

IN THE UNITED STATES DISCTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

UROLOGY CENTER OF GEORGIA, LLC)

Plaintiff,)

v.)

BLUE CROSS BLUE SHIELD)

HEALTHCARE PLAN OF)

GEORGIA, INC. and)

BLUE CROSS AND BLUE SHIELD)

OF GEORGIA, INC.)

Defendants.)

CIVIL ACTION FILE

NO. _____

**COMPLAINT FOR DAMAGES; REQUEST FOR INJUNCTIVE RELIEF;
AND DEMAND FOR TRIAL BY JURY**

COMES NOW Plaintiff and files this Complaint on behalf of itself and on behalf of a class of all persons similarly situated. Plaintiff shows the Court the following:

I. PARTIES, JURISDICTION & VENUE

1.

Plaintiff Urology Center of Georgia, LLC (“Urology Center”) is a resident of Bibb County, Georgia. Urology Center is a Georgia limited liability company and operates as an outpatient or ambulatory surgery center.

2.

Plaintiff Urology Center brings this action individually and on behalf of a class of all Georgia surgery centers that provide “out of network” services to patients insured or covered by Blue Cross, pursuant to an assignment of benefits from the patient, and whose reimbursements

have not been paid according to Blue Cross's agreements, contracts and/or plans. The class and sub-classes are further defined below.

3.

Defendant Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. is a for-profit health benefits company. Its principal address is 3350 Peachtree Road, N.E., Atlanta, Georgia 30326. Its registered agent for service of process is CT Corporation System, 1201 Peachtree Street, N.E., Atlanta, Fulton County, Georgia 30361. Defendant Blue Cross and Blue Shield of Georgia, Inc. is a for-profit health insurance company. Its principal address is 3350 Peachtree Road, N.E., Atlanta, Georgia 30326. Its registered agent for service of process is CT Corporation System, 1201 Peachtree Street, N.E., Atlanta, Fulton County, Georgia 30361. Defendants are hereinafter collectively referred to as "Blue Cross." Blue Cross maintains offices within the Middle District of Georgia.

4.

This Court has subject matter jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

5.

This Court has supplemental jurisdiction over Plaintiffs' state law claims pursuant to 28 U.S.C. § 1367(a).

6.

Defendants are subject to personal jurisdiction in this Court because they are authorized to and do transact business in Georgia, and because they maintain registered agents for service of process in this State. Defendants Blue Cross's continuous, systematic contacts within Bibb County and the Middle District of Georgia are substantial. Blue Cross maintains agents and one or more offices within this district; Blue Cross transacts a large amount of business within this

district; and Blue Cross derives revenue from its sales within this district. Defendants purposefully direct their business activities at residents of Georgia and of this district. Plaintiff's claims relate to Defendants' business within Georgia and this district. The exercise of personal jurisdiction over Defendants comports with due process.

7.

Venue is proper in this Court pursuant to 28 U.S.C. § 1391 because a substantial part of the events giving rise to this claim occurred in this judicial district and because Defendants Blue Cross reside in this judicial district. Plaintiff Urology Center also resides in this district and division.

II. FACTS

8.

As used in this complaint, the term "member" is intended to refer to and include patients who receive health benefits from Blue Cross insurance policies and/or health plans that are administered or insured by Blue Cross.

9.

Plaintiff brings this action to prevent Georgia's largest health benefits provider from intentionally preventing patients from exercising their rights to visit out-of-network providers for their health care. Defendants have targeted out-of-network providers, including outpatient non-hospital providers of surgical services, known as ambulatory surgery centers, for a drastic and unprecedented slash in reimbursement to a mere fraction of usual and customary charges. Defendants' actions violate federal and state laws protecting patients and providers, as well as Defendants' own contracts.

10.

Defendants offer Preferred Provider Organization (“PPO”) plans to members as an alternative to their traditional Health Maintenance Organization (“HMO”) plan. In PPO plans, enrollees elect to pay a higher premium in exchange for the flexibility to receive coverage for care received from any licensed provider, including providers who are not in Defendants’ preferred network. This is known as out-of-network care by out-of-network providers, and is similar to the traditional health insurance coverage that existed before “provider networks” were created.

