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**UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY**

AMERICAN MEDICAL ASSOCIATION,
MEDICAL SOCIETY OF NEW JERSEY,
MEDICAL SOCIETY OF THE STATE OF
NEW YORK, CONNECTICUT STATE
MEDICAL SOCIETY, TEXAS MEDICAL
ASSOCIATION, and NORTH CAROLINA
MEDICAL SOCIETY, and DARRICK E.
ANTELL M.D., and FREDERICK A.
VALAURI, M.D., individually and on behalf of
all others similarly situated

Plaintiffs,

vs.

AETNA HEALTH INC. PA, CORP., AETNA
HEALTH MANAGEMENT, LLC, AETNA
LIFE INSURANCE COMPANY, AETNA
HEALTH and LIFE INSURANCE COMPANY,
AETNA HEALTH INC., and AETNA
INSURANCE COMPANY OF
CONNECTICUT,

Defendants.

Civil Action No.

**COMPLAINT and
DEMAND FOR JURY TRIAL**

Plaintiffs Drs. Darrick E. Antell, M.D., and Frederick A. Valauri, M.D., bring this action on behalf of themselves and all others similarly situated, and Plaintiffs American Medical Association (“AMA”), Medical Society of New Jersey (“MSNJ”), Medical Society of the State of New York (“MSSNY”), Connecticut State Medical Society (“CSMS”), Texas Medical Association (“TMA”), and the North Carolina Medical Society (“NCMS”) (the “Associational Plaintiffs”) by way of Complaint against Defendants Aetna Health Inc. PA, Corp., Aetna Health Management, LLC, Aetna Life Insurance Company, Aetna Health and Life Insurance Company, Aetna Health, Inc. and Aetna Insurance Company of Connecticut (collectively “Aetna” or “Defendants”), say:

SUMMARY OF PLAINTIFFS’ ALLEGATIONS

1. Plaintiffs Drs. Antell and Valauri bring this case as a class action on behalf of themselves and all those similarly situated physicians and physician groups (the “Class”) who are, or have been nonparticipating, or “out of network,” providers (“Nonpars” or “Non-participating” physicians or providers), in that they did not participate in Aetna’s physicians networks during the period from January 1, 2005 through the present (the “Class Period”), alleging violations of the Employee Retirement Insurance Security Act of 1974 (“ERISA”), the Racketeer Influenced and Corrupt Organizations Act (“RICO”), and the Sherman Antitrust Act, 15 U.S.C. § 1 *et seq.*, as described herein. As a Nonpar in Aetna’s physicians’ networks, Drs. Antell and Valauri and the Class have been harmed by underpayments made by Aetna for out of network services that they provided to plan enrollees. These underpayments are pervasive and result from systematic operating procedures employed by Aetna, which affect thousands of Nonpars every year.

2. The Associational Plaintiffs bring this case on their own behalf and on behalf of their membership of physicians. The Associational Plaintiffs are dedicated to advocating for the rights of physicians and patients alike for the delivery of the highest quality of medical care. The Associational Plaintiffs have been directly injured by the egregious acts and practices of Aetna as set forth in this Complaint. As a result of Aetna's unlawful practices, the Associational Plaintiffs have been required to devote substantial time and resources counseling their members on how to deal with the practices at issue, monitoring the payment practices of Aetna, corresponding with Aetna, advocating on their members' behalf, and communicating with regulators concerning Aetna's misconduct, among other things. Accordingly, the Associational Plaintiffs, on behalf of themselves and their membership, allege violations of RICO and the Sherman Act against Aetna as set forth below. The Associational Plaintiffs also allege violations of ERISA on behalf of their membership.

3. Plaintiffs Drs. Antell and Valauri and the Associational Plaintiffs are collectively referred to herein as "Plaintiffs."

4. Participating, or in-network providers ("Pars") are physicians who have signed a contract with a particular managed care entity and receive reimbursement of eligible charges directly from that entity. Pars agree to provide healthcare services to plan enrollees at reduced rates in exchange for access to the plan's patient base, among other things. When visiting a Par, plan members are only responsible for co-payments, co-insurance, and payment for non-covered items (if any) at the time of service.

5. Nonpars, by contrast, do not have a signed contract with a particular managed care entity. Nonpars, therefore, may collect their full charges directly from patients at the time of service and are not required to accept reduced rates for procedures performed. Rather than require plan members to pay out of pocket and in full for medical services, Nonpars may also

agree to accept an assignment of benefits, which occurs when a plan member authorizes his health benefits plan to remit payment directly to the provider for covered services. Managed care entities may refuse to recognize the patient's assignment and still remit payment to the patient. Whether or not the health plan honors the assignment and pays the out of network benefit amount to the physician, Nonpars are entitled to bill the patient for the amount of the physician's charge which exceeds the amount the health plan covers, known as balance billing.

6. Aetna contractually promises its members that it will pay for services performed by Nonpars at the lesser of the billed charge or the usual, customary and reasonable ("UCR," also known as "U&C" and "R&C") amount for the service rendered. Aetna also contractually promises its members that the UCR rate for a service is the "prevailing charge" charged by most providers of comparable services in the specific area where the member received the service, with consideration given to the nature and severity of the member's condition, as well as any complications or unusual circumstances that would require additional time, skill, or experience on the part of the Nonpar.

7. Aetna has engaged in a pattern and practice of providing inadequate benefits for Nonpar services as part of its effort to increase the costs to its members of going out-of-network, thereby pressuring them to use in-network providers, subject to discounted rate. In doing so, Aetna has breached the terms and conditions of its health care plans, which govern the benefits available for its members and their treating health care providers.

8. As the company that issues, insures and administers the employee benefit plans through which a number of Plaintiffs' patients received their insurance, Aetna is subject to the ERISA and its governing regulations. Further, due to the role Aetna played in administering the

plans of each of the Plaintiffs, including making coverage and benefit decisions and deciding appeals, Aetna has assumed the role as a fiduciary under ERISA toward each of the Plaintiffs.

9. By breaching the terms and conditions of its health care plans, as alleged herein, Aetna has violated its duties and obligations under ERISA.

10. In their ordinary course of business, Plaintiffs obtain assignments from the patients, which allow them to be reimbursed directly by Aetna, and they then expect to be paid the unpaid portions of their bills by the patients. Further, Aetna has accepted and recognized the validity of these assignments received from Aetna subscribers through a pattern and practice of accepting them as valid and paying Plaintiffs directly as Nonpar providers. Pursuant to assignments they have received from Aetna patients, Plaintiffs have standing to pursue this claim for benefits under ERISA.

11. Aetna issues an Evidence of Coverage (“EOC” or “Certificate”) to its participants and beneficiaries (“Aetna Members”) that sets forth the benefits that Aetna promises to pay its members. According to Aetna’s publicly available website designed for use by Aetna Members, Aetna defines a member as “a subscriber or dependent who is enrolled in and covered by a health care plan.” *See* www.Aetnavigators.com (Glossary).

12. According to its website, Aetna’s Certificate represents a “legal agreement between an individual subscriber or an employer group (‘Contract holder’) and a health plan that describes the benefits and limitations of the coverage.” *Id.*

13. Aetna’s website defines “Health Benefit Plan” as “[t]he health insurance or HMO product offered by a licensed health benefits company that is defined by the benefit contract and represents a set of covered services or expenses accessible through a provider network, if applicable, or direct access to licensed providers and facilities.” *Id.*

14. Under the relevant plans, Aetna Members have an express right to receive benefits for services received from Nonpar providers. For other plans, including certain Health Maintenance Organization (“HMO”) plans, Aetna Members may use Nonpar providers in emergencies, when they are out of the home area, or when no participating provider is qualified or available to perform the medically necessary service. When Aetna Members receive Nonpar services, Aetna’s payment is based on the lesser of the billed charge or the usual, customary and reasonable (UCR) amount for that service in the geographic area in which it was performed. Aetna uses the terms “UCR,” “customary and reasonable,” and “reasonable charge” interchangeably. In addition, Aetna commits to provide benefits for all medically necessary services.

15. As explained on Aetna’s website, Aetna will calculate reimbursement for Out-of-Network or Nonparticipating providers by calculating UCR:

Out-of-Network. The use of health care providers who have not contracted with the health plan to provide services. Members enrolled in preferred provider organizations (PPO) and point-of-service (POS) coverages can go out-of-network for covered services, but will pay additional costs in the form of deductibles and coinsurance and will be subject to benefit and lifetime maximums. Because reduced fees are not negotiated with out-of-network providers, Aetna will calculate reimbursement based on the usual, customary and reasonable [“UCR”] charge (see *definition*). Members are responsible for all charges above UCR in addition to any deductible and coinsurance provisions.

16. Aetna calculates benefits for Nonpar services based on its determination of the UCR for the services at issue. Aetna’s website defines the Customary and Reasonable charge as follows:

The amount customarily charged for the service by other providers in the same Geographic area (often defined as a specific percentile of all charges in the Community), and the reasonable cost of services for a given patient. **Also called “Usual, Customary, and Reasonable” (UCR).**

17. Aetna's website also includes on its website its standard definition for "Reasonable Charge," as follows:

The charge for a covered benefit, which is determined by Aetna to be the prevailing charge level, for the service or supply in the geographic area where it is furnished. Aetna may take into account factors such as the complexity, degree of skill needed, type or specialty of the Provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Reasonable Charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

18. Aetna treats all of its definitions of UCR in its plans as having identical meanings and applies uniform policies for calculating UCR.

19. In-network or contracted or participating providers enter into contracts with Aetna to accept reduced or discounted fees for their services. When a Member uses a Par provider, his or her financial responsibility is limited to a specified co-payment, typically in the range of \$10 to \$30 per service.

20. Aetna's website defines "Non-Participating Provider" as follows: "This term is generally used to mean providers who have not contracted with a health plan to provide services at reduced fees. Also called Non-Preferred Care Provider." When an Aetna Member uses a Nonpar provider, Aetna imposes additional costs on the Member in the form of higher deductibles and coinsurance, and benefit and lifetime maximums. Aetna does not begin to pay for Nonpar services until the Aetna Member has satisfied his or her calendar year deductible. Once a Member satisfies the deductible, then Aetna will pay a share (typically 80%) of the allowed amount for Nonpar Services. If and when a Member reaches a maximum amount of out-of-pocket expenses for Nonpar services, typically in the range of \$1,500 - \$3,000, the Member has no further coinsurance obligation (*e.g.*, 20% of the allowed amount) for any additional

Nonpar services for that calendar year. Aetna does not credit amounts above UCR to the Member's deductible or out-of-pocket maximum.

21. Aetna is obligated to pay accurate UCR amounts to its Members for Nonpar services consistent with the UCR definition.

22. Aetna fails to comply with its own UCR definition by failing to reimburse based on accurate UCR rates to its Members for Nonpar services.

23. To determine UCR, Aetna primarily relies on a computer database of provider charge data obtained from a third party, Ingenix, Inc. ("Ingenix"), which is a wholly-owned subsidiary of United Healthcare Corporation, another major insurer. Ingenix's databases are also known as the Prevailing Healthcare Charges System ("PHCS") and Medical Data Research ("MDR") (collectively, "Ingenix Databases").

24. In December 1997, Ingenix purchased Medicode, Inc., a Salt Lake City-based provider of healthcare products, including MDR. In October 1998, Ingenix purchased the PHCS database from the Health Insurance Association of America ("HIAA"), a trade group for the insurance industry.

25. Aetna is a contributor of provider charge data to the Ingenix Databases. Prior to contributing its data to Ingenix, Aetna deleted valid high charges. Following receipt of the data from Aetna, Ingenix then removed additional valid high charges from all contributors' data. Ingenix then published the corrupted database, after Aetna and Ingenix had, in effect, "cooked the books." The corruption of the data invalidates its use by Aetna as the basis for determining UCR for Nonpar providers' services. Aetna and UnitedHealthcare Corp. ("UnitedHealthcare"), the owner of the Ingenix database, contributed approximately 70 percent of the data to the Ingenix database. These actions (among others referenced herein) violated both ERISA, a federal

law designed to protect group plan participants and beneficiaries, and the Racketeer Influenced and Corrupt Organization Act (“RICO”).

26. In addition to UCR determinations based on the Ingenix Databases, Plaintiffs and class members challenge other Nonpar benefit reimbursement reductions, including those imposed by use of the following methods: use of discounted amounts or Par provider fee schedules; use of Medicare data; use of the average wholesale price (“AWP”) to determine UCR for pharmaceutical drugs; failing to pay appropriately for emergency room (“ER”) services; failing to properly credit deductible amounts and out-of-pocket maximums; failing to provide an appropriate appeals process mechanism; approving requests for preauthorization without disclosing its nonpayment of a large percentage of the billed charges; threatening to refer members and Nonpar providers to collection agencies based on baseless allegations of overpayment by Aetna; refusing to pay for facility fees for the proper use of accredited office based surgical (“OBS”) facilities, and other improper practices (collectively, along with UCR, “Nonpar Benefit Reductions”).

