SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

MICHAEL A. KAMINS, on his own behalf and on behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers,

Plaintiffs,

v.

UNITED HEALTH-CARE INSURANCE COMPANY OF NEW YORK, INC., UNITED BEHAVIORAL HEALTH (DOING BUSINESS AS "OPTUMHEALTH BEHAVIORAL SOLUTIONS") and THE EMPIRE PLAN,

Defendants.

SUMMONS

Index No.

Date of Filing: June 4, 2014

To the Persons Named as Defendants Above:

PLEASE TAKE NOTICE THAT YOU ARE HEREBY SUMMONED and required to serve upon the Plaintiff's attorneys an answer to the complaint in this action within twenty days after the service of this summons, exclusive to the day of service, or within thirty days after service is complete if the summons is not personally delivered to you within the State of New York. In case of your failure to answer, judgment will be taken against you by default for the relief demanded in the complaint.

Plaintiff designates Suffolk County as the place of trial. The basis of the venue designated is Plaintiff's residence in Suffolk County.

Dated: June 4, 2014

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

MICHAEL A. KAMINS, on his own behalf and on behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, Plaintiffs, v. UNITED HEALTH-CARE INSURANCE COMPANY OF NEW YORK, INC., UNITED BEHAVIORAL HEALTH (DOING BUSINESS AS "OPTUMHEALTH BEHAVIORAL SOLUTIONS") and THE EMPIRE PLAN, Defendants.	Case No.: **CLASS ACTION COMPLAINT** **(JURY TRIAL DEMANDED)**

Plaintiff Michael A. Kamins, Ph.D., on behalf of himself and his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, brings this Class Action Complaint against Defendants United Healthcare Insurance Company of New York, Inc. ("United-NY"), United Behavioral Health ("UBH") (collectively, "United") and the Empire Plan (together with United, referred to herein as "Defendants"). Plaintiff hereby alleges upon personal knowledge as to himself and his beneficiary son and their acts, and upon information and belief as to all other matters, based upon, *inter alia*, the investigation made by and through their attorneys, as follows:

NATURE OF THE ACTION

1. Through this action, Plaintiff challenges Defendants' improper denials of insurance coverage for his son's medically necessary mental health care treatments. In particular, Plaintiff seeks to enjoin and reverse the Defendants' use of restrictive medical necessity, utilization review and precertification requirements for mental health care that violate various New York statutes, including the New York Parity Law (known as "Timothy's Law"), the Unfair Trade Practices Act and the prompt pay provisions of the Insurance Law. In asserting his claims, Plaintiff seeks

appropriate injunctive relief, payment of improperly denied benefits, and damages compensating for his son's injuries.

2. Dr. Kamin's son (referred to herein as "John") suffers from severe mental illness. While his treating psychiatrist requested preauthorization for two psychotherapy sessions a week for a period of several months, United denied coverage, agreeing only to permit two sessions ***per month*** on an indefinite, prospective basis. In doing so, United relied on undisclosed quantitative limits on coverage for outpatient mental health care contained in its own internal guidelines.

3. The Defendants' refusal to cover the care John requires has dramatically impacted his ability to function and quality of life. Because John was unable to receive the psychotherapy he required, his condition steadily deteriorated, at one point requiring him to be hospitalized for 2 weeks.

4. In addition to violating the New York statutes identified above, Defendants' conduct breaches both the terms of Dr. Kamins' health plan and Defendants' fiduciary duties to John and other similarly situated individuals.

5. Defendants have systematically and uniformly applied their overly-restrictive coverage requirements to deny benefits to members of the purported class. As a result, members of the purported class have been denied necessary mental health care and have been injured as a result.

PARTIES

6. Dr. Michael A. Kamins ("Kamins") is a Full Professor of Marketing and the Director of Research for the College of Business at the State University of New York, Stony Brook, having previously spent over 20 years as a full professor at the University of Southern California.

Dr. Kamins receives health insurance for himself and his family through Defendant the Empire Plan, offered by the New York State Health Insurance Program ("NYSHIP").

7. Dr. Kamins's son, whose health care treatment is at issue in this litigation, is a beneficiary under Dr. Kamins's plan and resides in California. To protect his privacy, Dr. Kamins's son will be referred to herein as "John." He has executed a Durable Power of Attorney, allowing his father to transact in all insurance matters related to his health care and to assert any legal claims on his behalf.

8. Defendant United-NY currently acts as administrator for Defendant the Empire Plan. United-NY and also acted as insurer for the Empire Plan's Mental Health and Substance Abuse Program until January 1, 2014, at which point the Program converted to a self-insured structure. United-NY is headquartered in Kingston, New York.

9. Defendant UBH acted as administrator for the Empire Plan's Mental Health and Substance Abuse program until January 1, 2014, at which point administration duties were transferred to nonparty Value Options. UBH is a corporation organized under California law, with a principal place of business in San Francisco, California. It operates under the brand name OptumHealth Behavioral Solutions and, in administering the Empire Plan, operated out of an office located in Kingston, New York.

10. Defendant the Empire Plan is a state employee welfare plan offered by the New York State Health Insurance Program ("NYSHIP"). It provides health insurance to over one million participating New York State employees and their dependents, including, but not limited to, members of the state judiciary and legislature, public school teachers, firefighters, and police officers.

JURISDICTION AND VENUE

11. This Court has personal jurisdiction over Defendants because they each transact business within the State of New York.

12. This Court has subject matter jurisdiction over this action because the causes of action asserted by Plaintiff arise under the common law and the laws of the State of New York.

13. Pursuant to CPLR 503(a), venue is proper in this Court because Plaintiff works and resides in Suffolk County.

FACTUAL BACKGROUND

The Mental Health Care Needs of Dr. Kamin's Son

14. Dr. Kamins's son, John, is highly intelligent and has substantial promise. Growing up in California, John graduated fifth in his class in a high school of 3,000 students, and was admitted to a number of top colleges. He chose to attend a prestigious Ivy League college on the East Coast.

15. During his first year in college, in 2010-2011, John began very successfully, achieving high grades. Unfortunately, John then began suffering from severe mental illness, including Bipolar Disorder, ADHD, and poly-substance abuse, leading to an inability to handle the pressures of daily life and prompting a serious suicide attempt. He received treatment, including various medications, from a psychiatrist affiliated with his college. As a result of John's decompensation, he received "incompletes" in the fall term of 2012, subsequently withdrew from the summer session, and returned to his home in Los Angeles.

16. Upon John's return to Los Angeles, Dr. Kamins considered residential treatment for his son. United, however, dissuaded him from doing so. United informed him that his health plan did not cover long term residential care and that John would need to first attempt and fail

outpatient treatment as a prerequisite to precertification for higher, inpatient levels of care. United also informed Dr. Kamins that his out-of-network benefits would not cover residential treatment. Consequently, John enrolled in an intensive one-month chemical dependency outpatient program at Glendale Adventist Hospital. This treatment did not address John's underlying, primary psychiatric symptoms. In September 2011, therefore, John began seeing an outpatient psychiatrist, Dr. Thomas M. Brod. Dr. Brod is a Diplomate of the American Board of Psychiatry and Neurology, a Distinguished Fellow of the American Psychiatric Association, and Associate Clinical Professor of Psychiatry at the Geffen UCLA School of Medicine.

17. From September 10, 2011 through January 11, 2012, Dr. Brod prescribed and managed John's medications while also providing psychotherapy twice weekly and once weekly neurofeedback. During this phase of his treatment, Dr. Brod diagnosed John as having a bipolar mood pattern and dysregulated personality, which had been masked by intense anxiety and attendant propensity toward angry outbursts.

18. According to Dr. Brod, John had unstable, hypomanic symptoms until his first confirmed, manic psychosis, which erupted in mid-December 2011. Additional symptoms included pressured speech, ideas of reference, auditory hallucinations and visual distortions, and paranoia of imagined strangers. During December 2011, John's moods were unstable and seriously disturbed, and Dr. Brod noted that John appeared to be "rapid-cycling."

