UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, et al.	:	
plaintiffs,	:	Civil No. 3:14-CV-01859-AVC
v.	:	
TRUE VIEW SURGERY CENTER ONE, LP, et al.	:	
defendants.	:	

RULING ON THE DEFENDANTS' MOTION FOR JUDGMENT ON COUNTS I – IV OF THE PLAINTIFFS' SECOND AMENDED COMPLAINT AND THE DEFENDANTS' MOTION TO DISMISS THE PLAINTIFFS' CLAIMS UNDER ERISA FOR LACK OF TRACEABILITY

This is an action for equitable relief and damages in which the plaintiffs, Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (hereinafter collectively "Cigna"), allege that the defendants, True View Surgery Center One, LP; Oprex Surgery (Houston), LP; LCS Surgical Affiliates, LP; Pasnar Houston, LLC; Oprex Surgery (Beaumont), LP; Oprex ASC Beaumont, LLC; and Altus Healthcare Management, LP (hereinafter collectively the "surgical centers"), defrauded Cigna using fee-forgiving billing practices. It is brought pursuant to the Employee Retirement Income Security Act ("ERISA")[1], the Connecticut Unfair Trade

[1] 29 U.S.C. § 1132(a).

Practices Act ("CUTPA")[2], and common law tenets concerning unjust enrichment, fraud, and tortious interference with contract.

The surgical centers have filed the within motion for judgment on the pleadings as to Counts I through IV of Cigna's second amended complaint pursuant to Federal Rule of Civil Procedure 12(c), arguing that the surgical centers are entitled to judgment as a matter of law. The surgical centers have also filed the within motion to dismiss Cigna's claims under ERISA for lack of traceability pursuant to Federal Rule of Civil Procedure 12(b)(6), arguing that the Court should dismiss Count I (insofar as it seeks monetary relief) and Count III of Cigna's second amended complaint.

The issues presented are: 1) whether Cigna is barred by the doctrine of collateral estoppel from pursuing Counts I through IV of Cigna's second amended complaint; and 2) whether Cigna has adequately alleged traceability in Counts I and III of Cigna's second amended complaint.

The court concludes that Cigna is barred by the doctrine of collateral estoppel from pursuing Counts I and III of Cigna's second amended complaint, and that Cigna is not barred by the doctrine of collateral estoppel from pursuing Counts II and IV of Cigna's second amended complaint.

[2] Conn. Gen. Stat. § 42-110a et seq.

For the reasons that follow, the motion for judgment on the pleadings is GRANTED in part and DENIED in part. Because the court grants the surgical centers' motion for judgment on the pleadings as to Counts I and III, the court finds the surgical centers' motion to dismiss Counts I and III moot.

FACTS

An examination of the amended complaint and the relevant memoranda reveals the following:

Cigna is a Connecticut-based managed care company that serves as a claims administrator and insurer. Cigna provides administrative services to employee health and welfare benefit plans (the "plans"), which permit individual plan members and their beneficiaries to seek health services or treatment at either "in-network" or "out-of-network" facilities. As plan administrator, Cigna then reimburses members for the services performed at these facilities. Reimbursement is subject to the requirement that members satisfy applicable cost-sharing obligations in the form of deductibles, copayments, and coinsurance. Such "covered expenses" satisfy "all terms and conditions of the plan, including that the expense is 'incurred' by or for a covered person. . . that the expense is medically necessary, and that it is included on the list of covered expenses appearing in the summary plan description and is not

excluded from coverage." Cigna reimburses only those covered expenses incurred and which the plan member is obligated to pay.

Cigna has entered into agreements with "in-network" facilities to provide access to Cigna's members in exchange for lower, fixed rates. While Cigna plan members are allowed to seek treatment from out-of-network providers, they must pay higher cost-share amounts. Cigna requires its members to bear greater cost-share burdens for out-of-network care to incentivize members to seek treatment at "in-network" facilities.

Cigna provides reimbursement for out-of-network claims in one of three ways. First, Cigna's repayment obligation can be calculated by the "maximum reimbursable charge," which is "the lesser of (a) the provider's normal charge for a similar service (typically deemed to be the amount billed) or (b) either a specified percentile of charges made by other providers of such services in the region or a specified percentile of the reimbursement rate that Medicare provides for such services in the same geographic area." Second, Cigna contracts with third-party vendors who then "negotiate with providers and facilities to re-price their out-of-network claims." These providers and facilities agree to "accept a preordained discount percentage to out-of-network claims and make the discount available to insurers like Cigna." Third, the billed amount is not re-

priced. No matter how the payment is calculated, however, "the billed amount is relevant and material to the determination of the 'allowed amount,' which is the amount that Cigna determines to be covered by its plan."