27. Nonpar Benefit Reductions leave Aetna Members financially responsible for unpaid amounts and act as exclusions from coverage. As the entity excluding benefits through its Nonpar Benefit Reductions, Aetna has the burden to demonstrate that its exclusions comply with its legal obligations. Plaintiffs allege that Aetna cannot sustain its burden regarding its Nonpar Benefit Reductions, and seek unpaid benefits and other relief for themselves and on behalf of ERISA Class members.

28. Aetna’s deceitful and pervasive business practices forced Plaintiffs and the Class to expend significant time and resources towards identifying, disputing and then appealing Aetna’s improper reimbursement determinations. Aetna’s Nonpar pricing methods violated

Aetna's legal obligations to Drs. Antell and Valauri and the Class, as assignees and beneficiaries of their patients' benefits, and violated federal and state law as herein described, causing Plaintiffs and the Class significant financial harm.

29. Plaintiffs, on behalf of themselves and all similarly situated Aetna Members, allege that Aetna's Nonpar Benefit Reductions violate ERISA and RICO. Plaintiffs' class action claims, including the respective "Class Periods," are defined below.

PARTIES

Individual Plaintiffs

30. Plaintiff **Dr. Darrick E. Antell** is a board certified plastic and reconstructive surgeon who has been in practice for over 20 years. He is an official spokesperson for the American Society of Plastic Surgeons and is a Fellow of the American College of Surgeons. He received his general surgery training at Stanford University Medical Center and his specialty training in plastic/reconstructive surgery at the New York Hospital/Cornell Medical Center and the Memorial Sloan-Kettering Cancer Center in New York City. He also has a Doctor of Medical Dentistry degree from Case Western Reserve University. Dr. Antell is a citizen of the state of Connecticut and is licensed to practice medicine in New York, and he is a Nonpar in Aetna's physician networks.

31. Plaintiff **Dr. Frederick A. Valauri** is a board certified plastic and reconstruction surgeon who has been in practice for over 30 years. He is past president of the New York Regional Society of Plastic and Reconstructive Surgery, is a member of some 20 professional societies, is Attending Surgeon at several New York hospitals and teaches cosmetic surgery to plastic surgery residents at those hospitals. Dr. Valauri received his M.D. from SUNY-

Downstate in Brooklyn. He is a citizen of the state of New York and is licensed to practice medicine in New York, and he is a Nonpar in Aetna's physicians networks.

The Associational Plaintiffs

32. Plaintiff **American Medical Association ("AMA")** is headquartered in Chicago, Illinois. The AMA is a national tax-exempt membership organization that represents the interests of approximately 240,000 physicians, residents and medical students, as well as their patients located in New Jersey and throughout the United States. As the largest medical association in the United States and as the owner of Current Procedural Terminology ("CPT" or "CPT Codes"), the AMA works to represent its members with respect to payment practices by payors, such as Aetna, to healthcare providers, particularly physicians. Both AMA physicians and AMA in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

33. AMA appears herein on behalf of itself and its members, and also as a representative of the Litigation Center of the AMA and State Medical Societies. The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

34. AMA has individual standing as it has been injured by Aetna's wrongful conduct as alleged herein. AMA has expended considerable time and resources helping its members deal with issues concerning Aetna's improper UCR reimbursements.

35. AMA also has associational standing on behalf of its members who have claims against Aetna for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit AMA seeks declaratory and injunctive relief.

36. Plaintiff **Medical Society of New Jersey (“MSNJ”)** is a New Jersey not-for-profit corporation organized and existing under the laws of New Jersey. MSNJ was founded in 1766, and is the oldest professional society in the United States. MSNJ represents approximately 8,000 physicians in the state of New Jersey. The organization and its dues-paying members are dedicated to a healthy New Jersey, working to ensure the sanctity of the physician–patient relationship. In representing all medical disciplines, MSNJ advocates for the rights of patients and physicians alike, for the delivery of the highest quality medical care. This allows response to the patients’ individual, varied needs, in an ethical and compassionate environment, in order to create a healthy New Jersey and healthy citizens. MSNJ’s stated mission is “[t]o promote the betterment of the public health and the science and the art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine.”

37. MSNJ has individual standing as it has been injured by Aetna’s wrongful conduct as alleged herein. MSNJ has expended considerable time and resources helping its members deal with issues concerning Aetna’s improper UCR reimbursements.

38. MSNJ also has associational standing on behalf of its members who have claims against Aetna for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit, MSNJ seeks declaratory and injunctive relief.

39. Plaintiff **Medical Society of the State of New York (“MSSNY”)** is a New York not-for-profit corporation organized and existing under the laws of the state of New York since 1807. MSSNY represents approximately 30,000 licensed physicians, medical residents, and medical students in New York State. MSSNY is committed to representing the medical

profession as a whole and advocating health related rights, responsibilities and issues. MSSNY is further committed to serving as a resource for its members and assisting them in addressing the many issues and needs which they face in providing health care to their patients. MSSNY strives to enhance the delivery of medical care of high quality to all people in the most economical manner, and to act to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public. Both MSSNY physicians and MSSNY in its own capacity have been injured by the egregious acts and practices of defendants as set forth in this Complaint.

40. MSSNY has individual standing as it has been injured by Aetna's wrongful conduct as alleged herein. MSSNY has expended considerable time and resources helping its members deal with issues concerning Aetna's improper UCR reimbursements.

41. MSSNY also has associational standing on behalf of its members who have claims against Aetna for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit, MSSNY seeks declaratory and injunctive relief.

42. Plaintiff **Connecticut State Medical Society ("CSMS")** is a federation of eight component county medical associations, with a total membership of approximately 7,000 physicians. CSMS itself is a constituent state entity of the American Medical Association. Founded by the physician-patriots of the American Revolution, the Society operates from a heritage of democratic principles embodied in its Charter and Bylaws. The philosophy and purpose of the CSMS is to promote the highest standards of medical care in the State of Connecticut, to work to preserve the integrity and independence of physicians, and to support the sanctity of the physician-patient relationship for the benefit of the public by, among other things,

facilitating and assisting its physicians in providing top quality care to their patients, providing them with a unified voice and enabling them to take concerted action on behalf of their profession and of their patients, and acting and advocating on their behalf to preserve the ability, independence and freedom of physicians to render the best possible care to every patient. Both CSMS physicians and CSMS in its own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

43. CSMS has individual standing as it has been injured by Aetna's wrongful conduct as alleged herein. CSMS has expended considerable time and resources helping its members deal with issues concerning Aetna's improper UCR reimbursements.

44. CSMS also has associational standing on behalf of its members who have claims against Aetna for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit, CSMS seeks declaratory and injunctive relief.

45. Plaintiff **Texas Medical Association ("TMA")** was organized by 35 physicians in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. Today, with more than 43,000 physician and medical student members, TMA's vision is still to "improve the health of all Texans." TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients. TMA has four main goals: to protect, improve, and strengthen the viability of medical practices in Texas; to ensure continued success in legislative, regulatory, and legal interventions to enhance the statewide environment in which Texas physicians practice medicine; to strengthen physicians' trusted leadership role within their communities; and to enhance the powerful, effective, and unified voice of Texas medicine. Both TMA physicians and TMA in its

own capacity have been injured by the egregious acts and practices of Defendants as set forth in this Complaint.

46. TMA has individual standing as it has been injured by Aetna's wrongful conduct as alleged herein. TMA has expended considerable time and resources helping its members deal with issues concerning Aetna's improper UCR reimbursements.

47. TMA also has associational standing on behalf of its members who have claims against Aetna for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit, TMA seeks declaratory and injunctive relief.

48. Plaintiff **North Carolina Medical Society ("NCMS")** is a North Carolina not-for-profit corporation organized and existing under the laws of North Carolina since 1849, with its headquarters located in Raleigh, North Carolina. NCMS represents over 11,000 members in North Carolina, including licensed physicians, physician assistants, medical interns and residents, medical students and retired physicians.

49. The philosophy and purpose of NCMS is to promote medical science, medical knowledge, and the highest standards of medical care in North Carolina. NCMS strives to enhance access to medical care of high quality to all people in North Carolina and to promote high standards in the practice of medicine in an effort to ensure that quality medical care is available to the public by *inter alia*, promoting competence in the art of medical practice, making the medical profession more useful to the public in the prevention and care of disease and improving the quality of life. NCMS is the largest physician organization in North Carolina. NCMS unifies doctors across North Carolina in all specialties and work settings on issues related to, *inter alia*: the physician-patient relationship, health and insurance regulation, and patient

safety. NCMS devotes significant resources to advocating physician viewpoints in the public policy arena. Specifically, NCMS and its member physicians take an active role in issues raised by private companies, institutions, administrative agencies and the North Carolina General Assembly and work to assure that the views of the medical community are presented in an organized and effective fashion.

50. NCMS has individual standing as it has been injured by Aetna's wrongful conduct as alleged herein. NCMS has expended considerable time and resources helping its members deal with issues concerning Aetna's improper UCR reimbursements.

51. NCMS also has associational standing on behalf of its members who have claims against Aetna for the violations alleged in this complaint. In addition to the redress it seeks for its own injury, and where its members are entitled to do so and the claims for relief otherwise permit NCSMS seeks declaratory and injunctive relief.

52. Plaintiffs AMA, MSNJ, MSSNY, CSMS, TMA, and NCMS are collectively referred to herein as the Associational Plaintiffs.

Defendants

53. Defendants **Aetna Health Inc. PA, Corp., Aetna Health Management, LLC, Aetna Life Insurance Company, Aetna Health and Life Insurance Company, Aetna Health, Inc., and Aetna Insurance Company of Connecticut**, offer, insure, underwrite and administer commercial health benefits, including those of Plaintiffs referenced above. Several of the Defendants, including Aetna Health, Inc. and Aetna Life Insurance Company, have offices located in Cranbury, New Jersey, and are licensed to do business in New Jersey.

54. "Aetna" is a brand name used for products and services provided by one or more of the Aetna group of subsidiaries that offer, underwrite, or administer benefits. When used in

this Complaint, “Aetna” includes all Aetna subsidiaries owned and controlled by any of the named Defendants whose activities are interrelated and intertwined with them. Due to the manner in which they function, all of the Defendants are functional ERISA fiduciaries and, as such, they must comply with fiduciary standards. In this Complaint, “Aetna” refers to all named Defendants and all predecessors, successors and subsidiaries to which these allegations pertain.

JURISDICTION AND VENUE

55. Plaintiffs assert subject matter jurisdiction for their ERISA claims under 28 U.S.C. § 1331, and 28 U.S.C. §1332(d).

56. Venue is appropriate in this District because (i) Aetna resides, is found, has an agent, and transacts business in this District and (ii) Aetna conducts a substantial amount of business in this district and insures and administers group health plans both inside and outside this District, including from offices located in New Jersey. Likewise, MSNJ is a citizen of New Jersey and represents physicians licensed to practice medicine in New Jersey.

57. This Complaint is filed as related to existing litigation pending in this District, namely, *Cooper v. Aetna Health, Inc., PA Corp.*, Case No.: 07cv3541(FSH)(PS), *Franco v. Connecticut General Life Insurance Co.*, Case No. 04cv1318 (FSH) (PS); *Wachtel v. Health Net,, Inc.*, Case No. 01cv4183 (FSH)(PS); *McCoy v. Health Net*, Case No. 03cv1801 (FSH)(PS); and *Scharfman v. Health Net*, Case No. 05cv301 (FSH)(PS).

OVERVIEW OF PLAINTIFFS’ LEGAL CLAIMS

58. Aetna is an ERISA fiduciary for the ERISA health plans at issue, and owes the Plaintiffs and the Classes, as defined below, fiduciary duties of care and loyalty, and it must apply its plan provisions in good faith.

59. Under ERISA, Aetna is required, among other things, to comply with the terms and conditions of its health care plans; to accord its Members an opportunity to obtain a “full and fair review” of any denied or reduced reimbursements; and to make various disclosures to Members. Such disclosures include accurately setting forth plan terms; explaining the specific reasons why a claim is denied and the internal rules and evidence that underlie such determinations; disclosing the basis for their interpretation of plan terms; and providing appropriate data and documentation concerning its coverage decisions.

60. In offering and administering its health care plans, Aetna assumes the role of “Plan Administrator,” as that term is defined under ERISA, in that it interprets and applies the plan terms, makes all coverage decisions, and provides for payment to Members and/or their providers. As the Plan Administrator, Aetna also assumes various obligations specified under ERISA. These obligations include providing its Members with a “summary plan description” (“SPD”), a document designed to describe in layperson’s language the material terms, conditions and limitations of the health care plan. The full details of the plan, which are summarized in the SPD, are contained in the EOCs.