19. During treatment, Dr. Brod learned that John was suffering from a secret eating disorder, which started in middle school. He also learned that John had previously struggled with an anxiety-related sleep disorder and long-standing, low-level auditory hallucinations, as well as migraines. Dr. Brod determined that John's ability to managing this anxiety had been disrupted by

his college living environment and led to self-destructive social aberrations and drug/alcohol abuse.

20. On December 31, 2011, John became violent during a family argument and was taken by paramedics to the Cedars-Sinai Emergency Room, after which he was given medication and released the following day. During the period of January 12, 2012 through June 15, 2012, Dr. Brod continued to treat John, seeing him three times weekly for psychotherapy, along with semi-weekly neurofeedback. Dr. Brod subsequently referred John to Dr. Robert Gerner, a psychopharmacologist for complex medication management, in which Dr. Brod continued to participate. Dr. Gerner is a Diplomate of the American Board of Psychology and Neurology and Associate Researcher at UCLA Department of Psychiatry and Behavioral Sciences.

21. During this period, John experienced grave disturbances in thinking, intense anxiety, impaired concentration, and a mostly manic mood with some brief, depressive oscillations. From January 25, 2012 through January 31, 2012, John was involuntarily re-hospitalized, after becoming manic and floridly psychotic.

22. By early April 2012, John's agitation diminished, but he remained on fairly high doses of antipsychotic and benzodiazepine medications. By that point, however, he was responsive enough to begin psychotherapeutic work on maladaptive behaviors. John contemplated a return to college but was unable to sustain himself in a UCLA Extension course. He continued to remain belligerent, confused, manic and depressed/demoralized, but Dr. Brod determined that psychotherapy was proving effective and that John's mind and affect had calmed by the end his psychotherapy sessions. This clinical achievement weighed in favor of sustaining psychotherapy at the prescribed frequency of three times per week.

23. By June 15, 2012, John was intent on returning to college in the East Coast. His mind was progressively clearer and his labile moods remained circumscribed. His anxiety also moderated, with high doses of medication. He continued, however, to have difficulty concentrating. This made it difficult for John even to read, creating substantial issues with his ability to handle college work. Dr. Gerner continued to manage John's medication for depression and other symptoms, reducing it when possible. Dr. Brod attempted to reduce psychotherapy to twice-weekly sessions while maintaining neurofeedback twice-weekly.

24. As described herein, during this time, United was taking active steps to reduce coverage for John's treatments. In fact, Dr. Kamins did not submit claims to United for services provided by Dr. Gerner because he was concerned that United would use these additional claims to further pressure John to reduce treatment.

25. Despite John's gains during this period, Dr. Brod concluded that John was still substantially impaired in the domains of insight, personal agency, and anxiety management – all key issues that suggested the need for continued, high frequency psychotherapy. Dr. Brod found that John continued to struggle with anxieties and frustrations, which limited his interpersonal functioning and made him incapable of intimate relationships. Dr. Brod concluded that John's mental illnesses continued to cause clinically significant distress and impairment in the activities of daily living (such as maintaining self-care, sleep, and stress-management), social relationships (parental, peer, and academic), and self-esteem.

26. In the summer of 2012, Dr. Brod assigned John a Global Assessment of Functioning ("GAF") score of 35. GAF is a numeric scale (0 through 100) used by mental health clinicians and physicians to rate the social, occupational, and psychological functioning of patients, *e.g.*, how well or adaptively one is meeting ordinary problems of life. The scale is promulgated and described

in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. A GAF of 35 represents "some impairment in reality testing or communication (*e.g.*, speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (*e.g.*, depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school)."

27. Based on the diagnoses and treatment of John's bipolar disorder, ADHD, eating disorder, substance abuse, and borderline personality disorder, Dr. Brod and Dr. Gerner jointly recommended that John continue to receive ongoing medication management and at least two psychotherapy sessions per week. As John's treating physicians, who had worked with him for some months, they were in the best position to understand his needs and the level of care necessary to avoid deterioration of his condition.

28. John returned to college in September 2012 in an effort to complete his degree. Unfortunately, he did not fare well. He continued to have serious symptoms resulting from his mental illness and was forced to withdraw once again.

29. John continues to suffer from mental illness and to require ongoing care of an intensity far exceeding what has been approved by United. His difficulties have been exacerbated by United's restrictions on his treatment and the resulting financial pressure placed on his parents, described below. As a consequence of inadequate access to outpatient mental health care, due to United's denials of coverage as described herein, John was re-hospitalized for two weeks on February 16, 2013.

United's Response to Claims Submitted by Dr. Kamins

30. After John started receiving mental health treatment, Dr. Kamins submitted benefit claims to United for payment. Shortly thereafter, United's internal algorithms identified John as a potential high utilizer of mental health services and United began imposing precertification and concurrent review requirements on his providers.

31. Pursuant to United's policies, Dr. Brod was required to complete and submit preauthorization forms for mental health care that are not required for medical care.

32. Filling out the form was not only burdensome, it was substantively insufficient to facilitate a meaningful review by United. The form did not provide a means for United to obtain a full understanding of John's needs so as to be able to make valid medical necessity determinations as to the scope of his treatment. Nevertheless, Dr. Brod complied with United's policies and submitted form after form.

33. For the first several months of John's treatment, United authorized most of the psychotherapy recommended by Dr. Brod. It did so through form letters that "certified" a specific number of 45-50 minute psychotherapy sessions. On September 27, 2011, for example, United sent such a letter to Dr. Brod at his Los Angeles address, certifying 10 sessions. It then confirmed Dr. Brod's obligation to continue obtaining pre-certification:

> OptumHealth Behavioral Solutions is the Mental Health and Substance Abuse (MHSA) Program administrator for The Empire Plan. The services indicated above have been certified. . . . It is your responsibility to submit a treatment plan . . . and request approval for any benefits beyond the initial 10 pass through sessions that might be needed. . . . You or the enrollee should contact us if there is more than one course of treatment within this certification period. A course of treatment is the period of time required to provide mental health and substance abuse care for the resolution or stabilization of specific symptoms or a particular disorder.

This letter confirmed United's precertification requirement. It not only required Dr. Brod to request approval in advance of further treatments, but to "submit a treatment plan" to United in advance for review and approval.

34. From September 2011 through May 2012, United generally pre-certified the requested treatments submitted by Dr. Brod, sending comparable letters every few weeks in response to the Outpatient Treatment Forms that Dr. Brod submitted.

35. On April 24, 2012, Dr. Brod submitted one such form, in which he indicated, with regard to Symptoms/Functional Impairment, that John was experiencing "severe" anxiety, cognitive impairment and work/school difficulties; "moderate" psychosis and relationships/ family difficulties; and "mild" depression, mania, impulsivity and substance abuse. Dr. Brod further stated that John's "compliance with medical treatment" was a problem but that he was receiving medication management guidance for a number of prescription drugs to address his symptoms. While stating that John was "Compliant, Progressing and Improving," Dr. Brod added that he "needs more treatment," and that the current "Expected Outcome and Prognosis" was: "Expect improvement, anticipate less than normal functioning." Dr. Brod concluded by stating that John needed more than 10 sessions (the maximum number which could be requested on the form) and that he would require more than one session each week.

36. By May 28, 2011, United's internal algorithms identified John as "high risk" for "Frequent Outpatient Visits and High-Utilization Member Payee." An internal ALERT note was appended by United to John's file. ALERT stands for "Algorithms for Effective Reporting and Treatment." A telephone "review" of John's case was promptly arranged by United with Dr. Brod.

37. In the May 31, 2012 telephonic review, United dramatically changed its approach to John's treatment. In response to Dr. Brod's May 2012 Outpatient Treatment Form, which

requested twice weekly sessions, United only approved additional outpatient psychotherapy sessions ***every other week***, stating in a June 4, 2012 letter that "[i]n order to ensure that services are medically necessary and will be covered, you should submit the attached Outpatient Treatment Report before the end of the certification period."