11.

Defendants also offer Point of Service (“POS”) plans. POS plans offer enrollees flexibility in determining how their plan will function. If they choose to use in-network care, they will pay no deductible and typically a minimal co-payment. If they choose to go outside the network, the POS plan functions like a PPO. The Point of Service option is an explicit “freedom of choice” feature which was added to traditional closed-network HMO plans in response to purchasers’ concerns about being confined to in-network care.

12.

PPO and POS premiums are higher than HMO premiums because the costs incurred by the enrollee seeking out-of-network care are higher. PPO and POS participants know that their care will be less expensive if they go to an in-network provider. They choose to pay higher premiums in order to have the option of going out-of-network, presumably because they believe the level of service outside of the network will be better or will better suit their individual needs. After purchasing such plans, they pay higher out-of-network deductibles and coinsurance for the same reasons. In order for PPO and POS enrollees to realize the benefit of their bargain when purchasing these plans, it must be practical for them to utilize their out-of-network benefit.

13.

Defendants' actions, as further explained *infra*, violate the contractual and statutory rights of Members of Defendants' PPO and POS health care plans. According to Defendants' own contracts. Defendants' members purchase PPO or POS health plans over traditional HMO plans to gain flexibility in choosing their providers. Indeed, Defendants represent this member choice as a benefit of its PPO and POS plans in marketing the plans to patients and brokers. The law favors, and serves to protect, the existence and fair functioning of these plans. (*See, e.g., "PPO Statute,"* O.C.G.A. § 33-30-20 *et seq.*).

14.

Defendants' deliberate frustration of the purposes and terms of its PPO and POS contracts constitutes a breach of contract for which Plaintiff, as assignee and/or third-party beneficiary, may seek redress under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001 *et seq.* and/or under Georgia law as to those plans and insurance policies not covered by ERISA. Further, by continuing to market and sell PPO and POS plans in exchange for higher premiums while intentionally undermining the insureds' ability to receive the bargained-for benefit of these plans, Defendants engage in deceptive and potentially confusing trade practices in violation of O.C.G.A. § 10-1-372(8) and (12).

15.

Plaintiff Urology Center is not in Defendants' preferred network. As a result of Urology Center's out-of-network status, nearly all of Urology Center's Blue Cross patients are enrolled in PPO or POS plans. Since January 2007, Urology Center has provided ambulatory surgical services on an out-of-network basis to numerous patients whose services were reimbursed by Blue Cross PPO or POS plans. On information and belief, one or more of these plans are "employee welfare benefit plans" as defined by Section 1002(1) of ERISA.

16.

For most of its patients who are Blue Cross enrollees, Urology Center, as assignee and/or third-party beneficiary of the patient's benefits, submits to Blue Cross on behalf of the patient claims for reimbursement of the charges for the services provided. Urology Center is then reimbursed directly by Blue Cross, as assignee and/or third-party beneficiary of these patients' benefits under their Blue Cross member contracts. These patients sign standard and uniform assignment of benefits forms which document the assignment of their rights to reimbursement to Urology Center. In addition, Urology Center indicates that it is the assignee to these patients' benefits on the claims it submits to Blue Cross for reimbursement. On information and belief, Blue Cross's member contracts provide that a member patient may assign benefits to non-preferred providers and that benefit payments will then be made directly to the provider.

17.

Upon information and belief, pursuant to its contracts, insurance companies like Defendants use so-called "usual, customary, and reasonable" ("UCR") charges to determine reimbursement for out-of-network services. UCR, as the title implies, refers to the amount a provider usually, customarily and reasonably charges for a given service within a geographic area.

18.

Prior to January 1, 2007, Defendants' calculation of UCR charges for out-of-network services was in line with the reimbursement Urology Center received (and continues to receive) from other commercial payors. However, on or about January 2007, Defendants cut this reimbursement by approximately 80%, to a level far below the usual, customary and reasonable charge Defendants were contractually obligated to pay. Defendants unilaterally slashed reimbursement for out-of-network

surgery to levels far below the UCR charges associated with such care to prevent or deter its enrollees from receiving out-of-network care at facilities like Urology Center's.