61. Aetna is obligated under ERISA to make its coverage determinations in a manner consistent with the disclosures contained in the SPD. To the extent there is a disparity or conflict between the SPD and the EOC, the SPD governs, so long as the Member benefits from the application of the SPD. If the employer, rather than Aetna, is deemed to be the Plan Administrator, Aetna remains responsible for ensuring that the SPD complies with the law under its duties as a co-fiduciary as provided in ERISA, 29 U.S.C. § 1105, even if the employer prepares or disseminates the SPD.

62. Aetna breached its fiduciary duties by failing to disclose the reimbursement rules it uses to reduce Members' benefits, and by failing to fulfill its obligations of good faith, due care and loyalty. Moreover, it breached its duties by manipulating the data it contributed to Ingenix so as to achieve a reduced reported number that it could then use for setting UCR.

63. Aetna's manipulation of its contribution of data submitted to Ingenix, and its knowing use of the inadequate and flawed Ingenix database to set UCR, further violates RICO, whereby Aetna knowingly paid inadequate benefits to its Members in order to maximize its own profits.

64. With respect to all its health care plans, Aetna is obligated to its Members to provide specific health care benefits and reimbursements. As detailed herein, Aetna has breached, and continues to breach, its obligations to Plaintiffs and the Classes, and in so doing has violated ERISA and RICO.

THE INGENIX DATABASES AND AETNA'S DETERMINATION OF UCR

65. Ingenix, the owner of the Ingenix Databases which Aetna primarily relies upon for making its UCR determinations, is a wholly-owned subsidiary of United Health Group. In December 1997, Ingenix purchased Medicode, Inc., a Salt Lake City-based provider of healthcare products, including MDR. In October 1998, Ingenix purchased the PHCS database from the Health Insurance Association of America ("HIAA"), a trade group for the insurance industry.

66. In 1973, HIAA developed the PHCS database. It obtained historical charge data for surgical and anesthesia procedures from numerous data contributors, including health insurance companies, third-party payors, and self-insured companies. The PHCS databases were later expanded to include data regarding dental (1977), medical (1988), and drugs/medical equipment (1998).

67. PHCS was designed to provide limited information about provider charges, and **not** to determine precise reimbursement amounts.

68. When Ingenix acquired both MDR and PHCS, it kept them as separate databases, but merged the underlying data. MDR and PHCS used different methodologies to produce the ultimate output for the respective databases. As a result, the dollar amounts differed for individual procedure codes at the reported percentiles.

69. Ingenix produces two cycles of Ingenix data per year that include medical, surgical, anesthesia and HCFA's common procedure coding system services ("HCPCS"). HCPCS includes pharmaceuticals, injections, blood, medical equipment, ambulance transport, medical screenings and similar services. Ingenix then sends the final fee schedule data to Aetna, which loads it into its computerized claim platform.

70. Following treatment of Aetna's members by Nonpar providers, the bill for their services is sent to Aetna for payment.

71. Aetna claims processors enter certain information from the claim (described below) and automatically access the Ingenix Databases. The claims processor's computer screen provides the dollar amount which Ingenix reported for an individual procedure code at the applicable percentile and Aetna used this dollar amount or less (as in the case of tiering) as the UCR Nonpar Benefit Reduction.

72. The computerized process of using Ingenix Databases at a particular percentile for the UCR dollar amount is sometimes referred to as "auto-adjudication."

73. To create the database that serves as the basis for both PHCS and MDR, Ingenix collects and compiles billed charge data contributed by "Data Contributors," consisting of health insurers and others.

74. Aetna is a significant Data Contributor because it contributed more charges to Ingenix than any other single data contributor. During the Class Period, Aetna's data accounted for over 14% of the total submissions to the Ingenix Databases. For certain modules, Aetna's data accounted for one-half of the total submissions.

75. The PHCS database reports both actual charge data and derived charge data; MDR reports only derived charge data. The billed charge data is often referred to as "actual" data. For any medical or surgical service for which the Ingenix PHCS Database ended up with fewer than nine charges, Ingenix created a derived charge, using relative values and conversion factors. All of Ingenix's MDR database is derived.

76. Ingenix uses four elements (or data points) from the charge data to create the Ingenix Databases. The four data points are: Date of service; CPT Code; the address where service was performed; and the amount of the provider's billed charge.

77. These four data points do not identify the provider, the patient (including age or general health status), or the type of facility where the service was performed. Ingenix does not survey or engage in sampling to determine number and types of providers in a given geographical area. The addresses it collects are not correlated with the place of service to describe or identify the facility where the service was performed. No patient or provider specific information is collected or analyzed.

78. Because it only collects these four data points, the Ingenix Databases (both AC and DC) do not -- and cannot -- determine from its pooled data (i) the number of physicians or other providers in a given geographic area; (ii) whether the data reflects physician or non-physicians billed charges; (iii) the number or percentage of providers furnishing billed charge data; (iv) the provider's usual charge; (v) the provider's licensure, specialty training, or

experience; (vi) degree of skill needed for the service; (vii) a patient's age or health status; (viii) the complexity of a patient's specific treatment; (ix) the place of service ("POS") (*i.e.*, the facility including hospital, clinic, physician office, nursing home, patient's home) as distinguished from the address; (x) the range of services or supplies provided by a facility; (xi) rates based on cost factors or the cost of providing the same or similar service or supply; or (xii) the prevailing charge level for any provider or service.

79. Ingenix edits out almost all charges submitted with a modifier. Modifiers consist of a two-digit number added to a five-digit CPT Code. Modifiers are used, for example, to indicate increased complexity or severity. Ingenix considered modifiers for the limited purpose of making professional/technical splits on charges such as x-rays that are taken by a technician and read by a professional.

80. Despite the fact that the Ingenix Databases lack modifier data, Aetna used them to determine UCR even when modifiers were present on the claim submitted to Aetna for pricing.

81. The CPT procedure codes can be used by any provider regardless of licensure, specialty training, or experience.

82. The use in the Ingenix Databases of only four data points, the merging of charges from various types of providers, the use of edits which eliminate valid high charges, and other data manipulations and procedures, invalidate the Databases for use in determining UCR and make them non-compliant with Aetna's contractual EOC and SPD definitions.

83. Aetna recognized the insurmountable structural defects caused by using only the four data points that should have prevented the Ingenix Databases from being used to determine UCR.

84. Aetna and Ingenix (as did HIAA) discussed expanding the Ingenix data to include additional data points.

85. Ingenix and HIAA sought expanded data from Aetna and other Data Contributors. The required expanded data included several additional data points, such as provider identification, licensure, specialty; patient age and gender; two-digit modifier; and place of service (hospital or doctor's office, etc.). Certain Data Contributors did not contribute expanded data to Ingenix and Ingenix continued to accept those Data Contributors' data that did not contain the required expanded data points.

86. Ingenix did not incorporate the expanded data points that were contributed into its Ingenix Databases.

87. Expanded data was deemed necessary by HIAA, and Ingenix and Aetna because the four data points are limited and inadequate as a basis for UCR.

88. Despite knowledge of their inadequacy, Ingenix continued to produce the Ingenix Databases with only the four data points and supplied them to Aetna for use during the Class Period.

89. Aetna knew the expanded data was not incorporated into the Ingenix Databases but it continued to purchase and use them for UCR determinations.

90. Aetna did not advise its members of the inadequacy of the four data points or Ingenix's failure to incorporate expanded data points into its Ingenix Databases.

91. In addition to using the Ingenix Databases for making UCR determinations despite knowing that they are invalid for that purpose, Aetna also affirmatively manipulates the data it contributes to Ingenix so as to further ensure that the Ingenix Databases reported invalid and unreasonably low charges.

92. Beginning in at least 1980, Aetna collected charge data from its claim systems for the purpose of calculating UCR for Nonpar services.

93. From 1980 through the present, without substantial change, Aetna applied certain profiling rules (“Profiling Rules”) to determine whether or not it would collect and send the charge data for a particular claim to Ingenix. If a claim “profiles,” it is collected by Aetna as UCR data. If a claim does **not** profile, it is **not** collected or sent to Ingenix by Aetna for use in the Ingenix Databases.

94. During all or part of the Class Period, Aetna used its profiling rules to pre-edit its charge data to remove valid high charges prior to sending the remaining charges to Ingenix for inclusion in the Ingenix Databases.

95. In 2005, Ingenix changed its data contribution forms to require Data Contributors to certify with each data submission that the contributed data was complete and was not pre-edited or otherwise manipulated.

96. Commencing in 2005, Aetna provided the required certifications to Ingenix attesting to the fact that its data submission was complete and not pre-edited. Aetna knew the certification was false and misleading. Ingenix intentionally did not take the necessary steps to determine whether Aetna’s certification was accurate or not.

97. Upon receipt of Aetna’s charge data (and that of other Data Contributors) Ingenix also edited (“scrubbed”) all charge data to remove certain valid high charges. As part of this process Ingenix “scrubbed” the Aetna charge data that Aetna had already pre-edited (“pre-scrubbed”).

98. Ingenix informed insurance companies that used the data (including Aetna) that it was not endorsing, approving, or recommending the use of Ingenix data for UCR. With each production, Ingenix included the following disclaimer:

The Ingenix data, whether charge data or conversion factor data, are provided to subscribers for informational purposes only. Ingenix, Inc. disclaims any endorsements, approval, or recommendation or particular uses of the data. There is neither a stated nor an implied 'reasonable and customary charge' (either actual or derived).

99. Ingenix also informed data users (including Aetna) that they cannot "represent" the Ingenix data **other than** as described in the disclaimer.

100. During the Class Period, Aetna was aware of this disclaimer but it did not disclose its existence or substance to its Members.

101. During the Class Period, Aetna was aware of the disclaimer but it "represented" the Ingenix data **other than** as described in the disclaimer. Among other things, Aetna used both actual and derived data as a "reasonable and customary charge," in direct contravention of the disclaimer.

102. In violation of the disclaimer and federal and state law (as further described herein) Aetna misstated the nature, accuracy and source of the UCR data it used for its Members.

103. The "conversion factor data" and "derived" data referred to in the disclaimer is not the same as the actual charge data contributed to Ingenix.

104. During the Class Period, derived data was used as UCR reimbursement for the majority of medical and surgical services nationwide. Derived data is not specific to a provider, patient or procedure (CPT code). Rather than setting out rates for healthcare services based on what providers actually charge in the marketplace, derived data uses relative values assigned to each separate medical procedure multiplied by a conversion factor. The theoretical rationalization

is that this process accounts for the types of charges for a range of procedures which are deemed to be related. This process is not statistically justifiable.

105. Derived charges do not reflect usual, customary and prevailing charges by actual providers; rather, they are artificial prices designed to underpay UCR.

106. The CPT Codes combined for derived data may represent very diverse procedures ranging from the most simple, including most of the charges, to the complex. For derived charges to provide a valid basis for determining reasonable compensation levels, an adjustment must be made to account for distribution and spread of the common and less common procedures. This adjustment requires computation of standard deviations. This computation is not performed by Ingenix. Because Ingenix fails to consider that some CPT codes have a wider distribution of charges (*i.e.*, standard deviation) than others, the derived percentiles understate the true upper percentile values for these CPT codes. This is a particularly significant problem because those CPT codes with a large number of observations tend to be the most common and have a greater standard deviation. The use of the derived data, which is improperly calculated, does not comply with Aetna's UCR definitions.

107. Relative values for Ingenix are also based on national data and are used to establish conversion factors. Derived data is, therefore, not specific to a geographic area, as UCR must be.

108. In addition to the structural limitations outlined in this Complaint, the database computations which use either actual charge data or derived data do not tabulate data according to the specific geographic area. For one example, Ingenix combines numerous three-digit zip codes used for postal purposes which are not medical service areas amenable to cost comparison.

These areas, known as “Geozips,” do not properly compare charges from similar geographic areas, leading to improper comparisons and invalid data.

109. The distortions created by the use of Geozips are recognized by Ingenix itself. In its MDR Customized Fee Analyzer, which Ingenix sells to providers to use in setting their rates, Ingenix states:

Because the fee ranges in the Analyzer are based on the first three digits of your geozip, you need to assess where your locale stands in relation to others in this three-digit area. For example, many different three digit areas contain both urban and rural locales with different charging patterns. Use your judgment to determine how to interpret the fee range for your particular community.

110. Aetna fails to exercise reasonable judgment in determining whether the specific Geozip applicable to particular UCR determinations is valid, including whether they may contain disparate “urban and rural locales with different charging patterns.” Instead, Aetna relies strictly on the geographic groupings provided by the Ingenix Databases, without taking into account possible “different charging patterns” in each Geozip. By so doing, Aetna’s UCR determinations have no valid basis, do not comply with EOC, SPDs and other plan documents, and are unreasonable, in violation of ERISA and other applicable law.

111. Ingenix does not audit the Data Contributors, nor verify the accuracy or completeness of their data submissions.

112. In instances where Ingenix knew Aetna’s data submission violated its stated data requirements, Ingenix did not audit Aetna because it needed Aetna’s data to allow the Ingenix Databases to be sold.

113. The information as to the Ingenix Databases’ deficiencies was not disclosed to Aetna Members, healthcare providers, or state regulators.