38. This was followed by a letter from United to Dr. Kamins's son, dated June 4, 2012, addressed to his family's Los Angeles address where he lived at the time, disclosing its adverse benefit determination. The decision was reported under the letterhead of OptumHealth, "a brand used by United Behavioral Health and its affiliates." Signed by Medical Director Liviu Sigler, MD, the letter stated:

> OptumHealth is responsible for making benefit coverage determinations for mental health and substance abuse services that are provided to covered persons under The Empire Plan. . . . I have reviewed the plan for your ongoing treatment with Thomas Brod, MD. Based on my review of the available documentation and all information received to date, I have determined that coverage is available under your benefit plan at the reduced frequency of bi-weekly outpatient sessions. Coverage is available at a reduced frequency for the following reason(s):
>
> Based on the available information, the patient appears to be improved and is compliant with treatment. Based on the clinical presentation, there appears to be no indication that the patient needs twice weekly outpatient sessions to manage the patient safely and effectively. Presently it appears that the patient could be safely and effectively treated with outpatient sessions up to twice a month and the frequency could be adjusted as needed according to the clinical situation. Would approve 2 visits and revise with a question of duplication of services.
>
> This determination does not mean that you do not require additional health care. Decisions about continuation of treatment should be made by the provider and the patient. The purpose of this letter is to inform you that, based on my review of the available information, I have determined that coverage is authorized under your benefit plan for treatment with Thomas Brod, MD for a total of two (2) sessions (bi-weekly) dates of service May 16, 2012 through June 16, 2012 and coverage is not authorized for twice weekly outpatient sessions for dates of service May 16, 2012 forward.

39. The letter added that it was an "Initial Adverse Determination" and was considered to be a "determination of medical necessity" under New York State law. It then offered Dr. Kamins a right to appeal under the provisions of the Empire Plan, giving him an address for the

OptumHealth Appeals Department located in Kingston, New York. It stated that, for clinical cases such as this one, where medical necessity was at issue, "a board certified physician in the same or similar specialty area as your treating physician will review and make the decision about your appeal request," adding that "[t]he OptumHealth physician or psychologist will not have had any previous involvement in decisions about your case."

40. As the direct insured under the policy that provided health insurance to John, and as John's father, Dr. Kamins wrote Dr. Sigler a letter dated July 11, 2012, formally appealing United's decision "to limit [John's] paid treatment with Dr. Brod from 12 sessions per 4 weeks to TWO sessions per month." In summarizing his objection to United's denial, Dr. Kamins stated:

> Frankly, I find your decision **ludicrous** and reflective of a total lack of understanding of [John's] condition. Dr. Brod has also spoken with me, telling me that your conversation with him was indeed not a conversation at all, but rather a monologue from YOU to him with your decision pre-determined independent of what input Dr. Brod had regarding [John's] case. Hence, not only does your decision reflect a lack of knowledge of [John's] case and key information relevant to [John], it also reflects a lack of concern and poor protocol. This is unacceptable in any field and reflects poorly on YOUR judgment as allegedly a "Board Certified Professional in Psychiatry."

41. Dr. Kamins then referred to United's oral assertion to Dr. Brod that the services being provided to John were "experimental, investigational and unproven." In response, Dr. Kamins stated that the treatment being provided by Dr. Brod was "well established, mainstream, and proven time and time again in academic publications . . ."

42. In the letter, Dr. Kamins identified three specific peer reviewed articles published in respected psychiatric journals which demonstrated that the treatments being offered by Dr. Brod to John were "effective and established time proven treatment for bi-polar disorder":

- Huxley, N.A., Parikh, S.V. and R.J. Baldessarini (2000), "Effectiveness of Psychosocial treatments in Bi-Polar Disorder: State of Evidence," *Harvard Review of Psychiatry*, 8(3), pp. 126-140;
- Rothbaum, B.O., and Astin, M.C. (2000), "Integration of

Pharmacoptherapy and Psychotherapy for Bipolar Disorder," *Journal of Clinical Psychiatry*, 61 (Supplement 9), pp. 67-75;

- Miklowitz, D.J. (2006), "A Review of Evidence Based Psychosocial Interventions for Bipolar Disorder," *Journal of Clinical Psychiatry*, 67 (Supplement 11), pp. 28-33.

43. Dr. Kamins noted that the Miklowitz abstract was particularly relevant, "putting [United's decision] in a questionable light," where it stated:

> Various forms of psychosocial interventions have been found efficacious as adjunctive treatments for bipolar disorder, including family-focused therapy, interpersonal and social rhythm therapy, cognitive-behavioral therapy and individual or group psychoeducation. When used in conjunction with pharmacotherapy, these interventions may prolong time to relapse, reduce symptom severity, and increase medication adherence. Cognitive behavioral therapy assists patients in modifying dysfunctional cognition and behaviors that may aggregate the course of bipolar disorder.

44. After describing the articles, Dr. Kamins then summarized the facts which United should consider in reversing its denial of benefits:

> [John] has been diagnosed not only with Bi-Polar disease, he also has ADHD and a severe anxiety disorder. It has literally taken us 8 months to arrive at this diagnosis and to come up with medications that have truly begun to help him.
>
> During this 8 month period of adjustment, [John] has not been able to fully benefit from the treatment Dr. Brod is giving him because his condition had not been diagnosed and therefore he was not operating under his full cognitive abilities. Now that he is ready to fully gain from the therapy, you want to cut its frequency by 83%!
>
> Out of my own pocket and without presenting any claim to you, I have hired a Psycho-pharmacologist to assist [John]. He has worked jointly with Dr. Brod for the past 4 months and I have paid him FULLY from my pocket. His name is Dr. Robert Gerner and his practice is in Westwood, California. I chose to pay for Dr. Gerner myself because Optum was already paying for Dr. Brod. My hope was that the benefit to [John] would be significant and his course of treatment speeded up if a psychopharmacologist was part of his team. This has occurred.
>
> Now that [John] has finally shown signs of getting better, you come along as a supposed professional and dictate a treatment for [John] which goes from 12 cognitive therapy sessions a month to 2! As Miklowitz states, such a plan as you prescribe ***risks quicker relapse, an increase in symptom severity and weakens the effectiveness of the medication [John] takes.*** Effectively in terms of [John's]

> treatment you are metaphorically "pushing him off the plank" instead of gradually reducing it. Anyone who tries to jump from 12 steps to 2 steps is bound to get hurt. In this case, we risk the possibility that [John] regresses at a critical time in his treatment. Effectively you are "prescribing" a treatment that puts the athlete back into action without having fully recovered from the injury. Your prescription is best considered as something that would be characterized as "maintenance" it is clearly not prescriptive.

45. Dr. Kamins ended his letter by informing United that it was "risking my son's health based upon poor logic, lack of awareness of key articles in your field, and a total disregard for his health and the progress he has made," adding that "you have NOT considered input from the key member of his team (Dr. Thomas Brod) who knows the most about his condition and was ignored in your phone call to him."

46. The appeal was denied in a letter dated July 12, 2012. The letter was signed by Lee Becker, MD, the Associate Medical Director for OptumHealth and the ***subordinate*** of Dr. Sigler, who issued the initial denial. According to the letter, "[t]his review was completed by an external reviewer, a licensed, board-certified psychiatrist who made a recommendation to OptumHealth," purportedly after a telephone conversation with Dr. Brod.

47. In explaining the basis for the denial, United stated:

> After fully investigating the substance of the appeal including all aspects of clinical care involved in this treatment episode, the external reviewer has made a recommendation. Based on the review and recommendation of the external reviewer, I have determined that benefit coverage is not available for the following reason(s):
>
> Based on the information available, the patient does not meet medical necessity criteria for the level of care requested. The patient is not in danger of utilizing a higher level of care, has not deteriorated in any fashion, is not in the middle of a crisis, and is not displaying any acute symptoms. The patient is compliant and cooperative with all aspects of treatment and will be returning to college in the Ivy League in the near future. There is no indication of any degree of instability, nor is there any indication that the patient is deteriorating. Therefore, medical necessity is not met and the recommended previous treatment of outpatient visits up to twice per month with an adjusted frequency based on the clinical situation seems reasonable and appropriate.
>
> This determination does not mean that you do not require additional health care or

> that you need to be discharged. Decisions about continuation of treatment should be made by the practitioner and the patient. The purpose of this letter is to inform you that, based on my review of the available information, I have determined that coverage is not authorized under your benefit plan for your ongoing treatment with Thomas Brod, MD for dates of service June 16, 2012 through October 31, 2012.