The surgical centers are out-of-network providers with whom Cigna has no contractual relationship. The amended complaint alleges that the surgical centers engaged in a systematic fee-forgiving scheme intended to circumvent the plans' cost-share obligations and thereby defraud Cigna. Specifically, it alleges that the surgical centers lured members to their out-of-network facilities by offering less expensive services and waiving cost-share obligations. The amended complaint further alleges that the surgical centers then billed Cigna for the full cost of treatment at "grossly inflated" amounts that misrepresented the true cost of services provided and did not disclose to Cigna their practice of waiving members' cost-share obligations. Consequently, Cigna alleges, it has made approximately $17 million in overpayments as a result of the surgical centers' allegedly fraudulent conduct.

Cigna has paid claims to the surgical centers on behalf of three hundred sixteen plans, which are all subject to this lawsuit. Of these three hundred sixteen plans, two hundred twenty-eight are administrative services only plans ("ASO") and are self-funded by employers. Seventy-four of the plans are

designated as fully-insured plans and are funded by Cigna. The remaining fourteen "minimum premium" plans require Cigna to reimburse claims paid above a certain threshold.

Two hundred ninety-three of the plans involved in this case are covered by ERISA, under which Cigna brings this action on its own behalf and in its capacity as a claims administrator and fiduciary for all plans at issue. Cigna avers that it has standing to sue under ERISA § 502(a)(3) to obtain "appropriate equitable relief" to redress violations of the ERISA plans and to enforce the terms of the ERISA plans. 29 U.S.C. § 1132(a)(3).[3]

In Count I of Cigna's amended complaint, Cigna requests a declaration that, "under the terms of the ERISA plans insured and/or administered by Cigna, no coverage is due where

[3] ERISA § 502(a), 29 U.S.C. § 1132(a), provides that a civil action may be brought:

(1) by a participant or beneficiary—
  (A) for the relief provided for in subsection (c) of this section, or
  (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
(3) by a participant, beneficiary, or fiduciary
  (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
  (B) to obtain other appropriate equitable relief
    (i) to redress such violations or
    (ii) to enforce any provisions of this subchapter or the terms of the plan.

Defendants do not enforce the plans' cost-share requirements or where Defendants charge for expenses that would not have been charged to the member if the member did not have insurance." Cigna also seeks a permanent injunction "directing Defendants to submit to Cigna only claims containing charges that Defendants actually charge the plan member as payment in full and not to submit charges which include amounts that Defendants do not actually require the member to pay or would not have charged if the member did not have insurance." Furthermore, Cigna seeks "the imposition of a constructive trust on monies currently held by Defendants as a result of the overpayments made by Cigna, an order restoring the overpayments currently being held by Defendants pursuant to an equitable lien, an accounting of the amounts received and owed by Defendants, and other appropriate equitable relief."

In Count II of Cigna's amended complaint, on behalf of the non-ERISA plans in this action, Cigna seeks a declaration that the claims for reimbursement submitted by the surgical centers "are not covered and are not payable under Cigna's plans." Cigna also seeks a declaration that the surgical centers "must return all sums received from Cigna."

In Count III of Cigna's amended complaint, on behalf of the ERISA plans in this action, Cigna seeks to enforce the terms of its plans "by recovering from Defendants specific portions of

particular funds." Specifically, Cigna seeks to recover from the total pool of funds paid to the surgical centers "the specific portion of those payments that were rendered overpayments as a result of Defendants' failure to follow plan terms." Cigna avers that it is "entitled to the imposition of a constructive trust on the sums it paid to Defendants in reliance on the fraudulent claims submitted by Defendants, as well as on any profits or income made by Defendants through the use of those amounts held in constructive trust." Cigna also seeks an order "restoring to Cigna. . . the specifically identifiable funds held in constructive trust by Defendants."

In Count IV of Cigna's amended complaint, on behalf of the non-ERISA plans in this action, Cigna alleges that the surgical centers "have been unjustly enriched as a result of their fraudulent billing practices." Cigna seeks restitution to recover the alleged overpayments it made to the surgical centers.