114. Although Aetna professed the ability to take account of factors such as “complexity; degree of skill needed; the type of specialty of the provider; the range of services or supplies provided by a facility,” and others, it did not change its methodology to compensate for the known deficiencies of the data it used to make Nonpar Benefit Reductions.

115. By systemically making Nonpar Benefit Reductions using flawed and invalid data and data that was not compliant with the contractual definition of UCR and other Nonpar Benefits, Aetna violated its EOC and SPDs during the Class Period.

116. In a separate investigation into the flawed Ingenix database conducted by the New York Attorney General, Andrew Cuomo, Mr. Cuomo concluded that “the Ingenix databases in fact under-reimburse consumers.” January 13, 2009 New York Attorney General Health Care Report “THE CONSUMER REIMBURSEMENT SYSTEM IS CODE BLUE” available at: http://www.oag.state.ny.us/bureaus/health_care/HIT2/pdfs/FINALHITIngenixReportJan.13,%202009.pdf

117. According to Mr. Cuomo’s report, an analysis of the New York market showed that insurers that used Ingenix and other similar methods to determine UCR “systematically under-reimburse New Yorkers for doctor’s office visits.” *Id.*

118. “When extrapolated across the State and the country, it is fair to say that the Ingenix databases have caused Americans to be under-reimbursed to the tune of at least hundreds of millions of dollars over the past ten years.” *Id.* Physicians like Drs. Antell and Valauri, the Class and members of the Associational Plaintiffs, of course, are primary victims of this under reimbursement scheme, as they are either ignorant to Aetna’s unlawful practices and fail to challenge its wrongful claims determinations, or they balance bill patients at increased levels but are forced to take a loss on their services nevertheless.

119. Moreover, Drs. Antell and Valauri and the Class have also been disparaged by the pervasive under-reimbursement scheme and their physician–patient relationships have been disrupted. According to Mr. Cuomo, “[t]he responsible consumer reads the plan documents and sees a thicket of words. One term seems intelligible: the “usual and customary rate” of a similar physician for a similar service in a similar area. That sounds reasonable. The consumer makes the leap out of network and submits the bill to the insurer, only to be told the consumer will not be fully reimbursed because the doctor’s charge exceeded the usual and customary rate. The fog of ignorance continues, thanks to the insurer. The physician-patient relationship is undermined, as the physician has been branded a charlatan whose bills are inflated. No one’s interests here are advanced, except perhaps when next time, the consumer decides to stay in network for fear of what bills may accrue for out-of-network care. The interests advanced in that event are those of the insurer, whether by accident or design.” *Id.* In addition to the negative impact that this disparagement has had on Nonpars like Drs. Antell, Valauri and the Class, the disruption of the patient-doctor relationship has significantly harmed the Associational Plaintiffs, which seek to safeguard this relationship.

120. According to the New York Attorney General, UnitedHealth and Aetna contributed 70% of the billing information for the Ingenix system.

121. In discussing where the blame for this under-reimbursement scheme should lie, the New York Attorney General explained that “the fault cannot be laid on Ingenix alone. All industry members have benefited unfairly at the expense of consumers over the past ten years, and they continue to benefit unfairly from a rigged system day after day.” *Id.* Aetna, as a significant participant in, and beneficiary of the Ingenix database, should therefore be held accountable for its use of the database to under-reimburse Drs. Antell and Valauri and the Class.

122. As part of the same investigation, Aetna's use of the Ingenix database and determination of UCR rates were also investigated by the New York Attorney General.

123. Aetna agreed to settle the Attorney General's investigation into its out of network reimbursement rates and practices. As part of this settlement, Aetna agreed to pay \$20 million to help create a new independent database to take the place of the Ingenix PHCS database, and agreed to stop using the Ingenix database within sixty days of the creation of the "new database."

124. Simultaneous with the release of the New York Attorney General's findings, UnitedHealthcare, the owner of the Ingenix database, settled claims centering on the Ingenix database and UCR reimbursements with the New York Attorney General and the AMA among others. As part of this settlement, UnitedHealthcare agreed to pay the New York Attorney General approximately \$50 million dollars. These funds are earmarked for the creation of an independent non-profit organization, which will own and operate a new database to be used for UCR determinations. This new database will be designed to take the place of the UnitedHealthcare owned Ingenix database.

125. Furthermore, UnitedHealthcare also agreed to the terms of a settlement with a class of consumers and providers, the AMA, MSSNY and others, including the payment of approximately \$350 million to settle claims, similar to those alleged in this case, related to the underpayment of reimbursement amounts for out-of-network medical services.

AETNA'S ER REIMBURSEMENTS

126. In all of the states in which Aetna operates, it is obligated to fully reimburse Aetna Members for use of out-of-network emergency services that satisfy a prudent layperson standard regardless of the type of insurance plan they have (*e.g.*, POS, PPO, HMO).

127. Under the prudent layperson standard, Aetna must fully pay for ER services, even if they subsequently are determined not to constitute an emergency, so long as the Aetna Member reasonably believed the condition to be emergent at the time the Member sought ER care. The standard precludes reliance on a medical professional's diagnostic conclusion at the time of discharge because the medical professional is not a prudent layperson and has information unavailable to the prudent layperson at the time ER care was sought.

128. For many Aetna Members, Aetna denied reimbursement for ER services that were properly considered emergent under the prudent layperson standard.

129. Aetna EOBs failed to disclose material information to Aetna Members when Aetna denied or reduce payment for ER services.

PLAINTIFFS' EXPERIENCES WITH AETNA/INGENIX

Plaintiff Dr. Frederick A. Valauri

130. Dr. Fredrick A. Valauri provided Nonpar physician health care services to an Aetna subscriber that had been preauthorized by Aetna. Dr. Valauri is a Nonpar with regard to Aetna.

131. On behalf of his Aetna covered patients, Dr. Valauri submitted a HCFA 1500 Form to Aetna seeking benefits for the services that were provided. He billed for his services, each designated by a separate CPT Code.

132. After Dr. Valauri submitted the appropriate forms for reimbursement, Aetna sent an Explanation of Benefits ("EOB") to Dr. Valauri, thereby acknowledging the validity of his assignment, in which it reported on its coverage determination for the services Dr. Valauri provided to the patient.

133. The EOB disclosed only that the Nonpar reimbursements were being paid at “prevailing” local rates or that at the reasonable and customary rates for his geographic area, or some other notation of UCR.

134. At all relevant times, Dr. Valauri expected to be reimbursed by Aetna at the lesser of his billed charges or the current UCR rate.

135. However, Dr. Valauri did not receive full payment for his billed charges from the Aetna subscribers. Aetna unlawfully diminished Dr. Valauri’s compensation by improperly calculating UCR rates and then misapplying these rates to his claims. Dr. Valauri’s EOBs often state that his billed charges purportedly exceed the UCR rate for the geographic area where the services were performed. Nowhere on the EOBs, however, or elsewhere in any other correspondence sent to Dr. Valauri and his patients from Aetna discuss or identify how it actually calculates UCR. The EOBs do not even specify whether Ingenix data or some other methodology was used in these calculations. With its methods for calculating UCR shrouded in a veil of secrecy, Aetna has been able to derive improper rates using faulty Ingenix data, and apply them to Nonpar claims in order to diminish lawful reimbursement.

136. Dr. Valauri also exhausted his remedies with respect to these claims, seeking appeals and final determinations, whether on his own, or through the patient, of the reimbursement amounts. The appeals were denied by Aetna, without paying Dr. Valauri based on his full non-discounted charges, and it provided him with no further opportunity to seek reconsideration of its decision.

137. Further, any appeal to Aetna was likely futile as Aetna did not fully disclose all the relevant information. Aetna’s appeal denials withheld material information, as detailed herein, that Aetna was obligated to disclose as a fiduciary. Because Nonpars are unaware of the

scheme that results in payors like Aetna failing to pay appropriate UCR rates, they are either powerless to appeal any such improper determinations or their efforts to appeal these determinations are futile.

138. Finally, Aetna's treatment of the appeals was contrary to ERISA and applicable regulations. It did not provide a "full and fair review." Because Aetna's appeal process violated procedural safeguards adopted in the ERISA regulations, any appeals are "deemed exhausted" by operation of law.

Dr. Darrick Antell

139. Dr. Antell is not a member of Aetna's provider network. Rather, when he provides health care services to Aetna subscribers, he does so as a Nonpar provider. As a Nonpar provider, Dr. Antell has not agreed to accept any discounted rates from Aetna for the services he provides, and he is entitled to bill his customary and reasonable charges for his services.

140. To provide proper care and treatment for his patients, at both lower risks and lower prices, Dr. Antell has created a certified on-site, state-of-the-art Office Based Surgical ("OBS") facility. Dr. Antell's OBS facility – which was originally incorporated as "850 Park Surgical," and is now incorporated as "Lenox Hill Ambulatory Surgery" – has received accreditation from the American Association for Accreditation of Ambulatory Surgical Facilities ("AAAASF") and the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). The AAAASF Certification states that Dr. Antell's OBS facility was providing a certificate "for having met the standards of a CLASS C ambulatory surgical facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital body functions." The JCAHO certificate states that Dr. Antell's OBS

facility “has been accredited” by the JCAHO, “which has surveyed this organization and found it to meet the requirements for accreditation.”

141. Dr. Antell has assumed substantial costs, both in establishing and maintaining his OBS facility, through which he provides the highest quality of care to his patients. As a result, as part of his customary and reasonable practice, Dr. Antell charges a “facility fee” for services he performs there to compensate him for the additional costs and effort of maintaining the facility.

142. Dr. Antell’s OBS facility satisfies the requirements of the Public Health Law (“PHL”) of the State of New York. Section 230-d of the Public Health Law defines Office-Based Surgery as follows:

“Office-based surgery” means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure where such surgical or other invasive procedure or liposuction performed by a licensee in a location other than a hospital, as such term is defined in article twenty-eight of this chapter, excluding minor procedures and procedures requiring minimal sedation.

143. Subdivision 2 of the PHL provides that physician practices in which office-based surgery is performed must obtain and maintain full accredited status. The accreditation requirements take effect 18 months from January 14, 2008, or on or before July 14, 2009. Both AAASF and JCAHO, which have accredited Dr. Antell’s OBS facility, have been designated by New York State as accepted accrediting agencies under the PHL, along with the Accreditation Association for Ambulatory Health Care. As a result, Dr. Antell has satisfied all requirements under New York law for maintaining, operating and performing surgical proceedings in his OBS facility.

144. While providing services to Aetna patients, Dr. Antell has repeatedly been subjected to reductions in reimbursements based on Aetna’s representations that his bills are in

excess of usual, customary and reasonable (“UCR”) amounts. In doing so, Aetna has relied improperly on the flawed and inadequate Ingenix database, which fails to identify proper UCR rates.

145. With respect to the UCR reductions Aetna imposed on Dr. Antell, any exhaustion of administrative remedies with respect the UCR determination would be futile, because Aetna, as a matter of policy, refuses to alter or reprocess claims that have been processed pursuant to the Ingenix database. Alternatively, Dr. Antell should be deemed to have exhausted any claims that otherwise were not exhausted, due to Aetna’s inadequate disclosure concerning grievance procedures and its violation of ERISA and the applicable ERISA regulations.

146. In addition to the UCR reduction, Aetna has also refused to reimburse Dr. Antell for his facility fees relating to surgeries performed in his OBS facility, claiming that he does not have a properly authorized facility.

147. This determination not to pay fees is contrary to Aetna’s own prior determinations, in which it had recognized Dr. Antell’s OBS facility and agreed that he could provide services in that facility for Aetna patients.

148. The American Society of Plastic and Reconstructive Surgeons, Inc. (“ASPRS”) has similarly taken the position that facility fees for OBS facilities are proper and should be reimbursed. As stated in a Position Paper of the ASPRS:

It is the position of the American Society of Plastic and Reconstructive Surgeons that reimbursement of reasonable charges for facilities accredited by AAAAPSF, or other recognized and approved accrediting agencies, for reconstructive plastic surgery procedures can play a significant role in reducing the cost of health care in general. This is supported by the fact that on an average, 60 percent of the procedures performed by plastic surgeons are reconstructive, as opposed to cosmetic. It is recognized that over 50 percent of those reconstructive procedures can be safely performed in office-based facilities.

* * * *

A growing number of large and respected third-party payors have amended their existing policies or liberalized their policy interpretation and are now providing reimbursement for in-office facility charges.

149. Based on information and belief, the patients' Aetna plans have no provision that health care services provided through an OBS facility, or that a facility fee charged for such services, would not be covered or reimbursed.

150. Given that charging and being reimbursed for facility fees for services provided at an accredited OBS facility is generally recognized in the medical and insurance community, there is no basis for Aetna to deny coverage for Dr. Antell's facility fees. Dr. Antell was entitled to charge his patient for the facility fee for his OBS facility and, under the terms and conditions of its health care plans, Aetna was obligated to pay such a fee as with UCR fees for Nonpar services.