48. The letter failed to address any of the specific arguments raised by Dr. Kamins in his appeal. Among other things, United failed even to acknowledge, let alone consider, the peer review literature cited by Dr. Kamins in support of the continued scope of treatment recommended by Dr. Brod. The letter ended by stating that it was Dr. Kamins' "Final Adverse Determination," but that he had an additional internal appeal review available.

49. Through a letter submitted by Dr. Brod dated September 4, 2012, Dr. Kamins and his son appealed United's continued denial of benefits, seeking a second-level appeal. In that letter, Dr. Brod, in collaboration with Dr. Gerner, submitted a detailed, single-space 10-page letter that provided specific information about John's condition, his treatment history, his diagnosis, and the providers' rationales for John's continued need for psychotherapy at least two times per week. The letter also painstakingly detailed United's violations of federal and state mental health parity laws resulting from United's utilization review procedures.

50. In the appeal letter, Dr. Brod and Dr. Gerner provided the following "Conclusions":

> Given that the patient's chronic Axis I, II and III conditions cannot be treated with medications alone, are prone to relapse and invariably affect each other, on-going psychotherapy at a rate of two to three times weekly is necessary to prevent further escalation of symptoms and deterioration of functioning, as evidenced by less intensive and/or interrupted treatments in the past.
>
> I am confident the proposed treatment plan is consistent with prevailing treatment standards and the OHBS 2012 Level of Care Guidelines: The general focus and goals of [John's] outpatient treatment are to reduce and alleviate his symptoms, to improve his level of functioning, and to prevent deterioration. We are actively engaged in mobilizing his strengths, building upon his existing coping strategies, and helping him utilize available support systems as appropriate. Interventions are interactive, requiring John to cooperate with and be actively involved in establishing clearly defined treatment objectives and identifying ways to measure improvement. The types and degrees of the patient's functional impairments are

reflected in the treatment plan highlighted above.

Because the patient's psychiatric conditions are biologically-based, impact day-to-day functioning, relationships, work performance, and cannot be alleviated on their own, however, it is expected both psychopharmacologic and psychotherapeutic treatment will be long-term. Moreover, there is clear and compelling factual and scientific evidence (cited above) that continued treatment at the frequency of multiple sessions a week is both the treatment of choice for comorbid disorders and required to prevent acute deterioration or exacerbation of symptoms.

Though tempered by experience with OHBS, it is my hope that appropriate examination of [John's] case will ensure the health plan adheres to legal mandates for parity, honors its contractual obligations to the patient, respects my good faith determination of medical necessity based upon current standards of practice and the Guidelines, and facilitates payment for psychotherapy at a frequency of three (3) times a week until such a time as treatment can be properly tapered.

51. On or about October 15, 2012, in another boilerplate letter dated September 12, 2012, United responded with a final denial to Dr. Kamins's son on OptumHealth letterhead sent to his Los Angeles address. This letter was again from Dr. Sigler. United's use of the same personnel to issue clinical denials and adjudicate subsequent appeals violates the terms of the Empire Plan as well as state law.

52. In summarizing the basis for the final appeals denial, United stated:

Coverage was not available for the service(s) or procedure(s) because OptumHealth determined that it did not meet the criteria for approval. The specific reason for the denial was medical necessity criteria was not met for the requested frequency of care.

A Second-Level clinical panel review was completed in response to a request received by our Appeals Department on September 5, 2012. The panel was comprised of Paul Francis Patti PhD Vice President of Clinical Operations OptumHealth Behavioral Solutions, Liviu Sigler, MD Medical Director Board Certified in Psychiatry, Anthony Ferrante, MD Certified in Psychiatry by the American Board of Psychiatry and Neurology.

This review included an examination of the following information: Medical records submitted by Thomas Broad and the Level of Care Guidelines. After fully investigating the substance of the appeal, including all aspects of clinical care involved in this treatment episode, the panel made a determination that benefit coverage is not authorized for the following reason(s):

Based on the available information, it appears that the patient does not meet medical necessity criteria for the requested frequency of care. The patient was reported to

> be showing considerable improvement beginning June 16, 2012 – Forward. The patient's mood was reported to be improved. It appears that the patient can be safely and effectively treated at twice a month treatment with this provider.
>
> This determination does not mean that you do not require additional health care, or that you need to be discharged. Decisions about continuation of treatment should be made by the practitioner and the patient. The purpose of this letter is to inform you that, based on my review of the available information, the panel has determined that coverage is not authorized under your benefit plan for your ongoing treatment with Thomas Brod, MD for the following dates of service: June 16, 2012 through October 31, 2012. This is considered by New York State law to be a determination of medical necessity.

53. The letter denied John's prescribed care despite his specific diagnosis of borderline personality disorder (in addition to diagnoses of bipolar disorder and substance abuse), and despite the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Borderline Personality Disorder underscoring that ***"[t]here are no studies demonstrating that brief therapy or psychotherapy less than twice a week is helpful for patients with borderline personality disorder."***

54. The letter also failed to reference or address ***any*** legal violations cited by Drs. Brod and Gerner and concluded that "[a]ll internal grievances through OptumHealth have been exhausted."

Continued Treatment Denials

55. In September 2012, in an effort to complete his degree, John returned to school. Because of United's refusal to authorize Dr. Brod's prescribed treatment regimen of twice weekly sessions, however, John was unable to receive the care required, leading to the steady deterioration of his condition. As a consequence, John was re-hospitalized for two weeks on February 16, 2013.

56. United recognized the medical necessity of John's two week hospitalization and covered its costs. Yet, once John was discharged and resumed outpatient treatment, United continued to restrict such services prospectively, despite the fact that his re-hospitalization so plainly demonstrated his need for more frequent psychotherapy. In a letter issued by

OptumHealth's Kingston, New York office John on March 28, 2013, one month after his psychiatric hospitalization, United confirmed that only a total of 10 sessions through March 27, 2014 (the entire coming year) were preauthorized. United did not offer any appeals rights when making this benefit decision, but only gave a telephone number "if [United] can be of any further assistance."

Coverage Under the Empire Plan

57. The Certificate of Insurance for the Empire Plan, which provides the mental health benefits for John's care, was prepared by United and "has been updated to include the Amendments through January 1, 2012." The 2012 document is the most current Certificate of Insurance available to Empire Plan members. It specifies that United-NY "is the insurer for The Empire Plan Mental Health and Substance Abuse Program." In addition, the Certificate of Insurance provides that all claims must be submitted to and determined by OptumHealth Behavioral Solutions, based in Kingston, New York, and that United-NY will pay any claims authorized by Optum.

58. The Certificate of Insurance provides that "[c]overed services for mental health and substance abuse care . . . include: . . . Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge; Alternatives to inpatient care (such as certified residential treatment facilities . . .); Outpatient mental health services; Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment; . . . Psychiatric second opinions." Medically necessary custodial care is also a covered benefit.

59. The Certificate of Insurance for the Empire Plan specifies that "Inpatient Care" includes "Residential Treatment Facilities, Halfway Houses and Group Homes." The Plan further states: "Covered charges will be payable in full under the network coverage if the admission is

certified by OptumHealth. Confinements for these services are covered only under the network portion of the Program. **No benefits are available under non-network coverage.**"

60. The Empire Plan provides for the full, in- and non-network coverage of hospital, medical, and surgical non-mental health care, subject to network and non-network benefit levels. As a result, coverage for mental health care is more restrictive than for medical conditions.

61. Other than the non-network restrictions on residential care for mental illness, services under the Empire Plan are covered when rendered by providers who are part of United's network ("Network Provider") or by ones like Dr. Brod, who are not ("Non-Network Provider"). The Plan states that, while benefits are lower if services are received from a Non-Network Provider, "[b]enefits ***are*** available for medically necessary care when you do not follow the Program requirements for network coverage" (emphasis added).