STANDARD

The surgical centers bring two motions: A motion for judgment on Counts I through IV of Cigna's second amended complaint and a motion to dismiss Cigna's claims under ERISA for lack of traceability.

Rule 12(c) of the Federal Rules of Civil Procedure states that, "[a]fter the pleadings are closed—but early enough not to

delay trial—a party may move for judgment on the pleadings." Fed.R.Civ.P. 12(c). "The legal standards for review of motions pursuant to Rule 12(b)(6) and Rule 12(c) are indistinguishable." DeMuria v. Hawkes, 328 F.3d 704, 706 n.1 (2d Cir. 2003). "Like a motion to dismiss, it is meant 'merely to assess the legal feasibility of the complaint, not to assay the weight of the evidence which might be offered in support thereof.'" Bradley v. Fontaine Trailer Co., No. 3:06-cv-62(WWE), 2009 WL 763548, at *2 (D. Conn. Mar. 20, 2009) (citing Ryder Energy Distribution v. Merrill Lynch Commodities, Inc., 748 F.2d 774, 779 (2d Cir. 1984)). On a motion for judgment on the pleadings, "the court must accept all well-pleaded allegations as true and draw all reasonable inferences in favor of the pleader." Hishon v. King, 467 U.S. 69, 73 (1984). The court may dismiss the complaint only if "it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46 (1957).

A court must grant a motion to dismiss pursuant to Fed. R. Civ. P. 12(b)(6) if a plaintiff fails to establish a claim upon which relief may be granted. Such a motion "assess[es] the legal feasibility of the complaint, [it does] not. . . assay the weight of the evidence which might be offered in support thereof." Ryder Energy Distrib. Corp. v. Merrill Lynch Commodities, Inc., 748 F.2d 774, 779 (2d Cir. 1984). When

ruling on a 12(b)(6) motion, the court must "accept the facts alleged in the complaint as true, and draw all reasonable inferences in favor of the plaintiff." Broder v. Cablevision Sys. Corp., 418 F.3d 187, 196 (2d Cir. 2005). In order to survive a motion to dismiss, the complaint must allege "enough facts to state a claim to relief that is plausible on its face." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570 (2007). The complaint must allege more than "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements." Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009). The court may consider only those "facts stated on the face of the complaint, in documents appended to the complaint or incorporated in the complaint by reference, and to matters of which judicial notice may be taken." Allen v. WestPoint-Pepperell, Inc., 945 F.2d 40, 44 (2d Cir. 1991).

DISCUSSION

The surgical centers argue that Cigna is barred by the doctrine of collateral estoppel from pursuing Counts I through IV in this action. Specifically, the surgical centers argue that "[b]ecause the Humble Court definitively rejected [the] contention [that Cigna's plan terms exclude coverage where a provider engages in fee forgiveness], Cigna should not be allowed to revisit it here." Cigna responds that collateral estoppel does not apply because the only "identical issue" is a

pure question of law, the "remaining issues decided in Humble are not identical to those in dispute here," and "applying collateral estoppel would be unfair and inappropriate in light of inconsistent prior judgments in Cigna's favor."

Under the doctrine of collateral estoppel, a litigant is prevented from "relitigating in a subsequent action an issue of fact or law that was fully and fairly litigated in a prior proceeding." Marvel Characters, Inc. v. Simon, 310 F.3d 280, 288 (2d Cir. 2002). Collateral estoppel applies when "(1) the identical issue was raised in a previous proceeding; (2) the issue was actually litigated and decided in the previous proceeding; (3) the party had a full and fair opportunity to litigate the issue; and (4) the resolution of the issue was necessary to support a valid and final judgment on the merits." Ball v. A.O. Smith Corp., 451 F.3d 66, 69 (2d Cir. 2006). To determine whether issues are "identical" under the doctrine of collateral estoppel, courts are to examine, "[w]hether the same transaction or connected series of transactions is at issue, whether the same evidence is needed to support both claims, and whether the facts essential to the second were present in the first." Marvel Characters, Inc. v. Simon, 310 F.3d 280, 288 (2d Cir. 2002). Collateral estoppel "may be applied non-mutually; third-parties may raise collateral estoppel defensively against a party who had fully and fairly litigated an issue to prevent

that party from raising the same issue in a subsequent lawsuit." Burton v. Undercover Officer, No. 15-3948-cv, 2016 WL 7131861, at *1 (2d Cir. Dec. 7, 2016). In disputes over private rights between private litigants, "no significant harm flows from enforcing a rule that affords a litigant only one full and fair opportunity to litigate an issue, and there is no sound reason for burdening the courts with repetitive litigation." Standefer v. U.S., 447 U.S. 10, 24 (1980).