151. Dr. Antell has appealed Aetna's denial of coverage for his OBS facility, and has exhausted all available appeal procedures. Moreover, any further appeals would be futile due to Aetna's firm practice of refusing to pay for OBS facilities used by Nonpar providers.

152. Based on the foregoing, in addition to seeking relief on behalf of himself and all other similarly situated physicians who have been subjected to improper UCR reductions based on Aetna's reliance on the Ingenix databases or other undisclosed policies to set UCR rates, Dr. Antell also seeks relief on behalf of himself and all other similarly situated physicians who have been denied coverage for facility fees for OBS facilities accredited by the accepted accreditation entities, including but not limited to the AAAASF and JCAHO.

153. The Associational Plaintiffs have also been injured by Aetna's wrongful conduct. Aetna's wrongful conduct causes direct injury to members of the Associational Plaintiffs by

delaying, denying, impeding and reducing lawful compensation for out-of-network services provided to Aetna's enrollees.

154. Aetna's wrongful conduct also causes direct injury to the Associational Plaintiffs because they have been, and continue to expend time and resources in dealing with Defendants' practices. This frustrates the Associational Plaintiffs' purpose which is to uphold the doctor patient relationship and ensure the delivery of quality medical care to patients.

155. As a result of Aetna's conduct, the Associational Plaintiffs have been required to devote substantial time and resources to dealing with the issues concerning Aetna's wrongful out-of-network reimbursement practices. Specifically, the Associational Plaintiffs devote significant time from several of its employees to deal with the practices at issue herein. The Associational Plaintiffs' efforts to counteract Aetna's unfair and deceptive practices include, *inter alia*, counseling their respective members on how to counteract the practices at issue, monitoring Aetna's practices, and advocating on their members' behalf.

156. Plaintiffs seek unpaid benefit amounts, treble damages and declaratory and injunctive relief for Aetna's conduct described herein, on their own behalf and on behalf of the members of the Associational Plaintiffs, and of the Class as defined herein.

AETNA'S RICO PREDICATE ACTS

157. During the RICO Class Period and ERISA Period, Aetna engaged in a series of predicate acts underlying its RICO violations. These predicate acts include the dissemination through the U.S. Mail of numerous fraudulent, misleading and deceptive EOBs and other communications to Class Members and by transmitting through wire fraudulent, misleading and deceptive representations on its public website, as detailed in this Complaint.

158. These representations to each of the named plaintiffs or their Nonpar providers were knowingly false and misleading. Aetna knew and recklessly disregarded that its method for setting reimbursement levels for Nonpar providers was fatally flawed and did not properly determine valid UCR levels, and that it did not have a valid basis upon which to represent that the providers' bills were "greater than the reasonable and customary charge" or the "prevailing charge level" for the relevant services in a particular geographic area.

159. In making its UCR determinations, Aetna relied primarily on the Ingenix Databases and, from time to time, used Medicare rates. Neither methodology is a proper basis for UCR. With regard to the Ingenix Databases, Aetna, while serving as a major contributor of the data underlying the Ingenix Databases, knowingly submitted data to Ingenix that Aetna had improperly pre-edited to remove high charges, thereby artificially lowering the reported charges that were used to set UCR. The Ingenix Databases are flawed for numerous other reasons, as detailed in this Complaint. Similarly, Medicare rates are not designed to and do not, establish UCR, and cannot legitimately be used for that purpose.

160. Regardless of whether the data Aetna relied upon from the Ingenix Databases were based upon actual or derived charges, they do not fall within the description provided by Aetna in its various EOBs. Because of the manipulation of the data by Aetna and Ingenix, as well as (among other reasons) the inclusion of data from all health care providers, regardless of licensure or experience, and the omission of modifiers, the number based on actual data nevertheless failed to reflect the prevailing or customary charges. For derived data, which represents the vast majority of CPT Codes in PHCS and all of the charges in MDR, the numbers reported by Ingenix have no relation to actual billed charges, whether prevailing or otherwise.

Thus, during the Class Period, Aetna defrauded its members through its false and misleading EOBs.

161. As a further aspect of its scheme to reduce Nonpar benefits below the level it was otherwise contractually required to pay, using the U.S. Mail and/or interstate wire facilities, Aetna submitted fraudulent certifications to Ingenix concerning its data. In particular, Ingenix requires its Data Contributors (including Aetna) to attest that the data being submitted for inclusion in the Ingenix Databases reflected all of the available data from the contributor, without being pre-edited or otherwise manipulated. Aetna falsely attested to this fact even though it had internal policies that precluded substantial data from being included in its submission to Ingenix. The impact of Aetna's manipulation of the data it submitted to Ingenix for inclusion in the Ingenix Databases was to lower the amount of the reported charges so as to reduce the ultimate numbers that Ingenix would report and which Aetna would use for making its UCR determinations. All of this material information was withheld from Plaintiffs and Class Members.

162. The EOBs sent by Aetna to Plaintiffs via U.S. Mail and reflecting UCR benefit reductions did not adequately disclose the basis for, nor the reasons behind, the exclusion of expenses, and thereby precluded Plaintiffs from the information they needed to challenge Aetna's UCR determinations. Aetna did not disclose whether it used a particular database, or Medicare rates, or some other methodology, and it did not disclose the required information about how Plaintiffs and Class Members might successfully appeal the UCR benefit reductions. Aetna failed to provide the specific reasons regarding unpaid Nonpar benefits, failed to impart necessary information about the appeals process, and failed to provide other information required under ERISA.

163. Aetna also sent through the U.S. Mails to Plaintiffs intentionally incomplete and misleading letters denying claims and appeals. Among other things, Aetna routinely failed to disclose in this letter that its reliance on the invalid Ingenix Databases served as a basis for its UCR reductions, focusing solely on the multiple surgical reductions.

164. Aetna's Internet website, to which its EOBs directed its Members and their providers for answers to their questions, was also fraudulent and misleading. The website represented to Aetna's Members, via the Internet (which utilizes interstate wire facilities), that Aetna made its UCR determinations based on the prevailing charges of what other providers charged for similar services. Moreover, the website represented that Aetna would take into account various factors, including the specialty of the provider and, if there were few charges or a small number of providers submitting charge data in a particular geographic area, it stated and represented that Aetna would consider the prevailing charges in other areas. These statements, as disseminated to Plaintiffs and Class members via Aetna's Internet website, were false. In fact, the Ingenix Databases use derived data for the vast majority of CPT Codes, such that when there are less than nine charges reported in a particular geographic area prevailing charges from other areas are not used, as Aetna falsely represents. Further, even if there are more than eight charges contained in the Ingenix PHCS Database, and they are used to provide a dollar amount for a CPT code at a given percentile, the eight or more charges could all come from one provider, or a few providers of different licensure, specialties, training and experience performed at different places of service for patients of different ages, gender and disparate health conditions. All of these factors affect the reasonableness of the billed charge. None of these factors are accounted for in the Ingenix Databases. Aetna has no way of knowing the number of providers who submitted data, or a way to differentiate between them, so that Aetna is unable to satisfy its representation

on its website of checking the actual charges from other areas when there were only a small number of instances that a certain service was provided in an area. In addition, even when actual charge data was reported by Ingenix in the Ingenix PHCS Database, Aetna had no basis for concluding that these data reflected actual prevailing charges for the reasons cited above and in light of the manipulation of data by Ingenix as well as the improper pre-editing of submitted data by Aetna itself.

ANTITRUST ALLEGATIONS

165. Aetna has committed, and conspired to commit, with its competitors including, *inter alia*, UnitedHealthcare and CIGNA, and/or with other third parties numerous violations of the Sherman Antitrust Act, 15 U.S.C. § 1 *et seq.* Aetna has combined, conspired and/or agreed with other parties to unreasonably restrain trade in *per se* violation of Section 1 of the Sherman Act by price fixing with regard to paying reasonable and customary rate for non-party transactions.

INTERSTATE COMMERCE

166. Aetna participates in, and affects, interstate commerce.

167. Aetna's activities, including the administration and operation of health plans and managed care plans, in every state in the United States, are in the regular, continuous and substantial flow of interstate commerce, and have a substantial effect upon interstate commerce.

168. Aetna's unlawful activities, concerted actions, conspiracy to restrain trade, and agreement to fix prices substantially affect and restrain the operation of interstate commerce.

RELEVANT MARKETS

169. The relevant product and/or service market affected by Aetna's conduct is the market for non-participating physician services

170. The relevant geographic market for the purposes of this action is the United States of America.

AETNA'S AGREEMENT TO FIX PRICES AND ENGAGE IN OTHER ANTICOMPETITIVE CONDUCT

171. Aetna reached agreement with its competitors, including UnitedHealthcare's, CIGNA, and/or a number of other non-parties to agree to determine UCR using primarily the Ingenix database, as described above. The above concerted action among these "competitors", including Aetna, and other co-conspirators has resulted in unlawful and anticompetitive price fixing agreements, and other horizontal restraints of trade and anticompetitive behavior.

172. UnitedHealthcare, via its alter ego Ingenix, facilitates the direct horizontal agreements through the compiling and sharing of competitive information and UCR rate data among all the conspirators, including Aetna

173. As stated above, many Aetna and other contributors to Ingenix are entitled to "free" use of the Ingenix Databases simply for continuing to submit data at the level which they submitted data when the database was owned by HIAA.

174. In fact, the agreement forging UnitedHealthcare's ownership, through Ingenix, of a database containing such sensitive pricing data for all of its major competitors, and allowing the return of compiled pricing data to each for free, seems like a textbook situation of adopting a standard peg or benchmark for determining the price to be paid to non-participating physicians for medical services.

175. Aetna engaged in price fixing when it agreed with its competitors including United to utilize precisely the same database to determine the UCR rates for medical services, which lead to them paying substantially the same reduced rates for services rendered to their subscribers.

176. DOJ Antitrust division notes in their Price Fixing “Primer” that price fixing agreement can take many forms. “[A]ny agreement that restricts price competitions violates the law.” “[E]xamples of price fixing agreements include those to:

- Establish or adhere to price discounts
- Hold prices firm ...
- **Adopt a standard formula for computing prices...**
- **Adhere to a minimum fee or price schedule.”** (emphasis added)

<http://www.usdoj.gov/atr/public/guidelines/211578.htm>

177. Aetna along with its co-conspirators adopted a standard formula for making UCR determinations, and each has agreed to a method of determining the maximum price or fee, via database schedule, that it will pay for out of network charges. This alone amounts to a naked agreement to fix prices.

178. Aetna’s agreement gives it, collectively along with its competitors, tremendous market power to set UCR at rates well below those which would exist at a competitive marketplace. In fact, no competitive pressure to raise UCR rates exists while all the conspirators act collectively to reduce prices. Without agreement and collective action between them, including the exchange and compilation of relevant pricing data, Aetna would be unable to systematically and across the board reduce their UCR rates paid.

179. As stated above, Aetna, UnitedHealthcare, CIGNA and others have agreed to participate in the creation of a database which has that affect by providing only certain data to the database in exchange for free use of the database alone amounts to a horizontal agreement to fix prices. Providing their sensitive payment information to their competitors would only be sensible

180. In addition to agreeing to price their UCR rates using the exact same databases, the insurers also engage in exactly parallel behavior. All have substantially similar contracts with their customers in which all material provisions are the same; all submit UCR rate data to the databases to be compiled, and are aware that the data submitted leads to skewing the relevant UCR determinations downward; all utilize Ingenix databases to determine UCR rates. These parallel behaviors allow their price fixing agreement to effectively depress the UCR rate paid to providers for services rendered to their subscribers, and otherwise reduce competition among would-be competitors.

181. Collusion, conspiracy and agreement are facilitated in this market as it is heavily concentrated, with a relatively standardized product, with numerous opportunities for the Aetna and its co-conspirators to agree and collude, including involvement and participation in the same trade associations, and availability of the same Ingenix Databases. Additionally, where pricing information is shared among the parties, defection from the agreement is easy to detect as it is there for all to see in the data contributed to Ingenix.

182. Likewise, there is virtually no incentive for the Aetna, or their co-conspirators, to compete in the out of network UCR determination portion of their business.

183. Additionally, UCR merely represents a cost of doing business to the Aetna. Agreement to systematically reduce these costs benefits each conspirator without affecting their

ability to compete for customers is to the direct benefit of Aetna and the other co-conspirators but cannot be achieved without their collective agreement.

184. In fact, as Aetna and its co-conspirators enjoy monopoly status or significant market power in certain areas or markets, the agreement to utilize this same database for UCR determinations actually allows all co-conspirators to essentially enjoy the monopoly status of their counterparts due to the use of data skewed by use of the in-network negotiated charge data used in those areas.

185. In addition, Aetna's, and their co-conspirators, agreement to fix and suppress prices actually has the perverse effect of encouraging more doctors to become members of their various "networks" where further cost reducing measures and other methods of control can be placed on them. This provides the Aetna with additional sales points to their customers.