Medical Necessity under the Empire Plan

62. Under the terms of the Plan, coverage for "Mental Health Care" is limited to services "which OptumHealth has certified to be . . . Medically Necessary," defined as: "(1) Medically required; (2) Having a strong likelihood of improving your condition; and (3) Provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by OptumHealth."

63. As it relates to the "appropriate level of care," this definition could be read to allow United to restrict coverage to services based on less than "generally accepted mental health and substance abuse practices," since a service must meet both that standard ***and*** United's "professional and technical standards." Thus, if United adopts more restrictive standards than those that are generally accepted, then the service will not be medically necessary under this definition.

64. This definition is more restrictive than the definition of "Medical Necessity" applicable to health care services in general under the Empire Plan Certificate of Insurance for the Basic Medical Program, which states:

> Medically Necessary or Medical Necessity means the health care services, supplies and Pharmaceutical Products which are determined by UnitedHealthcare to be medically appropriate and:
>
> 1. Necessary to meet your basic health needs;
> 2. Rendered in the least intensive and most appropriate setting for the delivery of the service or supply;
> 3. Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies that are accepted by UnitedHealthcare;
> 4. Consistent with the diagnosis of the condition;
> 5. Required for reasons other than the comfort or convenience of your or your Doctor;
> 6. Demonstrated through prevailing peer-reviewed medical literature to be either:
>   a. Safe and effective for treating or diagnosing the sickness or condition for which their use is proposed, or,
>   b. Safe with promising efficacy . . .

65. United's mental health care definition of medical necessity is also far more restrictive than the definition of "Medically Necessary Care" under the Empire Plan Certificate of Insurance for Hospital and Related Expenses Coverage issued by Empire Blue Cross Blue Shield:

> Medically necessary care is care which, according to Empire BlueCross BlueShield criteria, is:
>
> 1. Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
> 2. In accordance with generally accepted medical practices;
> 3. Not solely for your convenience, or that of your doctor or other provider; and
> 4. The most appropriate supply or level of service which can be safely provided to you.

66. In comparing the three definitions, it is self-evident that the definition used by United for mental health care is far more restrictive than the definitions for basic medical and hospital care. First, the second provision of the mental health care definition places a heightened

requirement that the proposed service has "a strong likelihood of improving your condition." Nothing similar is found in the other definitions. This provision requires not only a "strong" likelihood that the treatment will be beneficial, but also that the service will likely "improve" the condition, as opposed to a service that will sustain a patient's condition or prevent deterioration. The proper standard that would equate with the general definition applied to non-mental health services would be preventing deterioration or suboptimal function in the patient – and not a requirement of improvement from the patient's then current status.

67. Second, the third element of United's mental health care definition for medical necessity states that the treatment must be "in accordance with both generally accepted mental health and substance abuse practices ***and*** the professional and technical standards adopted by OptumHealth" (emphasis added). This means that even if the requested treatment is consistent with generally accepted standards of care, United may deny coverage based on its own "professional and technical standards," even if such standards conflict with generally accepted guidelines. Such a restriction could be interpreted to give United carte blanch to deny coverage for mental health services.

68. In contrast, the third element of the basic medical necessity definition, relating to the type, frequency and duration of treatment," specifies that a service must be "consistent . . . with scientifically based guidelines of national medical research or health care coverage organizations or government agencies that are accepted by UnitedHealthcare." This means that United cannot simply apply its own internal guidelines for determining medical necessity, but that United's policies must be consistent with those established by qualified outside sources.

69. Furthermore, whereas the mental health care medical necessity definition conditions treatment on occurring in "the lowest level of care," no such language appears in the

hospital program's definition of medical necessity. This is extremely significant because under the Empire Plan, medical conditions cannot be subjected to fail first policies or step therapy protocols as a prerequisite to inpatient services, whereas mental health care can be subjected to such limits when United implements the highly restrictive professional and technical standards adopted by OptumHealth.

Utilization Review Under the Empire Plan

70. Another key component of the Empire Plan's provisions concerning mental health care coverage is its requirement that such services are subject to preauthorization and/or concurrent review.

71. "In order to receive network coverage" for mental health services, the Empire Plan provides that subscribers "must call OptumHealth before outpatient treatment begins." It further states that, "[w]henever you or your family faces a mental health or substance abuse problem, including alcoholism, getting help begins with a call to OptumHealth," adding that, "[b]y making the call before you receive services, and then obtaining care from a provider referred to you by OptumHealth, you will qualify for network coverage." The Network Provider "will be responsible for obtaining certification from OptumHealth" to provide treatment.

72. Under the United Policies, Network Providers can provide up to 10 outpatient sessions without formal preauthorization, but thereafter all such services must be preauthorized, as detailed in United's 2012 New York State Empire MH/SA Plan Manual Addendum ("MH/SA Addendum"):

> As a network provider with OptumHealth, no authorization will be required for the first 10 visits of treatment you provide a new Empire Plan enrollee. The initial 10 pass through visits are given per provider, per member, per treatment episode. If treatment will be needed beyond the 10 pass through visits, an Outpatient Treatment Report (OTR) will be required to certify additional visits. It is recommended that OTR's be submitted two weeks prior to the required authorization start date to

> ensure authorization is in place prior to providing services. Services provided without prior certification (when required) are subject to denial, with no liability to the member above their copayment.

To the extent a patient, like John, receives three sessions per week, such that the 10 session limit is reached by the end of the third week, a provider would need to submit a pre-authorization form after the first week of treatment**.**

73. Similarly, preauthorization and concurrent review is required for Non-Network Providers, as stated in the Empire Plan Certificate of Insurance issued by United:

> If you choose a non-network provider for outpatient treatment, call OptumHealth early in your treatment so that OptumHealth can begin the process of determining whether your treatment will be covered. You must call before the sixth visit to begin the certification process. OptumHealth must certify any outpatient visits beyond the tenth such visit during any course of treatment.

74. United's preauthorization requirement with regard to Non-Network Providers is actually inconsistent with the Master Agreement between United and the New York State Department of Civil Service concerning the administration of the Empire Plan. The Master Agreement, for example, specifies in § 6.18.1a that United "must review the treatment plan for an insured when the insured's visits to the ***Network Provider*** exceed 10 pass through visits," but, in § 6.18.1b, states that United "shall perform concurrent review of Outpatient and Inpatient Services rendered by Non-Network Providers ***when requested by the Insured and Provider"*** (emphasis added). Thus, when not requested by the provider and the insured, United is ***not*** to perform concurrent review for Non-Network services.

75. This is further confirmed in the Vendor Questions and Answers published by the New York State Department of Civil Service in response to questions concerning the Request for Proposal and administration of the Empire Plan's mental health care provisions. In response to Question 18 as "instances in which prior authorization is not required," the New York State

Department of Civil Service states: "Generally, non-network benefits do not require prior authorization." United's policies are contrary to that response.

76. Moreover, in its Technical Proposal submitted to the New York Department of Civil Service as part of its 2008 Request for Proposal, United confirmed: "As noted in the RFP requirements, we will also provide review of non-network care ***when requested by the member or provider***" (emphasis added).

77. John's experiences with United exemplify its application of the preauthorization and concurrent review requirements to restrict coverage for mental health care. To obtain coverage for his services from Dr. Brod, a Non-Network provider, Dr. Brod had to repeatedly prepare Outpatient Treatment Reports and present them to United for preauthorization before further services could be reimbursed. He also had to submit to intrusive telephonic "reviews." Eventually this led to United's denial of the vast majority of the requested services, as detailed above, ***prospectively*** reducing John's psychotherapy sessions from two per week to only two per month. This reduced the ability of Dr. Brod to justify the services retroactively, as United had already denied them in advance.

Psychotherapy versus Medication-Based Treatments

78. The utilization review policies imposed by United on mental health care target non-medication treatments, reflecting United's bias against psychotherapy and other types of treatments, notwithstanding their recognized effectiveness in treating many mental health conditions. In United's MH/SA Addendum, for example, United states that "[p]reauthorization is required for all inpatient and alternative levels of care, with providers required to call Optum "to pre-certify care." However, the same limits are not placed on medication management:

> Effective January 1, 2012, Psychiatrists and Nurse Practitioners providing medication management services without psychotherapy are no longer required to

> obtain authorization. All medication management services must meet medical necessity criteria and may be subject to retrospective review.