The United States District Court for the Southern District of Texas has addressed the issue regarding whether Cigna may rely on plan language stating that "no coverage is due where Defendants do not enforce the plans' cost-share requirements or where Defendants charge for expenses that would not have been charged to the member if the member if not have insurance" as a basis for denying a provider's benefits claims. Conn. Gen. Life Ins. Co. v. Humble Surgical Hospital, LLC, No. 4:13-CV-3291, 2016 WL 3077405 (S.D. Tex. June 1, 2016). In Humble, the court held that Cigna's interpretation of this "exclusionary" language was "legally incorrect," and that "ERISA does not permit the interpretation embraced by Cigna." Id. at *18. The court found that because "[t]he average plan participant would not understand from the exclusionary language. . . that his/her coverage is expressly conditioned on whether Humble collects upfront, the entirety of his/her deductible, co-pay and co-

insurance before Cigna pays," Cigna's "'exclusionary' language interpretation does not pass muster under the 'average plan participant' test," which ERISA requires. Conn. Gen. Life Ins. Co. v. Humble Surgical Hospital, LLC, No. 4:13-CV-3291, 2016 WL 3077405, at *18 (S.D. Tex. June 1, 2016).

In this case, Counts I and III of Cigna's second amended complaint seek relief on behalf of ERISA plans. In Count I, Cigna seeks declaratory and injunctive relief under ERISA. Specifically, Cigna requests a "declaration that, under the terms of the ERISA plans insured and/or administered by Cigna, no coverage is due where Defendants do not enforce the plans' cost-share requirements or where Defendants charge for expenses that would not have been charged to the member if the member did not have insurance." In Count III, Cigna seeks recovery of overpayments under ERISA. Specifically, Cigna seeks to recover payments it made "that are not covered under the relevant plans, because they. . . do not satisfy the plans' cost-share requirements, and are excluded by the plans' provisions excluding charges that plan members are not obligated to pay or that would not have been charged if the members did not have insurance." In both Counts I and III, Cigna is relying on the interpretation of its ERISA plans that the United States District Court for the Southern District of Texas held to be "legally incorrect" in order to effectively deny providers'

benefit claims. Therefore, the doctrine of collateral estoppel bars Cigna from relitigating those Counts.[4]

Counts II and IV of Cigna's second amended complaint, on the other hand, seek relief on behalf of non-ERISA plans. In Count II, Cigna seeks declaratory relief. In Count IV, Cigna seeks recovery of overpayments based on a theory of unjust enrichment. In Humble, the court held that ERISA did not permit Cigna's interpretation of the exclusionary language in Cigna's ERISA plans. Conn. Gen. Life Ins. Co. v. Humble Surgical Hospital, LLC, No. 4:13-CV-3291, 2016 WL 3077405, at *18 (S.D. Tex. June 1, 2016). Because Counts II and IV of Cigna's second amended complaint concern non-ERISA plans, the court finds that the "identical issue" was not "fully and fairly litigated in a prior proceeding." Marvel Characters, Inc. v. Simon, 310 F.3d 280, 288 (2d Cir. 2002). Therefore, Cigna is not barred by the doctrine of collateral estoppel from litigating those Counts.

CONCLUSION

The court concludes that the surgical centers have established that they are entitled to judgment on the pleadings as to Counts I and III of the second amended complaint, and that the surgical centers have failed to establish that they are

[4] Because the court grants the surgical centers' motion for judgment on the pleadings as to Counts I and III for the foregoing reasons, the court finds it unnecessary to address Cigna's additional arguments in its memorandum in opposition.

entitled to judgment on the pleadings as to Counts II and IV of the second amended complaint.

The surgical centers' motion for judgment on the pleadings (doc. 133) is GRANTED in part and DENIED in part. Because the court grants the surgical centers' motion for judgment on the pleadings as to Counts I and III, the court finds the surgical centers' motion to dismiss (doc. 126) moot.

It is so ordered this 8th day of March 2017, at Hartford, Connecticut.

_____/s/_____
Alfred V. Covello, U.S.D.J.