19.

Defendants' actions have exposed its members, enrollees and insureds to potentially devastating balance bills for out-of-network ambulatory surgery services received.

20.

By reducing reimbursement to rates that providers simply cannot afford to accept, and exposing patients to enormous balance bills, Blue Cross is effectively denying its members the bargained-for out-of-network benefits of their PPO and POS plans.

21.

In spite of this drastic reduction in reimbursement, Defendants did not make any good faith attempt to ensure that Plaintiff, or the class, were adequately informed and given a chance to prepare for the change. Indeed, because Blue Cross regularly delays its reimbursement by approximately 90 days, it took several months before Urology Center even became aware of this severe reduction in reimbursement by Blue Cross. Accordingly, it took Urology Center's billing department several months to notice that its expected reimbursements were not matching the historical payments made by Blue Cross. Urology Center's billing personnel contacted Blue Cross on numerous occasions to find out the reasons for these issues and to seek an administrative remedy for Defendants' underpayment of claims. None of these efforts were successful.

22.

On information and belief, Blue Cross did not adequately inform its members that their agreed out-of-network benefit would be drastically reduced.

23.

Blue Cross allegedly faxed a letter to out-of-network ambulatory surgery centers dated December 12, 2006. The innocuous “fax” stated that its purpose was to “advise [out-of-network providers] of an upcoming change” in reimbursement rates and stated that Blue Cross “will update its maximum allowable rates” for such providers effective January 1, 2007. Nowhere did the notice even indicate that Blue Cross was preparing to reduce agreed benefits and reimbursement for out-of-network services, much less that Blue Cross would slash payments to less than 20% of the UCR charges that had been paid historically and that still are paid by other insurance companies.

24.

Defendants’ drastic reduction in payment for ambulatory surgical treatment provided by out-of-network providers will have the ultimate practical effect of denying its members (who have paid a premium for the option of using an out-of-network provider) the ability to choose an out-of-network provider. Defendants’ conduct violated its legal obligations to Plaintiff and the Class, as assignees and beneficiaries of their patients’ benefits, and violated federal and state law as described herein, causing Plaintiff and the Class substantial damages and harm.

III. CLASS REPRESENTATION ALLEGATIONS

A. DEFINITION OF THE CLASS

25.

In accordance with Federal Rule of Civil Procedure 23(b), Plaintiff brings this action on behalf of itself and on behalf of a class of all others similarly situated in the State of Georgia.

26.

The time period for the class is the number of years immediately preceding the date on which this Complaint was filed as allowed by the applicable statute of limitations, going forward into the future

until such time as Defendants take remedial action so as to ensure that the class members receive the reimbursements to which they are legally and contractually entitled.

27.

Plaintiff's proposed Rule 23(b)(2) class is defined as follows:

All surgery centers located in the State of Georgia which provided or will provide services to patients whose health benefits are or were provided, insured or administered by Blue Cross, while being designated as "out of network" by Defendants.

28.

Plaintiff's proposed Rule 23(b)(1) and/or (b)(3) class is defined as follows:

All surgery centers which at any time during the relevant time period were located in the State of Georgia, provided services to patients whose health benefits are or were provided, insured, or administered by Blue Cross while being designated as "out of network" by Defendants, and to whom reimbursements have not been paid based on "usual, customary and reasonable" rates.

29.

Excluded from Plaintiff's class are Defendants, any entity in which Defendants have a controlling interest, and any agents, employees, officers, and/or directors of Defendants, or any of them, and their representatives, heirs, successors, and/or assigns.

30.

The identity of the class members is readily ascertainable based on objective criteria and can be ascertained using information possessed by Defendants, along with computer records and clerical assistance, thus rendering unnecessary an evidentiary hearing on each claim.

31.

This action is brought and may properly be maintained as a class action pursuant to Federal Rule of Civil Procedure 23.

B. NUMEROSITY

32.