79. As with the medical necessity definition discussed above, the preauthorization and concurrent review requirements imposed by United on mental health care violate state parity laws. Before psychotherapy can even commence, Network Providers must contact Optum, thereby immediately triggering its ability to influence access to care. Similarly, Non-Network Providers must contact Optum after the fifth visit (or likely within two weeks), again triggering a process by which United can exert pressure to reduce or terminate care.

80. For both Network and Non-Network mental health care, United then imposes an explicit pre-authorization requirement on all outpatient psychotherapy services. Thus, United can apply its unlawful medical necessity definition and attendant policies to restrict care.

81. In comparison to the strict preauthorization and concurrent review requirements imposed by United on mental health care claims, the vast majority of outpatient medical/surgical services are not subjected to the same level of oversight and control. While applicable regulations treat outpatient mental health services as comparable to primary care, United does not require preauthorization and concurrent reviews for routine medical/surgical office visits, which medical/surgical providers are permitted to offer, subject (at most) only to retrospective review.

82. Similarly, United does not differentiate between the type of treatment a medical/surgical provider offers (*i.e.,* medication versus other routine, office-based services). For mental health care, however, United imposes preauthorization and concurrent review requirements ***only*** on psychotherapy, not on treatment limited solely to medication (as distinguished from subjecting certain medications to preauthorization.) This creates a disparity in coverage.

Fail-First Policies, Step-Therapy Protocols, and Policy Exclusions

83. United also subjects precertification of higher levels of care (such as residential, partial hospitalization, and intensive outpatient treatment) to fail-first policies and step therapy protocols (embedded in its Level of Care Guidelines) not otherwise employed for precertification of inpatient treatment of medical conditions, thereby creating further disparity in coverage and hindering access to care.

84. With respect to non-network inpatient treatment of mental health and substance abuse conditions (*i.e.,* residential, halfway house, and group home), the Certificate of Insurance issued by United categorically excludes such coverage, although the Empire Plan provides for reimbursement of all approved non-network, inpatient treatment of medical/surgical conditions. In excluding such coverage, United violates state parity laws.

85. Moreover, while United expeditiously informs Empire Plan members that non-network residential treatment for mental health and substance use disorders is excluded from coverage, it routinely fails to inform them that medically necessary custodial care is a covered benefit. The Certificate of Insurance for the Mental Health and Substance Abuse Program defines "custodial care" as follows:

> Custodial care means the spectrum of services and supplies provided expressly for protection and monitoring in a controlled environment, regardless of setting, and assistance to support essentials of daily living in patients whose persistent symptoms, behavior management, and/or medical and psychological problems result in serious ongoing impairment in central life role function.

Thus, members precluded from accessing non-network residential treatment who might otherwise benefit from medically necessary custodial care due to lack of psychological resources are not even alerted to the existence of such coverage by United.

Disparate Financial Burdens under the Empire Plan

86. United further burdens its Empire Plan beneficiaries with greater expenses for mental health care services than it does for medical/surgical treatments as a result of its copayment requirements. In particular, the Empire Plan requires two separate deductibles and coinsurance maximums – one for mental health services and another for substance abuse services. Further, these distinct requirements apply separately to each enrollee, dependent partner, and dependent children. The Certificate of Insurance states:

> The Substance Abuse outpatient deductible, and the Mental Health outpatient deductible for Practitioner services are separate deductibles and cannot be combined . . . The Mental Health and Substance Abuse Program deductibles are separate from the Basic Medical and Managed Physical Medicine Program annual deductibles. The mental health and substance abuse deductibles cannot be combined with any other deductible or out of pocket provision.

United's Appeals Violations

87. The Empire Plan's Certificate of Insurance provides that "another OptumHealth **peer** advisor will review your case and make a determination" (emphasis added) when a provider requests an appeal involving a clinical matter. The clear import from the statement is that the reviewer will be ***independent***. With regard to John's care, United violated this provision by allowing a subordinate of the Medical Director (certainly not her peer) who made the original decision to adjudicate the first appeal.

88. With regard to the second level appeal, the Empire Plan Certificate of Insurance states:

> Level 2 Clinical appeals are conducted by a panel of two board-certified psychiatrists from OptumHealth and a Clinical Manager. Panel members have not been involved in the previous determinations of the case. . . .

89. This, too, was violated by United with respect to John's claims since the Medical Director who issued the original denial was on the panel and signed the final denial. Not only do

these actions represent a deceptive act or practice, they also violate New York insurance law, which requires appeals to be adjudicated by independent reviewers.

VIOLATION OF NEW YORK'S PARITY LAW

90. Under New York's mental health parity law, known as Timothy's Law, an insurer issuing a health insurance group policy in New York, including United and the Empire Plan, must provide "broad based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, however defined in such policy, at least equal to the coverage provided for other health conditions." N.Y. Ins. Law § 3221(l)(5)(A). Moreover, an insurer "which provides coverage for inpatient hospital care or coverage for physician services shall provide comparable coverage for adults and children with biologically based mental illness," including but not limited to schizophrenia/psychotic disorders, major depression and bipolar disorder "under the terms and conditions otherwise applicable under the policy." N.Y. Ins. Law § 3221(l)(5)(B).

91. In order to provide mental health coverage that is "at least equal" to coverage for other health conditions or constitutes "comparable coverage," United may not impose restrictions on care that exceed those applicable to medical/surgical care, such as more stringent medical necessity definitions, financial burdens, and exclusions of out-of-network residential treatment for mental health and substance use disorders. With respect to utilization review practices, the opening section of Timothy's Law is unequivocal: While the law was not "intended to limit or restrict the right of . . . health insurers to require that all services covered by them satisfy reasonable and appropriate utilization review requirements," such requirements must be "applied in a consistent fashion to all services covered" by such health care plans. 2006 N.Y. Laws, Ch. 748, § 1.

92. In its Technical Proposal submitted to the New York Department of Civil Service as part of its Request for Proposal, United asserts:

> As a national leader in behavioral health, OptumHealth currently administers benefits for many New York-based companies that employ 50 or more employees, and, therefore, are subject to the provisions of Timothy's Law . . .
>
> Often it is the lack of access to services, which was the issue experienced by Timothy O'Clair's family, that exacerbates and complicates behavioral healthcare and outcomes. A study conducted by Harvard Medical School, Group Health Cooperative's Center for Health Studies, and OptumHealth Behavioral Solutions found that a systematic approach to identifying and treating depression not only improves clinical outcomes, but also results in higher job retention, decreased sickness, lower work-absence, and increased work productivity. The study, published in the September 2007 issue of the Journal of the American Medical Association (JAMA), was funded by the National Institute of Mental Health.
>
> We have actively engaged with lobbyist, specialty, and collaborative organizations to help shape the language in the Federal parity bills in the Senate and House. In addition, we have for many states acted in a consultant role to help them as they design and implement their own parity bills. We have significant experience in this area through our management of two large, insured programs for federal employees that started when federal parity went into place. In addition, as noted above, our Chief Medical Officer, Rhonda Robinson-Beale, M.D., has particular expertise in behavioral health parity and is involved in national boards (*e.g.*, NCQA) and professional organizations (e.g., American Managed Behavioral Healthcare Association).
>
> Drawing upon our parity experience, we have already identified significant opportunities to reduce plan spend for the Program. We would be pleased to provide the DCS with additional information during the management interview.