186. A market with the characteristics described above facilitates collusion and agreement to fix prices, and detection and discipline are also easy to maintain.

187. As noted above, it was only after investigation by the New York Attorney General, that United agreed that the Ingenix database must be independently maintained and that the agreement to fix prices using the database must be abandoned.

ANTITRUST INJURY

188. Aetna's market power results from the combined power of all their competitors who also reached agreement to utilize the same database to determine UCR and their role as primary payors' give them the power to impose artificially low UCR rates and other anti-competitive restrictions on doctors that could not exist in a competitive market.

189. Competition between the payors has also been reduced by the agreement to improperly reduce UCR amounts.

190. Without the agreement to fix UCR rates and reduce competition among payors, Plaintiffs would be paid more for the medical services they rendered to Aetna's subscribers.

CLASS ACTION ALLEGATIONS

191. Plaintiffs Drs. Antell and Valauri bring this action on behalf of themselves and all others similarly situated (the "Class") under Rule 23 of the Federal Rules of Civil Procedure. The requirements of subparts 23(a) and (b)(1), (b)(2) and (b)(3) of the Federal Rules of Civil Procedure are met. The Class is defined as follows:

All non-participating physicians and physicians' groups, within the boundaries of the United States of America, who were entitled to receive benefits from any Aetna insured or administered health plan, at any time during the period commencing January 1, 2005 through the present and were paid less than their billed charge for "out-of-network" medical services rendered to any Aetna subscriber.

Plaintiffs Drs. Antell and Valauri also bring this class action on behalf of an "ERISA Subclass" defined as:

All non-participating physicians and physicians' groups, within the boundaries of the United States of America, who were entitled to receive benefits from any Aetna insured or administered group health plan subject to ERISA, at any time during the period commencing January 1, 2005 through the present and were paid less than their billed charge for "out-of-network" medical services rendered to any Aetna subscriber.

Excluded from the Classes are any judge(s) or justice(s) to whom this action is assigned, as well as any relative of such judge(s) or justice(s) within the third degree of relationship, and the spouse of any such person.

RULE 23(a)

Numerosity

192. This putative class includes thousands of Nonpars throughout the United States and is therefore so large to make joinder of all members impracticable within the meaning of Fed. R. Civ. P. 23(a)(1).

Commonality

193. Pursuant to Fed. R. Civ. P. 23(a)(2), there are questions of law or fact common to all class members, including, but not limited to, the following:

1. Whether the amounts paid to the Class, have been fixed, artificially maintained, and/or stabilized at levels below those that would prevail in a competitive market;

2. Whether Aetna's use of the Ingenix database or its other Nonpar Pricing Methods (including default formulas) to calculate usual, customary, or reasonable charges in determining Nonpar reimbursement violated ERISA, RICO, or common law;

3. Whether Aetna's denial of coverage for accredited OBS facilities violated ERISA, RICO, or common law.

4. Whether Aetna's Nonpar benefit reductions violated ERISA, RICO, or common law;

5. Whether Aetna misapplied Par policies such as multiple procedure reductions to claims submitted by the Class;

6. Whether Aetna's use of the Ingenix Database itself resulted in lower UCR determinations than were available in a market with perfect information;

7. Whether Aetna's failure to properly disclose the specific reason for UCR and Nonpar Pricing Methods in its Explanation of Benefits ("EOBs") as well as failure to disclose material information (including the offer to disclose the relevant evidence) violated ERISA or common law;

8. Whether ERISA requires each Class member to prove exhaustion or futility;
9. Whether Aetna combined, conspired and/or agreed with its co-conspirators, including United, in a price fixing conspiracy that sought, and was able, to artificially lower, fix or maintain the price paid to Plaintiffs Drs. Antell and Valauri and the Class by Aetna as UCR rates; and
10. Whether AETNA violated RICO and, if so, the appropriate damages to be awarded; and
11. Whether interest should be added to the payment of unpaid benefits under ERISA or common law.

Typicality

194. The claims of Plaintiffs Drs. Antell and Valauri are typical of the claims of the defined class, within the meaning of Fed. R. Civ. P. 23(a)(3), and are based on and arise out of the same uniform and standard illegal practices of the Defendants alleged by the Plaintiffs.

195. The proposed class representative states claims for which relief can be granted that are typical of the claims of absent class members. If litigated individually, the claims of each class member would require proof of the same material and substantive facts, rely upon the same remedial theories, and seek the same relief.

Adequacy

196. Plaintiffs Drs. Antell and Valauri are committed to pursuing this action and are prepared to serve the proposed class in a representative capacity with all of the obligations and duties material thereto. Plaintiffs Drs. Antell and Valauri will fairly and adequately represent the interests of the members of the class within the meaning of Fed. R. Civ. P. 23(a)(4) and has no interests adverse to, or which directly and irrevocably conflict with, the interests of the other class members.

197. Plaintiffs Drs. Antell and Valauri have retained competent counsel experienced in class action litigation. Said counsel will adequately prosecute this action, and will assert, protect and otherwise well represent the named class representatives and absent class members.

RULE 23(b)(1)(A) AND (B)

198. The prosecution of separate actions by individual class members would create a risk of adjudication with respect to individual class members which would, as a practical matter, be dispositive of the interests of other members of the Class who are not parties to this action, or could substantially impair or impede their ability to protect their interests.

199. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent of varying adjudications with respect to individual members of the Class which would establish incompatible rights within the Class.

RULE 23(b)(2)

200. Aetna's actions are generally applicable to the class as a whole, and Drs. Valauri and Antell seek equitable remedies with respect to the class as a whole, within the meaning of Fed. R. Civ. P. 23(b)(2).

RULE 23(b)(3)

201. The common questions of law and fact enumerated above predominate over individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy, within the meaning of Fed. R. Civ. P. 23(b)(3). Common or general proof will be used by each class member to establish each element of their ERISA, RICO and antitrust claims. Additionally, proceeding as a class action is superior to other available methods of adjudication. The likelihood that individual members of the class will prosecute separate actions

is remote due to the time and expense necessary to conduct such litigation since the cost of litigation far exceeds what any one class member has at stake.

COUNT I

CLAIM FOR UNPAID BENEFITS UNDER GROUP PLANS GOVERNED BY ERISA (On Behalf of All Plaintiffs and the ERISA Subclass)

202. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

203. Aetna must pay benefits to Aetna Members that are insured by, funded by or administered by Aetna pursuant to the terms of their ERISA plans.

204. Drs. Antell and Valauri and the Class have standing to pursue these claims as assignees of their patients' out of network benefits claims to Aetna.

205. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

206. Aetna violated its legal obligations under ERISA and federal common law each time it made the Nonpar Benefit Reductions described in this Complaint.

207. Aetna further violated its obligations under ERISA when it failed to comply with applicable state law, such as by making Non-Par Benefit Reductions that were inconsistent with various state regulations. Aetna systemically violated these regulations, including by using Outdated Data from inapplicable geographic areas, reducing payment for multiple procedures or assistant surgeons, and using Ingenix data to price hospital UCR.

208. Aetna's lack of disclosure to its Members violated its legal obligations.

209. Aetna violated obligations each time it engaged in conduct that discouraged or penalized its Members' use of Nonpar providers, such as by making Nonpar Benefit Reductions.

210. Plaintiffs, on their own behalf and on behalf of the members of the ERISA Class, seek unpaid benefits, recalculated deductible and coinsurance amounts and interest back to the date their claims were originally submitted to Aetna. Plaintiffs also sue for declaratory and injunctive relief related to enforcement of the plan terms, and to clarify rights to future benefits or reimbursements. Plaintiffs' request attorneys' fees, costs, prejudgment interest and other appropriate relief against Aetna.

COUNT II
FOR DECLARATORY RELIEF RELATING TO
AETNA'S VIOLATION OF ERISA
(On Behalf of All Plaintiffs and the Class)

211. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

212. Drs. Antell and Valauri and the Class have standing to pursue these claims as assignees of their patients' out-of-network benefits claims to Aetna.

213. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

214. Under federal law, Plaintiffs and the Class are entitled to receive protections under ERISA including (a) a "full and fair review" of all claims denied by Aetna; (b) compliance by Aetna with ERISA claims procedure regulations; and (c) receipt of accurate materials summarizing such group health plans, known as Summary Plan Descriptions ("SPD") materials under § 102 of ERISA, 29 U.S.C. § 1022.

215. Any time Aetna deprived its members of "full and fair review" or proper compliance with ERISA claims procedure regulations, it violated § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), and thus violated the rights of Plaintiffs and the Class.

216. Although Aetna was obligated to do so, it failed to provide a “full and fair review” of denied claims pursuant to § 503 of ERISA, 29 U.S.C. § 1133, and its implementing regulations, *inter alia*, by failing to disclose the “specific reasons” for benefit denials, failing to disclose data and/or the methodology used to determine UCR or Nonpar reimbursement, and failing to comply with appeal procedures imposed by ERISA and the federal common law.

217. Applicable federal claims procedure regulations set forth minimum standards for claim procedures, appeals, notice to members and the like. By engaging in the conduct described herein including, but not limited to, making benefit determinations for Nonpar claims that are inconsistent with the terms of group health plans, and failing to disclose information concerning the data and/or methodology it used to determine UCR or other Nonpar reimbursements, Aetna failed to comply with such regulations

218. The consequences of Aetna’s failure to comply with the regulations (as well as federal common law), are that Aetna failed to provide reasonable claims procedures and failed to make required disclosures to Plaintiffs and the Class.

219. Administrative remedies are deemed exhausted, *inter alia*, by virtue of the invalid Ingenix database, other invalid Nonpar pricing methods discussed *supra*, and Aetna’s failure to provide reasonable claims procedures. By virtue of the conduct alleged in this Complaint, any appeal would have been futile.

220. Aetna’s failure to disclose material information about its UCR and other methods for pricing Nonpar claims (including default formulas and rounding rules) constitute violation of federal common law, which obligates fiduciaries such as Aetna to provide this material information.

221. Plaintiffs and the Class are entitled to a declaration by this Court that Aetna's actions as alleged herein are in violation of its duties and obligations of ERISA as detailed herein.

COUNT III

VIOLATION OF FIDUCIARY DUTIES OF LOYALTY AND DUE CARE **(On Behalf of All Plaintiffs and the ERISA Subclass)**

222. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

223. During the Class Period, Aetna acted as a "fiduciary" to Plaintiffs and the ERISA Class, as such term is understood under 29 U.S.C. § 1002(21)(A).

224. As an ERISA fiduciary, Aetna owed, and owes, its Members in ERISA plans a duty of care, defined as an obligation to act prudently, with the care, skill, prudence and diligence that a prudent administrator would use in the conduct of a like enterprise. Further, ERISA fiduciaries must act in accordance with the documents and instruments governing the group plan. 29 U.S.C. § 1104(a)(1)(B) and (D). In failing to act prudently, and in failing to act in accordance with the documents and instruments governing the plan, Aetna violated its fiduciary duty of care.

225. As an ERISA fiduciary, Aetna owed and owes its Members a duty of loyalty, defined as an obligation to make decisions in the interest of its Members, and to avoid self-dealing or financial arrangements that benefit it at the expense of its Members under 29 U.S.C. § 1106. Aetna cannot, for example, make benefit determinations for the purpose of saving money at the expense of its Members.

226. Drs. Antell and Valauri and the ERISA Subclass have standing to pursue these claims as assignees of their Members' out of network benefits claims to Aetna.

227. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

228. Aetna violated its fiduciary duties of loyalty and due care by, *inter alia*, making Nonpar Benefit Reductions that were unauthorized by EOCs and SPDs and which benefited Aetna at the expense of Aetna Members; failing to inform Aetna Members of flaws in the Ingenix Databases that make their use inappropriate to calculate UCR reimbursement; making false representations requiring its Nonpar Benefit Reductions; failing to credit deductibles and out-of-pocket maximums properly; changing its benefit practices without advance disclosure to Members; failing to properly credit deductible and out of pocket maximums; violating ER laws; misrepresenting facts to regulators, sending baseless overpayment actions to collection, failing to disclose in pre-authorizing action appeals that Aetna's nonpar reimbursement practices would leave the member financially responsible for the bulk of the "approved" service; and violating federal and state law.

229. Aetna also violated its fiduciary duties by using noncompliant SPDs required by federal law.

230. Aetna breached its fiduciary duties by sending noncompliant EOBs and other communications to Plaintiffs and the ERISA Subclass.

231. Plaintiffs and the ERISA Subclass are entitled to assert a claim for relief for Aetna's violation of its fiduciary duties under 29 U.S.C. § 1132(a)(3), including injunctive and declaratory relief, and its removal as a breaching fiduciary.

COUNT IV

VIOLATIONS OF RICO **18 U.S.C. § 1962(c)** **(On Behalf of All Plaintiffs and the Class)**

232. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein. This claim is asserted by Plaintiffs on behalf of themselves and the members of the RICO Class.