The class is so numerous that individual joinder of all class members as parties to this action would be impracticable. The exact number of class members can be ascertained through appropriate discovery. Plaintiff estimates the number of class members is in the hundreds.

C. COMMONALITY

33.

Under Rule 23(a)(2), there are questions of law or fact common to all class members, including, but not limited to, the following:

- (a) Whether Blue Cross has failed to reimburse out-of-network surgical care based on UCR;
- (b) Whether Blue Cross has unilaterally capped reimbursement for out-of-network surgical care;
- (c) Whether Blue Cross' conduct is a breach of contract;
- (d) Whether Blue Cross' conduct violates ERISA;
- (e) Whether Blue Cross' conduct violates the Georgia Unfair and Deceptive Trade Practices Act; and
- (f) Whether injunctive relief should be granted to force Blue Cross to handle future out-of-network claims for ambulatory surgery center services in accordance with Blue Cross contractual language.

D. TYPICALITY

34.

Under Rule 23(a)(3), Plaintiff's claims are typical of the claims of the defined class, and are based on the same failure by Blue Cross to reimburse for out-of-network surgical care according to contract language and UCR.

E. ADEQUACY

35.

Under Rule 23(a)(4), Plaintiff Urology Center and its counsel are prepared to serve the defined class in a representative capacity with all the concomitant obligations and duties.

F. RULE 23(b)(1) CONSIDERATIONS

36.

The prosecution of separate actions by individual class members would create a risk of inconsistent or varying adjudications which would establish incompatible standards of conduct for Blue Cross and/or adjudications with respect to individual class members that as a practical matter would substantially impede other class members' ability to protect their interests.

G. RULE 23(b)(2) CONSIDERATIONS

37.

Blue Cross has acted and/or refused to act on grounds generally applicable to the class, thus making appropriate final injunctive and/or declaratory relief with respect to the class as a whole.

H. RULE 23(b)(3) CONSIDERATIONS

38.

Common questions of law and fact, including those enumerated above, predominate over individual questions. A class action is a superior method for fair and efficient adjudication of this

controversy. Common proof will be used to establish the claims of each class member. This is a class of Georgia surgery centers who have similar interests in pursuing their claims in this forum as opposed to in an unwieldy purported class in some far off forum that seeks to bring dozens of defendant entities and virtually every out-of-network physician in every state in the country into one action.

VI. LIABILITY OF DEFENDANTS

COUNT I: BREACH OF CONTRACT

(Third-Party Beneficiary)

39.

The allegations contained in paragraphs 1 through 38 are incorporated by reference as if fully set forth herein.

40.

Patients seen by Plaintiff and class members during the class period have entered into PPO or POS contracts with Defendants. This includes both individual insurance policies and health plans that are not covered by ERISA.

41.

The terms, conditions and provisions of these patients' PPO or POS contracts establish that Plaintiff is an intended third-party beneficiary of healthcare benefits payments Defendants owe to Defendants' PPO and POS enrollees.

42.

Defendants' failure to indemnify Plaintiff as third-party beneficiary by paying only a fraction of UCR charges for out-of-network services provided to Defendants' members constitutes a breach of contract.

43.

Defendants' actions also deny its members their contractually agreed-upon benefit to be allowed to incur out-of-network co-payment responsibilities and choose to receive quality and convenient services from any licensed and qualified provider.

44.

Defendants' conduct in breach of contract has caused Plaintiff and the class damages.

(Assignee)

45.

The allegations contained in paragraphs 1 through 44 are incorporated by reference as if fully set forth herein.

46.

Plaintiff and the class are assignees of health care benefits payments provided to Defendants' PPO and POS members pursuant to signed assignment-of-benefit forms assigning the right to payment for services to Plaintiff and/or class members.

47.

Defendants' failure to indemnify Plaintiff and the class as assignee of its PPO and POS members' benefits by paying only a fraction of the actual UCR charges for out-of-network services constitutes a breach of contract.

48.

On information and belief, Defendants' members' contracts provide that Defendants will offer coverage for services rendered by out-of-network or non-preferred providers. By failing to cover the costs of such services to these members, Defendants have breached this term of its agreements.

