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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

BETH SHAPIRO, LORI ANN LOMBARDI, and HEATHER GITLIN, on behalf of themselves and on behalf of all others similarly situated,	Case No. 22-cv-1958
Plaintiff,	
- v. -	**CLASS ACTION COMPLAINT**
AETNA, INC. and AETNA LIFE INSURANCE COMPANY,	
Defendants.	

Beth Shapiro ("Ms. Shapiro"), Lori Ann Lombardi ("Ms. Lombardi"), Heather Gitlin ("Ms. Gitlin") (collectively, "Plaintiffs"), on behalf of themselves and on behalf of all others similarly situated, bring the following complaint against Defendants Aetna, Inc. and Aetna Life Insurance Company ("Aetna" or "Defendant"), as follows:

FACTUAL BACKGROUND

1. Aetna is in the business of insuring and/or administering health plans, many of which are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 to 1461 (the "Aetna Plans"). In that role, Aetna receives, reviews, and/or processes benefits claims for services rendered by in-network and out-of-network medical providers to

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individuals enrolled in Aetna Plans ("Aetna Members").

2. Many Aetna Plans are "self-funded" where the plan sponsor is responsible for payment of claims from its own funds and those contributed by employees. Aetna acts as a third-party fiduciary and claims administrator for its self-funded Aetna Plans.

3. Most Aetna Plans cover health care services received by Aetna Members from either in-network ("INET") providers (who have negotiated contracts with Aetna and agreed to accept a reduced amount from billed charges for the services rendered) or out-of-network ("ONET") providers (who are not contracted with Aetna and have not agreed to accept payments based on Aetna and its agents' reimbursement determinations).

4. To that end, Aetna Plans generally define ONET providers to be "a provider who in not a network provider," i.e., a provider who is not "listed in the directory for your plan."

5. Aetna Plans also typically define the amount in benefits to be paid for a particular covered service under the plan to be based on a "Negotiated Charge" for INET providers and a "Recognized Charge" for ONET providers.

6. For INET services, the Negotiated Charge is the amount a network provider has agreed to accept as a reduced amount from that provider's standard billed charges for rendering services and patient liability is limited to in-network cost sharing obligations. Based on a negotiated and agreed amount between the INET provider and Aetna, there is no balance bill owed by the member to an INET providers. In distinguishing between INET and ONET providers on its website, Aetna states the following:

> An out-of-network doctor can bill you for anything over the amount that Aetna recognizes or allows. This is called "balance billing." A network doctor has agreed not to do that.

7. For ONET services, Aetna Plans specify that the Recognized Charge (sometimes also referred to as the "allowed amount" or the "out-of-network plan rate") will be (i) a specified

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percentage of the rates at which Medicare reimburses for the applicable services or other similar provision, (ii) the "reasonable amount rate" or a similar provision that is generally based on "usual, customary and reasonable", "prevailing charge" or "reasonable charge" ("UCR") rates, or rates that represent what most other providers in the same geographic area would charge for the same treatment or (iii) 'an amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided" (collectively referred to as the "ONET Rates"). Generally, ONET providers are permitted to balance bill patients for the difference between their standard charges and the ONET Rates as defined under the applicable Aetna Plan.

8. Historically, Aetna Plans reimbursed ONET services at UCR rates for many plans. Aetna previously set ONET UCR rates based on the "Ingenix Database," which was developed and promulgated by UnitedHealthcare, a competing health insurance company and claims administrator. Several litigations were brought against UnitedHealthcare and other insurers, however, based on the allegation that the Ingenix database was improperly designed to underreport UCR charges. Ingenix was therefore later replaced by "FAIR Health."

9. FAIR Health was established as part of the settlement of an investigation by the Office of the Attorney General of New York State into the health insurance industry's practice of determining out-of-network reimbursement based on data compiled and controlled by UnitedHealthcare, which the Attorney General determined was operating under a clear conflict of interest and was alleged to underpay out-of-network services.

10. FAIR Health was formed "to establish and maintain a new database that could be used to help insurers determine their reimbursement rates for out-of-network charges and provide

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patients with a clear, unbiased explanation of the reimbursement process.

11. Using millions of healthcare claims submitted to it by insurers, health care plans, and providers, FAIR Health created a database that reflects the rates that most providers charge in each area based on the zip code where a health care service is being provided and the Current Procedural Terminology ("CPT") Code to be used by the provider for each specific healthcare service. CPT Codes are numbers developed and licensed by the American Medical Association to identify each individual healthcare service for billing purposes.

12. Upon the zip code and CPT Code being input into the database, FAIR Health will provide the UCR for the pertinent procedure in the designated geographic area. As FAIR Health explains:

> The Estimated Charge is what FAIR Health, based on its database, estimates that a medical provider in your area may bill for the procedure you selected when performed out-of-network. This estimate is based on the charges billed by providers for this service in the geozip where the service was performed. (A geozip, which defines a geographic region in our database, generally corresponds to the first three digits of a zip code.)
>
> The estimate shown is based on the 80th percentile, meaning that 80% of the charges in our database for this procedure in your area were lower than or equal to our estimate and 20% were higher than or equal to our estimate. We use the 80th percentile because many insurers use the 80th percentile to determine usual, customary and reasonable (UCR) rates upon which they base out-of-network reimbursement.

13. Since the demise of Ingenix, FAIR Health has become the gold standard in determining out-of-network pricing for services rendered to patients insured through benefit plans that contemplate UCR pricing.

14. In or around 2011, Aetna adopted Fair Health as the basis for calculating ONET Rates in the vast majority of its self-funded benefit plans, generally using the 80th percentile of Fair Health. This is confirmed by the language of those plans themselves, as well as in letters and

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other claim-related communications sent by Aetna as a fiduciary to its self-funded plan clients to Aetna Members and their providers, including Explanation of Benefit ("EOB") statements and appeal letters describing the manner Aetna calculates ONET UCR rates. This is further confirmed by Aetna's own description of these terms on its website.

15. By reimbursing at this level, ONET providers received a fair payment for their services and "Balance Billing," i.e., the patient being billed for the difference between an ONET provider's charge, and the Fair Health amount was minimal.

16. Aetna would also access independent third-party networks through its National Advantage Program ("NAP"), to reimburse ONET services at amounts lower than the UCR rate. Aetna highlights that a plan is part of NAP by placing the NAP identification on the member's insurance card. Originally, NAP was established in part to identify those situations where Aetna contracts with several national third-party NAP vendors to access their provider networks ("NAP Contracts") and contracted rates ("NAP Contract Rates"). NAP vendors include Multiplan and Beech Street, who administer third-party provider networks.

17. When reimbursement is made through these NAP Contracts at the NAP Contract Rates as required under Aetna Plans and other applicable documents, the ONET provider agrees not to balance bill the member. Generally, Aetna's access to NAP Contracts on behalf of its self-funded clients was/is referred to as the "Base Program." The Base Program offers access to contracted rates for medical claims that could otherwise be paid at billed charges under indemnity plans, "the out-of-network portion of network-based plans, or for emergency/medically necessary services not provided within the network."

18. In exchange for reducing payments made to their self-insured employer clients through NAP Contract Rates and eliminating any balance bill to the affected member, Aetna was

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