IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

AMISUB (SFH), INC. d/b/a SAINT FRANCIS HOSPITAL and SAINT FRANCIS HOSPITAL – BARTLETT, INC.,	)	CASE NO:
Plaintiffs,	)	
v.	)	Jury Trial Demanded
CIGNA HEALTH AND LIFE INSURANCE COMPANY,	)	
Defendant.	)	

COMPLAINT

Plaintiffs AMISUB (SFH), Inc. d/b/a Saint Francis Hospital ("Saint Francis") and Saint Francis Hospital – Bartlett, Inc. ("Bartlett") (collectively, St. Francis and Bartlett are referred to as "Plaintiffs" or the "Hospitals"), by and through undersigned counsel, sue Defendant Cigna Health and Life Insurance Company ("Cigna"),[1] and allege as follows.

NATURE OF THE ACTION

1. The Hospitals bring this lawsuit to assert their right to full payment from Cigna in connection with emergency services the Hospitals provided to Cigna's insureds. Cigna has failed to pay the Hospitals adequately for medically necessary emergency health care services that the Hospitals provided in their emergency rooms located in Shelby County, Tennessee. Cigna, on behalf of the plans that it underwrites and insures itself and on behalf of the Self-Funded Plans it

[1] Cigna also administers health plans that are either sponsored by public or private employers for the benefit of their respective employees, referred to as "Self-Funded Plans."

administers, is required to pay the reasonable value of services rendered to patients by the Hospitals and covered under those health plans. Health plan beneficiaries for whom the Hospitals performed services without full reimbursement and which are not governed by an express contract are referred to herein as "Cigna Members."

2. With respect to all of the claims at issue in this lawsuit, the Hospitals were non-participating providers, meaning they did not have an express contract with Cigna or the Self-Funded Plans to accept discounted rates for their services, nor did they ever agree to be bound by Cigna's reimbursement policies or rate schedules for the claims it administers on behalf of itself or the Self-Funded Plans. Specifically, the reimbursement claims at issue in this action are only those non-participating commercial claims (including for patients covered by Affordable Care Act health insurance exchange products (the "Exchange")) that Cigna adjudicated as covered and allowed as payable for services rendered on and after January 1, 2019 at rates below the billed charges and the reasonable value of the services rendered, as measured by the community where they were performed and by the facilities and persons who provided them (collectively, the "Non-Participating Claims").[2]

3. Federal and Tennessee law both obligate hospitals offering emergency services to evaluate, examine, and treat all patients who come into an emergency room, regardless of the existence, or extent, of insurance coverage, and regardless of a patient's ability to pay for the care.

4. Similarly, insurance companies like Cigna and self-funded insurance plans like the Self-Funded Plans are legally and contractually obligated to ensure that their members receive

[2] Cigna offers multiple different health insurance products in the Memphis market. The Hospitals participate in the network for some of these products, but not others. The Non-Participating Claims all involve services rendered to Cigna Members who are enrolled in health insurance plans or products in which the Hospitals do not participate. As such, no contracts govern or specify the reimbursement rate for the Non-Participating Claims.

such services. Indeed, Cigna markets its insurance products as providing coverage for emergency care, 24 hours a day, 7 days a week, 365 days per year, and without the need to obtain prior approval for the services.

5. Thus, hospitals that provide emergency medical care to payors' members, as the Hospitals in this case do for Cigna Members, relieve payors of the immense burden they carry to provide their members with emergency medical care regardless of when, where, or to what extent their members need it.

6. Under such circumstances, an equitable obligation arises to account for the benefit the hospitals provide to the payors. It requires that payors pay hospitals the reasonable value of the services rendered, as measured by the community where they were performed. In the absence of such an obligation, payors would have free reign to enrich themselves unjustly at the expense of the hospitals by receiving premium payments from or on behalf of Cigna Members and/or fees from Self-Funded Plans to provide and cover emergency services, and in turn inappropriately retaining those payments without paying for the fair value of the emergency services Cigna is obligated to provide and cover.

7. Here, at all material times, Cigna (for itself and as the claims administrator for the Self-Funded Plans) has satisfactorily determined that the Hospitals' reimbursement claims were covered and medically necessary under the various health plans. Indeed, Cigna (on behalf of its fully insured plans and on behalf of the Self-Funded Plans it administers) adjudicated the Non-Participating Claims as payable, albeit at a rate far less than the reasonable value of the emergency medical care furnished.

8. In fact, Cigna's payments on the Non-Participating Claims, on average, have been nearly 50% lower than the already discounted rates at which Cigna reimbursed claims under the

plans in which the Hospitals were participating providers. By contrast, for the five and a half years prior to January 1, 2019, Cigna had an agreement with the Hospitals to reimburse out-of-network or non-participating services at 75% of the Hospitals' billed charges, a smaller discount than the agreements for plans in which the Hospitals were participating providers reflecting that the Hospitals did not receive the benefits associated with being a participating provider. This accurately reflects the widely accepted and recognized industry norm that providers and payors agree to lesser discounts from the provider's charges when the services rendered are "out-of-network" or "non-participating," thereby reflecting the economic consequences of the absence of in-network benefits providers would otherwise receive.

9. This action seeks redress for Cigna's underpayments. The Hospitals seek damages in the amount of the difference between what Cigna (on behalf of its fully insured plans and on behalf of the Self-Funded Plans it administers) paid for the Non-Participating Claims and the reasonable value of the services rendered, as measured by the community where they were performed. By filing this lawsuit, the Hospitals seek recovery of the total amount underpaid by Cigna, plus interest for loss of use of that money, which damages are ongoing in nature as additional Non-Participating Claims accrue.

10. In addition to their damages, the Hospitals also request an order from the Court declaring that, on a going forward prospective basis, Cigna (on behalf of its fully insured plans and on behalf of the Self-Funded Plans it administers) must pay the Hospitals the reasonable value of the emergency medical care they furnish to Cigna Members, as measured by the community where they were performed, and to be proven at trial.

11. To be clear, and for avoidance of doubt, this lawsuit solely concerns the *rate* of payment to which the Hospitals are entitled under Tennessee law, not whether a *right* to receive

payment exists. This lawsuit does not challenge the *right* to receive payment under any plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). Cigna's underpayments (on behalf of its fully insured plans and on behalf of the Self-Funded Plans it administers) are an acknowledgement that the Hospitals' services were covered and medically necessary under Cigna Members' respective health plans. Thus, the Non-Participating Claims asserted herein do not concern any claims arising from the denial of benefits under any health plan, or the denial of coverage under any health plan for emergency medical care rendered to Cigna Members. In short, there is no dispute that the Hospitals are entitled (*i.e.*, the right) to be paid for the services they rendered; this dispute concerns *only* the appropriate amount (*i.e.*, the rate) of such necessary reimbursement.

12. Neither Medicare Advantage nor managed Medicaid products are at issue in this action. The Non-Participating Claims only involve commercial and Exchange products that Cigna has underwritten and fully insures itself, or that Cigna administers on behalf of the Self-Funded Plans.

13. Because Cigna has already conceded coverage and adjudicated the Non-Participating Claims as payable, this lawsuit does not challenge any coverage determination under any health plan that may be subject to ERISA.

14. Nor does this lawsuit involve any claim by the Hospitals for benefits under a health plan based on an assignment of benefits from any Cigna Member. Defendant's obligations to reimburse the Hospitals at a reasonable rate arise from legal duties predicated on contracts implied-in-fact and/or implied-in-law directly with the Hospitals, not pursuant to any assignment of any rights under the Cigna Members' health plans.

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