233. Drs. Antell and Valauri and the Class have standing to pursue these claims as assignees of their patients' out of network benefits claims to Aetna.

234. The Associational Plaintiffs have standing to pursue these claims both individually and on behalf of their members through associational standing.

235. At all relevant times, Aetna was a "person" within the meaning of RICO, 18 U.S.C. §§ 1961(3) and 1964(c).

236. At all relevant times, and as described in this Complaint, Aetna carried out its underpayment scheme to Aetna Members in connection with the conduct of an association-in-fact "enterprise," within the meaning of 18 U.S.C. § 1961(4), comprised of Aetna and Ingenix (the "Aetna-Ingenix Enterprise" or the "Enterprise").

237. At all relevant times, the Aetna-Ingenix Enterprise was engaged in, and its activities affected, interstate commerce within the meaning of RICO, 18 U.S.C. § 1962(c).

238. As described herein of this Complaint, the Aetna-Ingenix Enterprise has and continues to have an ascertainable structure and function separate and apart from the pattern of racketeering activity in which Aetna has engaged. In addition, the members of the Aetna-Ingenix Enterprise function as a structured and continuous unit, and performed roles consistent with this structure. The members of the Aetna-Ingenix Enterprise performed certain legitimate and lawful

activities that are not being challenged in this Complaint, including the provision of health insurance and plan and claims administration services by Aetna, which was done for many claims lawfully and without resort to unlawful practices. However, the collection and dissemination of health insurance information by Ingenix was not legitimate when it involved the creation, use and dissemination of invalid data for use in making UCR determinations. Aside from legitimate activities carried out by the members of the Aetna-Ingenix Enterprise, its members used the Enterprise's structure to carry out the fraudulent and unlawful activities alleged in this Complaint including, but not limited to, intentional underpayment of Aetna Members resulting from the use of flawed and invalid data for its UCR determinations.

239. The purpose of the Aetna-Ingenix Enterprise was to create a mechanism by which Aetna could reduce benefit payments for Nonpar services through use of flawed and invalid data, but to do so through a means that subscribers would be unable to challenge effectively. In particular, as described herein, the Aetna-Ingenix Enterprise created what appeared to be an appropriate and unassailable database which reported actual charge data; the Ingenix Databases were designed to appear valid as a basis for UCR when, in fact, they were invalid. Through their roles in the Aetna-Ingenix Enterprise, Ingenix benefited indirectly through the monies saved by UnitedHealthcare, its parent corporation, and by enhancing its ability to earn licensing fees through the sale of the Ingenix databases, while Aetna benefited by reducing the amount of benefits it paid for Nonpar services through the use of the Ingenix Databases to price UCR. Ingenix also used data submitted by Data Contributors to create other products, the licensing and sale of which directly benefited Ingenix.

240. As alleged herein, although Ingenix issues a disclaimer to the users of the Ingenix Databases, including Aetna, Aetna continued to use the Ingenix Databases in a manner directly at

odds with the disclaimer, while Ingenix knew that its users were using the Ingenix Databases improperly to make UCR determinations. At the same time it was issuing a disclaimer in an effort to provide itself with legal protection, Ingenix was also promoting Ingenix Databases as a cost-savings mechanism that could save substantial sums to those who used them in making UCR determinations. Thus, Aetna and Ingenix expressly observed the disclaimer in the breach despite the fact that the disclaimer was correct in reporting that the Ingenix Databases could not be used as a basis for making UCR determinations.

241. Similarly, as alleged herein, while Ingenix required certifications from the Data Contributors, including Aetna, that purportedly verified that they were submitting all available data and were not pre-editing or otherwise manipulating the data prior to its contribution, Ingenix knew full well that these certifications were invalid because users of the Ingenix Databases, including Aetna, were not submitting all of their data and were pre-editing and manipulating the data prior to its submissions in furtherance of Ingenix's effort to understate UCR amounts. The pre-editing and incomplete submission of data to Ingenix benefited Ingenix, and users of the Ingenix Databases, including United Health Care, Ingenix's parent company, and Aetna. Ingenix also failed to conduct any audits or reviews of its data to ensure that the data were valid and appropriate.

242. Ingenix and Aetna knew that the Ingenix Databases were being used without Aetna Members, or other health plan members, ever being informed of the disclaimer or the inherent flaws in the Ingenix Databases. For example, Aetna falsely reported to Class members that its reductions were based on UCR when, in fact, the reductions were based on flawed and invalid Ingenix Databases that substantially underreported UCR. Aetna referred overpayment recovery actions to collection agencies based on the flawed Ingenix data. At the same time,

Aetna ensured that lawfully required information concerning Nonpar Benefit Reductions was not disseminated to Aetna Members, in violation of Aetna members' EOCs and federal law.

243. Aetna participated in the Aetna-Ingenix Enterprise in order to shift the costs of medical treatment provided by Nonpar providers from Aetna to its Members, to reduce Aetna's UCR payments and to create an appearance of legitimacy for its Nonpar Benefit Reductions. Aetna provided false and incomplete information to Aetna members to convert those withheld funds for the Aetna-Ingenix Enterprise's own direct and indirect financial gain, and to discourage its Members from using Nonpar providers. Because Aetna saves money when Par providers render services, the Aetna-Ingenix Enterprise saved Aetna money at the expense of Aetna Members. In turn, the Enterprise benefited from the pattern of racketeering activity through the reduction of UCR costs by Aetna and other users of the Ingenix Databases, which would not have been obtained absent entry into the Enterprise and was, in addition to the conduct of Aetna alleged above, the shared goal of the Enterprise for which its members functioned as a continuous unit.

244. Aetna further used the Enterprise to facilitate its goal of reducing Nonpar benefits by submitting pre-edited and manipulated data to Ingenix, thereby artificially reducing the numbers that would be reported in the final Ingenix Databases and which Aetna relied upon to make UCR determinations. As part of this fraudulent scheme, as alleged herein, Aetna submitted false certifications to Ingenix which attested that it was submitting all of its data, when it was not. Neither Ingenix nor its parent company, UnitedHealthcare, took steps to audit or otherwise validate the data that Ingenix was receiving from Aetna and other data contributors. Ingenix was aware of the manipulation of data by Data Contributors such as Aetna, but allowed it to occur, since it was consistent with Ingenix's goal to underreport UCR.

245. If Aetna had not entered into the Aetna-Ingenix Enterprise by submitting pre-edited and manipulated data to Ingenix, it would not have been able to obtain the benefits it did from the Enterprise. Ingenix needed sufficient data to allow it to represent to its customers that the Ingenix Databases were the largest available and had sufficient numbers to remove any doubt as to their validity. Ingenix also needed data that reported sufficiently low charges so that it could represent to its users that the Ingenix Databases would save users money used to make UCR determinations. Without data from Aetna and UnitedHealthcare, the Ingenix Databases could not have been successfully marketed for UCR pricing. Similarly, Aetna could not have saved the millions of dollars it did if it had not used the Ingenix Databases for making UCR determinations even though it knew that they were flawed and invalid. By using the Ingenix Databases for making its UCR determinations, misrepresenting them as providing a valid and unassailable basis for such decisions, and deterring its subscribers from challenging or otherwise raising questions over how it set UCR, Aetna was able to benefit substantially from its role in assisting the control and direction of the Enterprise, along with Ingenix and United Health Care.

246. Through its wrongful conduct as alleged herein, Aetna, in violation of 18 U.S.C. § 1962(c), conducted and participated in the conduct of the Enterprise's affairs, directly and indirectly, through a "pattern of racketeering activity," as defined in 18 U.S.C. § 1961(5).

247. Aetna, acting through its officers, agents, employees and affiliates, has committed numerous predicate acts of "racketeering activity," as defined in 18 U.S.C. § 1961(5), prior to and during the RICO Class Period, and continues to commit such predicate acts, in furtherance of its underpayment scheme for Nonpar services, including (a) mail fraud, in violation of 18 U.S.C. § 1341, and (b) wire fraud, in violation of 18 U.S.C. § 1343. Such predicate acts include the following:

- (a) by mailing or causing to be mailed and otherwise knowingly agreeing to the mailing of various materials and information including, but not limited to, materially false and invalid UCR determinations and EOBs, for the purpose of saving Aetna money at its Members' expense, with each such mailing constituting a separate and distinct violation of 18 U.S.C. § 1341; and
- (b) by transmitting or causing to be transmitted and otherwise knowingly agreeing to the transmittal of various materials and information including, but not limited to, materially false UCR determinations and related explanation of such determinations, by means of telephone, facsimile, and the Internet, in interstate commerce, for the purpose of effectuating the above-described false payment schemes, and each such transmission constituting a separate and distinct violation of 18 U.S.C. § 1343.

248. As set forth above, Aetna instructed its claims personnel to make Nonpar Benefit Reductions which were contrary to law and its members' EOCs and SPDs. Aetna knew that the data contributed to Ingenix was flawed and incomplete, but Aetna continued to use the Ingenix Databases anyway.

249. In furtherance of its underpayment scheme for Nonpar services, Aetna, in violation of 18 U.S.C. §§ 1341 and 1343, repeatedly and regularly used the U.S. Mail and interstate wire facilities to further all aspects of the intentional underpayment to its member by delivering and/or receiving materials, including EOCs and SPDs, EOBs, appeal determinations, and other materials necessary to carry out the scheme to defraud Plaintiffs and other Members.

250. The foregoing communications via U.S. mail and interstate wire facilities contained false and fraudulent misrepresentations and/or omissions of material facts, had the design and effect of preventing a meaningful evaluation and review of the Enterprise's UCR determinations, and/or otherwise were incident to an essential part of Aetna's scheme to defraud described in this Complaint. Further, they were used to provide the under-payment scheme for Nonpar services with an appearance of legitimacy and regularity, and/or postpone ultimate

discovery and complaint of the under-payment scheme for Nonpar services, thereby making their discovery less likely than if no such mailings or wire transmissions had taken place.

251. The misrepresentations and omissions in these materials have included and include those set forth previously in this Complaint.

252. As named fiduciaries and claims administrators of various of the Aetna plans, Aetna occupied and occupies a position of trust and it had, and has, a special relationship with its Members that requires it to accurately represent the terms and conditions of the Aetna plans, and to disclose all facts the omission of which would be reasonably calculated to deceive persons of ordinary prudence and comprehension.

253. Aetna knew that its Members would reasonably rely on the accuracy, completeness and integrity of disclosures by the Enterprise. Aetna Members did rely to their detriment on misrepresentations and omissions from the Enterprise.

254. Each such use of the U.S. Mail and interstate wire facilities alleged in this Complaint constitutes a separate and distinct predicate act.

255. The above-described acts of mail and wire fraud are related because they each involve common members, common Nonpar claim practices, common results impacting upon common victims, and are continuous because they occurred over several years, and constitutes the usual practice of Aetna such that they amount to and pose a threat of continued racketeering activity. Aetna's scheme to defraud is open-ended and not inherently terminable.

256. The direct and intended victims of the pattern of racketeering activity described previously herein are beneficiaries and their assignees and the members of the RICO Class, whom Aetna has underpaid Nonpar services.

257. Plaintiffs and Members of the RICO Class were injured by reason of Aetna's RICO violations because they directly and immediately were underpaid benefits. Aetna further deprived them of the knowledge necessary to challenge its underpayments. Their injuries were proximately caused by Aetna's violations of 18 U.S.C. § 1962(c) because these injuries were the foreseeable, direct, intended and natural consequence of Aetna's RICO violations (and commission of underlying predicate acts) and, but for Aetna's RICO violations (and commission of underlying predicate acts), they would not have suffered these injuries.

258. Pursuant to Section 1964(c) of RICO, 18 U.S.C. § 1964(c), Plaintiffs and the members of the RICO Class are entitled to recover threefold their damages, costs and attorneys' fees from Aetna and other appropriate relief.

COUNT V

VIOLATIONS OF SECTION 664 OF RICO 18 U.S.C. § 1962(c) (On Behalf of All Plaintiffs and the ERISA Subclass)

259. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein, including, but not limited to, the allegations contained in Count VI and its description of the Aetna-Ingenix Enterprise. This claim is asserted by Plaintiffs on behalf of themselves and the members of the ERISA Subclass, as those terms are defined in this Complaint.

260. Drs. Antell and Valauri and the ERISA Subclass have standing to pursue these claims as assignees of their patients' out of network benefits claims to Aetna.

261. The Associational Plaintiffs have standing to pursue these claims on behalf of their members through associational standing.

262. Section 1961(1)(B) of RICO specifically identifies as a predicate act “any act which is indictable under . . . [§] 664 (relating to embezzlement from pension and welfare funds)” as a predicate act. 18 U.S.C. § 1961(1)(B). Section 664 of Title 18 provides:

Theft or embezzlement from employee benefit plan

Any person who embezzles, steals, or unlawfully and willfully abstracts or converts to his own use or to the use of another, any of the moneys, funds, securities, premiums, credits, property, or other assets of any employee welfare benefit plan or employee pension benefit plan, or of any fund connected therewith, shall be fined under this title, or imprisoned not more than five years, or both.