49.

Defendants' conduct in breach of the contracts with its members has caused Plaintiff and the class damages.

COUNT II: ERISA

50.

The allegations contained in paragraphs 1 through 49 are incorporated by reference as if fully set forth herein.

51.

Blue Cross administers and insures health benefit plans covered by ERISA. Blue Cross acts a fiduciary under ERISA.

52.

Defendants have improperly withheld payments due and owing to Plaintiff and the class, as assignees and/or third-party beneficiaries of plan benefits, pursuant to the terms of employee benefit plans. Specifically, Defendants, unilaterally, without adequate notice, and contrary to the terms of its ERISA plans, cut reimbursement rates due to Plaintiff and the class as assignees and third-party beneficiaries of Blue Cross members' benefits.

53.

Defendants' actions have denied Defendants' members and Plaintiffs and the class, as assignees and third-party beneficiaries, the benefits due and owing them in exchange for the higher amounts paid for PPO and POS benefits.

54.

Defendants have failed to cure these breaches of its obligations in spite of Plaintiffs' repeated notifications to Defendants of Defendants' illegal conduct and efforts to obtain proper reimbursement.

In response to these notifications and efforts to obtain proper reimbursement, Blue Cross has, in fact, displayed indifference regarding its obligations.

55.

Plaintiffs' efforts to obtain redress constitute exhaustion of administrative remedies. These efforts, and Defendants' response, also demonstrate the futility of seeking administrative relief for class members.

56.

These actions in violation of Defendants' obligations under ERISA and plan terms have caused Plaintiff and the class damages.

57.

Plaintiff and the class are entitled to appropriate equitable relief including a declaration that Blue Cross' actions violate its duties and obligations under ERISA.

58.

Plaintiffs also seek to recover attorney's fees and costs which this Court has discretion to award pursuant to 29 U.S.C. § 1132(g)(1).

COUNT III: UNFAIR AND DECEPTIVE TRADE PRACTICES

59.

The allegations contained in paragraphs 1 through 58 are incorporated by reference as if fully set forth herein.

60.

Defendants' conduct, in the form of continuing to market and sell PPO and POS plans as providing patients with a choice among conveniently located out-of-network providers in exchange for higher premiums, while simultaneously undermining these patients' ability to receive

out-of-network care by refusing to reimburse the customary charges for care from such local providers, constitutes a deceptive or potentially confusing trade practice in violation of O.C.G.A. § 10-1-372(3) and (12) and has damaged Plaintiff and all other putative class members. Defendants' conduct is causing actual confusion or misunderstanding on the part of patients and providers. Among other things, Defendants are confusing consumers and creating a misunderstanding by selling them policies that state on their face that they provide coverage for local and accessible out-of-network providers, and that the consumer's personal liability is limited to an "Out-of-Pocket Maximum," when in fact Defendants leave their members exposed to huge unpaid balances, greatly exceeding this maximum.

61.

Not only have Defendants' actions left patients with the false impression that they will be able to continue receiving out-of-network care pursuant to their PPO and POS Contracts, but they have also misled and confused Plaintiff, the class, and their patients by sending inadequate and unassuming "notice" letters which merely cite an upcoming "change" in reimbursement without notifying providers and patients of the drastic reduction of coverage which Defendants never announced and silently implemented in an attempt to grow its profit margins at the expense of providers and patients.

62.

It is the policy of the State of Georgia to protect patients from certain managed care practices, to protect the ability of patients to choose their health care providers, and to promote reasonable local accessibility to health care. The Georgia General Assembly foresaw the dangers that could arise from abusive use of PPO plans by health insurers, and took steps to ensure that PPO plans would not be converted from plans that merely identified "preferred" providers to plans that in effect made provider choice cost prohibitive.

63.

