patients' plans with Cigna, those patients likely would not have used the ASCs' facilities, given the exorbitant rates charged by the ASCs. Accordingly, each of the ASCs' and SurgCenter's misrepresentations to patients were closely related to and were essential to the accomplishment