93. Furthermore, in its April 18, 2008 Technical Management Interview with New York State government officials, United represented:

> There is tremendous opportunity that we see that exists, if you look through some of the pre-materials that we provided, to look at how we can not only improve the emotional health of State employees and their dependents but also improve the performance of medical programs, because, as you know, when a person is physically needy, they often times have behavioral and emotional needs as well. And what we will demonstrate to you is the opportunity and the commitment to supporting both of those areas . . .
>
> [W]e are very mindful that often times ***members who experience behavioral health***

> ***concerns and problems are the most vulnerable in the medical system*** . . . and ***we've proposed a program that really focuses on access, full access, to the membership and full continuum of care*** . . . we recognize that many people who are suffering from disabling mental illnesses are not able to care for themselves, are not able to think and problem solve and act on their own behalf, so we propose a program that anticipates that and will be proactive in nature. (Emphasis added.)
>
> [State Official]: [M]y biggest concern is that people are just not uniformly pushed toward outpatient regardless of what the assessment of the circumstances are.
>
> [OptumHealth Representative]: And I'd just like to reinforce that. We do not have a program philosophy that you have to fail outpatient before you attend inpatient.

94. Despite United's material inducements, its practices fall far short, and each of the United policies and practices described above which violate Timothy's Law. Because of the limitations placed on mental health care coverage, United fails to provide mental health coverage that is "at least equal" or "comparable" to the coverage provided for other types of conditions. Its medical necessity definitions, utilization review policies, financial burdens, and coverage exclusions with respect to mental health care are not applied "under the same terms and conditions" governing medical conditions.

VIOLATION OF NEW YORK GBL § 349

95. Section 349 of New York's General Business Law declares as unlawful any "deceptive acts or practices in the conduct of any business, trade or commerce, or in the furnishing of any service in this state." This provision provides to health insurers with regard to their sale and operation of health insurance policies.

96. United has violated this provision by administering its mental health insurance policies in a manner violating the New York Parity Law. Its disparate medical necessity definitions for mental health conditions, exclusions of inpatient benefits of mental health conditions, disparate financial requirements, misrepresentation of covered benefits to insureds, and utilization review policies with respect to the Empire Plan all violate the New York Parity Law. Moreover, United's

utilization review practices are contrary to its Master Agreement and its representations to the State with regard to how it would administer the Plan. Among other things, United imposes restrictions on coverage for mental health care which are contrary to generally accepted standards of care and contrary to law and to its contractual obligations, as detailed herein.

97. United's practices are further deceptive with regard to how it handles appeals of its mental health care claims. New York Insurance Law § 4904(d) provides that "appeals shall only be conducted by clinical peer reviewers, provided that any such ***appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination***."

98. Furthermore, the Master Agreement between United and the State of New York requires the following steps for providing appeals to denials of benefits:

> 8.1.2 Establish two levels of internal appeal as follows:
>
> 8.1.2a A level one (1) appeal performed by an independent Peer Advisor; and,
>
> 8.1.2b A level two (2) appeal performed by an independent review committee, comprised of the BHA's medical director or alternate board certified psychiatrist; a board certified psychiatrist from the Insurer; and, the BHA's director of clinical operations, or an appropriate designee. The level two (2) appeal must be available when a Peer Advisor has made a non-certification determination on a request for initial or continued treatment, and a level one (1) appeal has upheld the non-certification determination decision.

Furthermore, United, in its Technical Proposal, maintains:

> Most appeals will be coordinated out of our Program-dedicated office, where a local Care Manager will be responsible for performing the initial Utilization Management review. Because our dedicated Medical Director for the Program will have issued a denial of care, appeals will therefore be conducted by off-site Peer Advisors not involved in any previous Utilization Management or appeals decisions . . .
>
> Level One outpatient and Alternative Level of Care (ALOC) appeals are performed by an independent Peer Advisor and processed in the same manner as Level One inpatient appeals, described above, with one exception: Peer Advisors have two (2) business days to reach and submit a review determination.

> If the member is dissatisfied with the outcome of the Level One appeal, he or she may request a Level Two (2) appeal. Level Two appeals will be available when a Peer Advisor has made a non-certification determination on a request for initial or continued treatment, and a Level One (1) appeal has upheld the non-certification decision. The process for Level Two appeals will be the same for inpatient, outpatient, and ALOC cases.
>
> Level Two appeals will be performed by an independent review committee, which will be comprised of the Department's designated Medical Director or alternate board-certified psychiatrist; a board-certified psychiatrist not involved in the prior determination; and OptumHealth's Director of Clinical Operations, or an appropriate designee. None of the committee members will have been involved in the original adverse determination or first-level appeal.

99. Contrary to New York Insurance Law § 4904(d), the provisions of the Master Agreement, and United's own representations, United's appeals are not independent, full, or fair. The first level of appeal for John was adjudicated by a subordinate of the Medical Director who issued the initial denial. The second level of appeal was determined by a panel consisting of the same Medical Director who signed the initial denial letter without adequately investigating or responding to the substance of the dispute. Thus, this sham process violates statutory and contractual requirements.

100. Additionally, United fails to reimburse clean claims pursuant to its Master Agreement with the State of New York and in violation of New York's Prompt Pay Law. The Master Agreement between United and New York requires that United process claims according to the following schedule:

> Network Claims Guarantee: The Insurer guarantees that at least one-hundred percent (100%) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Insurer will be turned around in eighteen (18) ***Business*** Days from the date the claim is received electronically or in the Insurer's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. (Emphasis added.)
>
> Non-Network Claims Guarantee: The Insurer guarantees that at least one-hundred percent (100%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Insurer will be turned

> around in eighteen (18) ***Calendar*** Days from the date the claim is received electronically or in the Insurer's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. (Emphasis added.)

United routinely fails to reimburse network and non-network mental health claims within the time periods set by contract.

101. United has engaged in various misrepresentations and omissions in the sale of and/or circulation of plan documents that are directed toward consumers, including potential subscribers, to induce such consumers to subscribe, or to continue with, the Empire Plan and other state-based insurance policies. Such conduct constitutes a deceptive act or practice under New York law.

VIOLATION OF THE NEW YORK STATE PROMPT PAY STATUTE

102. Under New York's prompt pay statute, N.Y. Ins. Law § 3224-a, an insurer who has no valid basis to deny or delay payment of a health insurance claim must pay such claim within 45 days of receipt of a claim or bill for the services at issue. Failure to pay the claim timely subjects the insurer to penalties as well as an obligation to pay the subscriber or provider interest on top of the full benefits otherwise due and owing.

103. United has violated the New York prompt pay statute by, among other things, failing to pay for covered services within the time frame required by law for the various reasons detailed herein.

CLASS CLAIMS

104. Dr. Kamins brings this action on behalf of the following class of similarly situated subscribers under the Empire Plan:

> All persons receiving health insurance coverage under the Empire Plan who, from inception of the statute of limitations period applicable to this claim until the final termination of this action ("Class Period"), submitted health insurance claims to United for mental health care services which were subjected to United's: 1)

disparate medical necessity definitions and treatment criteria for mental health and substance use disorders, 2) out-of-network facility exclusions; 3) preauthorization or concurrent review requirements and appeals; and 4) did not receive payment of benefits within the time frame required under the New York prompt pay statute.

COMMON CLASS CLAIMS, ISSUES AND DEFENSES FOR THE CLASS

105. The following common class claims, issues and defenses for the Class arise for the defined Class Periods:

1. Whether Defendants violated Timothy's Law by applying preauthorization and concurrent review requirements as well as medical necessity definitions for mental health services that were not comparable to or more stringent than policies applied to medical/surgical services;
2. Whether Defendants violated New York's GBL § 349 by violating the New York Parity Law in applying preauthorization and concurrent review requirements as well as medical necessity definitions for mental health services that were not comparable to or more stringent than policies applied to medical/surgical services;
3. Whether Defendants violated New York's GBL § 349 by failing to assure independence in appeal adjudications of mental health care claims;
4. Whether Defendants violated the New York prompt pay statute by failing to pay clean claims in a timely fashion;
5. Whether Defendants breached the terms of the Empire Plan by applying restrictive coverage policies for mental health care;
6. Whether Defendants breach their fiduciary duties to Empire Plan members by applying restrictive coverage policies for mental health care;
7. Whether members of the proposed Class are entitled to an injunction prohibiting Defendants from applying the policies identified herein for reducing coverage for mental health care services;
8. Whether members of the proposed Class are entitled to payment of benefits improperly denied as a result of Defendants' restrictive coverage policies.
9. Whether members of the proposed Class are entitled to payment of damages for injuries suffered as a result of Defendants' use of illegal coverage policies;
10. What is the statute of limitations for the various statutes identified herein.