263. Each of the Aetna healthcare plans which is an “employee welfare benefit plan” within the meaning of ERISA, 29 U.S.C. § 1002(1)(A), and otherwise is subject to “any provision of title I of the Employee Retirement Income Security Act of 1974,” 29 U.S.C. § 1001, *et seq.*, is included in this Count, including Plaintiffs’ plans.

264. Each of the Aetna healthcare plans that are subject to ERISA is funded by insurance coverage Aetna provides or administers. The applicable plan documents expressly state that all benefits due under the plan terms will be paid and that the underlying benefits they expressly guarantee are plan assets.

265. Plaintiffs’ governing plan documents warrant that all benefits due under the plans will be paid. By improperly reducing payments on Nonpar claims, Aetna intentionally caused Plaintiffs and members of the ERISA Subclass to be underpaid guaranteed benefits to which they were otherwise entitled in accordance with the terms of their group health plans.

266. For fully insured health care plans, in which Aetna both administered the plans and paid the benefits from its own assets, Aetna benefited from the conversion of assets from its ERISA plans. Whereas these assets should have been held by Aetna in its fiduciary capacity under ERISA, and paid to its Members, Aetna improperly withheld such funds and maintained

them as part of its own assets for Aetna's own benefit. For self-funded health care plans, Aetna improperly prevented payment of benefits to the plan participants and beneficiaries in order to justify its receipt of administrative fees. Insurers such as Aetna benefited in the same way, while Ingenix benefited indirectly through the savings generated by its parent, United Healthcare, and directly through the licensing fees it received from Aetna and other insurers who used the flawed Ingenix Databases to commit RICO violations.

267. Aetna acted with specific intent to deprive Plaintiffs and ERISA Subclass members of guaranteed benefits, and was sufficiently aware of the facts to know that it was acting unlawfully and contrary to the trust placed in them by Plaintiffs and ERISA Subclass members and the insurers whose plans it was administering.

268. Each false payment on a claim constitutes a separate and distinct predicate act, in violation of 18 U.S.C. § 664, of converting or misappropriating funds specifically earmarked within the applicable plan as a guaranteed benefit for the intended beneficiary, for Aetna's direct or indirect benefit.

269. As set forth above, Aetna concocted multiple schemes to make improperly reduced payments for Nonpar services.

270. In furtherance of its false payment schemes, Aetna, in violation of 18 U.S.C. §§ 1341 and 1343, repeatedly and regularly used the U.S. Mail and interstate wire facilities to advance all aspects of the false payment schemes by delivering and/or receiving materials, including plan documents, insurance policies, summary plan descriptions, certificates of coverage, claim forms, reimbursement checks, EOBs describing UCR determinations, appeal determinations, overpayment actions, preauthorization decisions, referrals to collection agencies,

representations to regulators, and other materials necessary to effectuate the false payment schemes, as well as to contribute, edit and manipulate the source data for the UCR Databases.

271. The foregoing mail communications and wire communications contained false and fraudulent misrepresentations and omissions of material facts, and otherwise were incident to an essential part of the false payment schemes and were used to provide the false payment schemes with an appearance of legitimacy and regularity, and postpone ultimate discovery and complaint of the false payment schemes, and thereby make the discovery of the false payment schemes less likely than if no such mailings or wire transmissions had taken place, and had the design and effect of preventing a meaningful evaluation and review of Aetna's Nonpar Benefit Reductions.

272. As named fiduciaries and claims administrators of various of the Aetna healthcare plans, Aetna occupied and occupies a position of trust and it had, and has, a special relationship with Plaintiffs and the ERISA Subclass members that requires it to accurately represent the terms and conditions of the Aetna healthcare plans, and to disclose all facts the omission of which would be reasonably calculated to deceive persons of ordinary prudence and comprehension.

273. Each such use of the U.S. Mail and interstate wire facilities constitutes a separate and distinct predicate act of racketeering activity.

274. The above-described acts of conversion of employee benefit plan funds, and mail and wire fraud, are related because they each involved common participants, common methodologies, common results impacting upon common victims and a common purpose of executing the false payment schemes, and are continuous because they occurred over a significant period of years, and constitute the usual practice of Aetna such that they amount to and pose a threat of continued racketeering activity.

275. The purpose of Aetna's false payment schemes was to underpay the guaranteed benefits to which Plaintiffs and ERISA Subclass members are entitled to under health group plans, and convert those withheld funds for its own direct or indirect financial gain. It created an appearance of regularity and legitimacy by providing false and incomplete information to Plaintiffs and ERISA Class members, in order to increase revenue through its plan and claims administration business.

276. The direct and intended victims of the pattern of racketeering activity described previously herein are Plaintiffs and ERISA Subclass members, who Aetna deprived of the complete guaranteed benefits to which they are entitled for Nonpar services.

277. Aetna's RICO violations injured Plaintiffs and ERISA Subclass members by depriving them of hundreds of millions of dollars in guaranteed benefits on their claims for reimbursement of out-of-network charges, as well as the knowledge necessary to challenge false and manipulative UCR determinations, and their injuries were proximately caused by the violations of 18 U.S.C. § 1962(c) because these injuries were the foreseeable, direct, intended and natural consequence of Aetna's RICO violations (and commission of underlying predicate acts), and but for Aetna's RICO violations (and commission of underlying predicate acts), Plaintiffs and ERISA Subclass members would not have suffered the injuries suffered by them.

278. As a result of its misconduct, Aetna is liable to Plaintiffs and ERISA Subclass members in an amount to be determined at trial.

279. Pursuant to Section 1964(c) of RICO, 18 U.S.C. § 1964(c), Plaintiffs and ERISA subclass members are entitled to recover threefold their damages, and costs and attorneys' fees from Aetna.

COUNT VI

VIOLATIONS OF SECTION ONE OF THE SHERMAN ACT **(On Behalf of All Plaintiffs and the Class)**

280. Plaintiffs hereby repeat the allegations of the prior paragraphs of the Complaint as if fully set forth herein.

281. Drs. Antell and Valauri and the Class have standing to pursue these claims as assignees of their patients' out of network benefits claims to Aetna.

282. The Associational Plaintiffs have standing to pursue these claims both individually and on behalf of their members through associational standing.

283. Aetna, along with Ingenix, and other competitors, has combined, conspired and/or agreed with one another, and/or with unnamed coconspirators, to unreasonably restrain trade in violation of Section One of the Sherman Act, 15 U.S.C. § 1. Aetna combined, conspired and/or agreed with UnitedHealthcare, Ingenix, CIGNA and other co-conspirators to engage in a horizontal price fixing conspiracy that sought, and was able, to artificially lower, fix or maintain the price paid to Plaintiffs by Aetna as UCR rates.

284. The above agreement and/or conspiracy to fix prices is a *per se* violation of Section 1 of the Sherman Act, which operates at the expense of doctors (as well as subscribers) resulting in lower UCR rates of payment to doctors. The above agreement and conspiracy illegally restrains competition in a number of ways, including:

- a. Fixing the price of UCR rates for non participating physician services at levels far below the level that would exist in a truly competitive market;
- b. Accomplishing this price fixing by agreeing to peg the UCR rates to the same Ingenix database thereby using the same essential pricing formula;

c. Putting extreme additional competitive pressure on non-participating doctors to become part of particular networks by collusively refusing to even honor competitive market rates for those medical services in the UCR determinations.

285. The above “price fixing” scheme has reduced the amount Plaintiffs’ are paid for their services below competitive levels. However, because of the overwhelming market power that the users of Ingenix including Aetna, collectively, maintain in the marketplace for medical and health services, and because of the conspiracy and/or agreement among Aetna, and its competitors themselves to fix prices and not compete, there is no alternative purchaser or way to avoid interaction with the conspiracy. Because of the conspiracy among the them and/or with other parties, the Aetna and its co-conspirators, including United, and Aetna maintain their oligopsony by reducing costs all while squeezing Plaintiffs’ payments for their services to unconscionably low levels.

286. All of the aforementioned agreements and/or conspiracies affect interstate commerce and have resulted in antitrust injury to all Plaintiffs and the Class.

287. The Plaintiffs are entitled to damages under 15 U.S.C. § 15, *et seq.*

288. As a result of the illegal agreements and/or conspiracies, Aetna has caused the Plaintiffs to suffer financial loss in that Aetna, with its agreements to fix prices and collective market strength, pays Plaintiffs at UCR rates that are set at unconscionably low and uncompetitive levels.

289. As a consequence of Aetna’s illegal agreements and/or conspiracies, Plaintiffs and the Class have suffered and will continue to suffer financial loss and have been injured and will continue to be injured in their business of providing medical services. Among other things, Plaintiffs and the Class received less payment for their medical services than they would have in

the absence of the agreement among Aetna the other users of Ingenix to fix the prices paid for Plaintiffs' out of network medical treatment. Plaintiffs are entitled to recover such actual damages as the jury may find, threefold, plus costs, expenses and attorneys fees. Plaintiffs further seek injunctive relief in the form of order prohibiting Aetna from engaging in the anti-competitive, discriminatory and otherwise wrongful behavior described above.

WHEREFORE, Plaintiffs demand judgment in their favor against Defendants as follows:

A. Certifying the Class and the ERISA Subclass, as set forth in this Complaint, and appointing named Plaintiffs Drs. Antell and Valauri as Class representatives for the Class and the ERISA Subclass.

B. Declaring that Aetna has breached the terms of its EOCs and SPDs and awarding unpaid benefits to Plaintiffs and the members of the ERISA Class, as well as awarding injunctive and declaratory relief to prevent Aetna's continuing Nonpar Benefit Reductions that are undisclosed and unauthorized by EOCs and SPDs;

C. Declaring that Aetna has violated its fiduciary duties including the duties of loyalty and care to Plaintiffs and the ERISA Subclass, and awarding appropriate relief, including unpaid benefits, restitution, interest, declaratory and injunctive relief to Plaintiffs and the ERISA Subclass, and removing the Aetna Defendants as fiduciaries;

D. Enjoining Aetna from violating applicable law and ordering remedial relief for its past violations of applicable law, including regarding ER, tiering and use of Medicare rates for UCR;

E. Enjoining Aetna's use of EOBs that violate applicable law;

F. Declaring that Aetna has failed to provide a “full and fair review” to Plaintiffs and the ERISA Class under 29 U.S.C. § 1133, and awarding injunctive, declaratory and other equitable relief to Plaintiffs and the members of the ERISA Class to ensure compliance with ERISA and its regulations;

G. Declaring that Aetna has violated its disclosure and related obligations under ERISA and federal common law, including under 29 U.S.C. § 1022, for which Plaintiffs and the ERISA Class are entitled to injunctive, declaratory and other equitable relief;

H. Declaring that Aetna has violated federal claims procedures, and awarding Plaintiffs and the ERISA Subclass declaratory and injunctive relief to remedy such violations;

I. Declaring that Aetna and the Ingenix-Aetna Enterprise engaged in a scheme to reduce the amount of Aetna’s payments to its Members, in violation of 18 U.S.C. § 1962(c);

J. Declaring that Aetna, through the Ingenix-Aetna Enterprise, made false payments on claims arising under ERISA plans, thereby converting or misappropriating funds specifically earmarked within the applicable plan as a guaranteed benefit for the intended beneficiary, for Aetna’s direct or indirect benefit, in violation of 18 U.S.C. § 664, justifying monetary and injunctive and other relief;

K. Declaring that Aetna violated federal antitrust law and is liable to Plaintiffs and the Class pursuant to 15 U.S.C. § 15, *et seq.* for threefold their damages, costs and attorney fees;

L. Preliminarily and permanently enjoining Aetna from using the Ingenix Databases as well as Medicare fees to determine UCR, along with other Nonpar Benefit Reductions;

M. Preliminarily and permanently enjoining Aetna from making Nonpar Benefit Reductions where Members’ EOCs and SPDs do not disclose or authorize them;

N. Preliminarily and permanently enjoining Aetna from discouraging Nonpar services or placing undisclosed obstacles in the path of Aetna members seeking to access Nonpar care, including in the ER;

O. Preliminarily and permanently enjoining Ingenix from “approving” members’ requests for preauthorization without disclosing the financial consequences that will occur despite Aetna’s “approval”;

P. Preliminarily and permanently enjoining Aetna from committing the antitrust violations described above in the future and/or declaring their invalidity;

Q. Ordering Aetna to recalculate and issue unpaid benefits to Plaintiffs and Class members that were underpaid as a result of Aetna’s Nonpar Benefit Reductions;

R. Awarding Plaintiffs and the Class compensatory damages, trebled where required by law, and disbursements and expenses of this action, including reasonable counsel fees, in amounts to be determined by the Court and other appropriate relief;

S. Awarding interest from the date of initial Nonpar Benefit Reductions for Plaintiffs and Class Members for all unpaid amounts; and

T. Granting such other and further relief as is just and proper.

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