Defendants' decision to stop paying the usual, customary and reasonable costs of ambulatory surgical treatment in smaller local facilities also violates O.C.G.A. § 33-30-23(b), which provides that "[Preferred provider] arrangements shall not: (1) Unfairly deny health benefits for medically necessary covered services; [or] ... (5) Have an adverse effect on the availability or the quality of services." By offering reimbursement arbitrarily capped at below-market, below-cost rates at which local providers cannot operate, Defendants are violating obligations that state law imposes on all PPOs. It is also denying its enrollees their contractually agreed-upon benefit to be allowed to incur out of network co-payment responsibilities and choose to receive high quality and convenient care from any licensed and qualified provider.

64.

Defendants' actions violate Georgia law and thereby constitute deceptive or potentially confusing trade practices in violation of O.C.G.A. § 10-1-370, *et seq.* Defendants' conduct is causing actual confusion or misunderstanding on the part of class members and patients.

65.

Defendants' conduct is creating injury, and a likelihood of further injury to the class, including but not limited to, class members' relationships with their patients.

66.

Plaintiff and the class are "persons" likely to be injured by Defendants' deceptive trade practice as defined in Georgia' Uniform Deceptive Trade Practices Act, O.C.G.A. § 10-1-373(a).

67.

Defendants willfully engaged in these trade practices knowing them to be deceptive, thereby also entitling the class to recover attorneys' fees and costs.

COUNT IV: QUANTUM MERUIT

68.

The allegations contained in paragraphs 1 through 67 are incorporated by reference as if fully set forth herein.

69.

Class members have performed valuable services for Blue Cross members.

70.

Blue Cross has accepted the benefit of these services in the form of insurance premiums and fees paid by its members in exchange for the services rendered.

71.

Defendants have failed to compensate class members for the value of these services.

72.

Class members expected Defendants to compensate them for the value of the services provided at the time the services were rendered.

73.

Defendants' failure to compensate for the value of ambulatory surgery services provided to Defendants' enrollees is unjust and class members are entitled to the quantum meruit value of these services.

COUNT V: UNJUST ENRICHMENT

74.

The allegations contained in paragraphs 1 through 73 are incorporated by reference as if fully set forth herein.

75.

Defendants, by engaging in the wrongful conduct described herein, have been enriched unjustly by depriving class members of the usual, customary and reasonable value of services provided to Defendants' enrollees.

76.

Defendants have unfairly benefited from its refusal to compensate class members for the value of these services, meanwhile continuing to accept higher premiums from its PPO and POS members in exchange for reimbursement of these more costly out-of-network services.

77.

Because Defendants have been unjustly enriched by its wrongful conduct, equity demands that Defendants compensate the class for the value of services provided to their members.

COUNT VI: EXPENSES OF LITIGATION

78.

The allegations contained in paragraphs 1 through 77 are incorporated by reference as if fully set forth herein.

79.

Defendants willfully engaged in deceptive trade practices in violation of the Uniform Deceptive Trade Practices Act. Defendants have also acted in bad faith, been stubbornly litigious and caused Plaintiff and the class unnecessary trouble and expense.

80.

Accordingly, the class is entitled to its costs and expenses of litigation, including its attorneys' fees pursuant to O.C.G.A. §§ 10-1-373(b)(2) and 13-6-11.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff Urology Center of Georgia, LLC, individually and in its representative capacity of behalf of the class of all persons similarly situated, respectfully requests the following relief:

- (A) That process issue and be served upon Defendants to appear and answer this Complaint as provided by law;
- (B) That the case be certified as a class action pursuant to Federal Rule of Civil Procedure 23(b)(2) and/or (b)(3) and that Plaintiff be appointed representative for the class;
- (C) That the Court award the class economic damages, including any and all compensatory damages, punitive damages, any applicable penalties, any authorized attorney fees, interest, and costs, and any further relief as the Court deems just, equitable, and proper for each member of the class;
- (D) That the Court grant appropriate equitable and injunctive relief, including a declaration that Blue Cross has violated the terms of its agreements and enjoining Blue Cross from failure to pay according to UCR and the language of its agreements;
- (E) That Plaintiff and the class have a trial by jury;
- (F) That Plaintiff and the class have such other and further relief as the Court deems just and proper.

Respectfully submitted, this 29th day of April, 2009.

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