ADDITIONAL CLASS ACTION ALLEGATIONS

106. The members of the Class are so numerous that joinder of all members is impracticable. Upon information and belief, the Class consists of thousands of subscribers who

are subject to Defendants' policies that are at issue in this action. In the third quarter of 2012, for example, 6,850 Empire Plan members submitted claims for Non-Network outpatient mental health services, while 48,853 Empire Plan members submitted claims for Network outpatient mental health services. The precise number of members in the Class is within Defendants' exclusive custody and control. Based on reasonable estimates, the numerosity requirement of CPLR § 901(a)(1) is easily satisfied for the Class.

107. Common questions of law and fact exist as to all Class members and predominate over any questions affecting solely individual members of the Class, including the class action claims, issues and defenses listed above.

108. The claims of Plaintiff, as the proposed Class Representatives, are typical of the claims of the Class members because, as a result of the conduct alleged herein, Defendants violated the various state statutes as detailed herein, and provided improper coverage of mental health care services.

109. The Plaintiff will fairly and adequately protect the interests of the members of the Class, is committed to the vigorous prosecution of this action, has retained counsel competent and experienced in class action litigation and in the prosecution of health care claims, and knowledgeable in mental health care issues, and has no interests antagonistic to or in conflict with those of the Class. For these reasons, Plaintiff is an adequate class representative.

110. A class action is superior to other available methods for the fair and efficient adjudication of this controversy because joinder of all members of the Class is impracticable. Further, the expense and burden of individual litigation make it impossible for the Class members individually to redress the harm done to them. Notably, many members might be too ashamed or

intimidated to prosecute their individual claims. Given the uniform policy and practices at issue, there will also be no difficulty in the management of this litigation as a class action.

COUNT I

CLAIM FOR RELIEF UNDER THE NEW YORK PARITY ACT
(on behalf of Plaintiff and the putative Class)

111. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count I is brought under Timothy's Law, N.Y. Ins. Law § 3221(l)(5), *et seq.*

112. Through the preauthorization and concurrent review policies applied to mental health claims, the procedures and guidelines followed for making medical necessity decisions with regard to coverage for mental health care services, Defendants failed to provide coverage for mental health care services which is equal or comparable to other health conditions.

113. Defendants' policies impose limits on mental health care claims which that are more restrictive than those placed on non-mental health care claims, and enforce utilization review requirements which are not applied in a consistent fashion to mental health and other health conditions. This had led to reduced coverage for mental health care services in violation of Timothy's Law.

114. During the Class Period, Dr. Kamins and the members of the putative Class have been harmed by Defendants' violations of Timothy's Law. Dr. Kamins, on his own behalf and on behalf of the members of the putative class, seeks to enjoin Defendants from pursuing policies that violate Timothy's Law, as detailed herein, requests that Defendants reprocess and reimburse benefits which were denied or reduced as a result of such policies, and requests that Defendants pay appropriate interest back to the date such claims were originally submitted. Dr. Kamins also sues for declaratory and injunctive relief related to enforcement of Timothy's Law, and further

requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

COUNT II

CLAIM FOR RELIEF UNDER NEW YORK GBL § 349
(on behalf of Plaintiff and the putative Class)

115. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count II is brought under GBL § 349, New York's Unfair Trade Practices Act.

116. By applying preauthorization and concurrent review as well as sham appeals policies to mental health claims, implementing procedures and guidelines for medical necessity decisions with regard to coverage for mental health care services, and utilizing fee schedules which violate state parity laws to restrict mental health care coverage, Defendants have engaged in deceptive acts and practices in the conduct of their health insurance business and in the furnishing of insurance administration services in this State, in violation of GBL § 349.

117. During the Class Period, Dr. Kamins and the members of the putative Class have been harmed by Defendants violations of New York's Unfair Trade Practices Act. Dr. Kamins, on his own behalf and on behalf of the members of the putative Class, seeks to enjoin Defendants from pursuing the policies that violate GBL § 349, as detailed herein, requests that Defendants reprocess and reimburse benefits which were denied or reduced as a result of such policies, and sues for declaratory and injunctive relief related to enforcement of the Unfair Trade Practices Act, and further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

COUNT III

CLAIM FOR RELIEF UNDER N.Y. INS. LAW § 3224-a
(on behalf of Plaintiff and the putative Class)

118. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count III is brought under New York Insurance Law § 3224-a, New York's prompt pay law.

119. By receiving clean claims for mental health care benefits, and denying or delaying payment of such claims based on invalid and illegal policies and procedures, Defendants are obligated to comply with New York's prompt pay statute, requiring payment for all benefits due under such claims within 45 days of receipt. For the reasons detailed herein, Defendants have failed to make timely payments, in violation of this Law.

120. During the Class Period, Dr. Kamins and the members of the putative Class have been harmed by Defendants' violations of New York's prompt pay statute. Dr. Kamins, on his own behalf and on behalf of the members of the putative Class, seeks to enjoin Defendants from pursuing the policies that violate N.Y. Ins. Law § 32224-a, as detailed herein, requests that Defendants reprocess and reimburse benefits which were denied or reduced as a result of such policies, and requests that Defendants pay appropriate interest back to the date such claims were originally submitted. Dr. Kamins also sues for declaratory and injunctive relief related to enforcement of the New York prompt pay statute, and further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

COUNT IV

CLAIM FOR BREACH OF CONTRACT

(on behalf of Plaintiff and the purported Class)

121. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth herein.

122. As detailed herein, Defendants failed to provide Plaintiff with the appellate process required by the terms of the Empire Plan for benefit denials.

123. As a result of Defendants' breach of the terms of terms of the Empire Plan, Plaintiff was denied the due process he was entitled to. Plaintiff was thus injured by Defendants' depravation of his opportunity to challenge Defendants' benefit determinations as provided by the terms of the Empire Plan.

124. During the Class Period, Dr. Kamins and the members of the putative Class have been harmed by Defendants' breaches of the terms of the Empire Plan. Dr. Kamins, on his own behalf and on behalf of the members of the putative Class, seeks damages resulting from Defendants' breaches. Dr. Kamins further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

COUNT V

CLAIM FOR BREACH OF FIDUCIARY DUTY

(on behalf of Plaintiff and the putative Class)

125. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth herein.

126. Plaintiff and the members of the putative Class entrusted Defendants with authority to make coverage determinations consistent with the terms of the Empire Plan. As a result, Defendants owed fiduciary duties to Plaintiff and the members of the putative Class.

127. Through their application of restrictive coverage policies that contravened New York law and, in some cases, the very terms of the Empire Plan itself, Defendants breached their fiduciary duties to Plaintiff and the members of the putative Class.

128. During the Class Period, Dr. Kamins and the members of the putative Class have been harmed by Defendants' violations of their fiduciary duties. Dr. Kamins, on his own behalf and on behalf of the members of the putative Class seeks damages resulting from Defendants' fiduciary breaches. Dr. Kamins also requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

WHEREFORE, Plaintiff demands judgment in his favor against Defendants as follows:

Certifying the Class and its claims, as set forth in this Complaint, for class treatment;

Appointing the Plaintiff as Class Representative for the proposed Class, as detailed herein;

Designating the Maul Firm, P.C. and Psych-Appeal, Inc. as counsel for the Class;

Declaring that Defendants' preauthorization and concurrent review requirements with regard to outpatient mental health care services, and its medical necessity definition for mental health care services, are in violation of state laws, including the mental health parity laws, as detailed herein;

Issuing a permanent injunction ordering Defendants to cease imposing preauthorization and concurrent review requirements with regard to outpatient mental health care services, and to cease relying on the medical necessity definition for mental health care services as incorporated into the Empire Plan or plans with similar definitions;

Ordering Defendants to recalculate and issue unpaid benefits to Class Members whose claims were underpaid or denied as a result of Defendants' actions as detailed herein;

Ordering Defendants to pay damages to Plaintiff and the Class for injuries caused by Defendants' conduct;

Awarding Plaintiff's disbursements and expenses for this action, including reasonable counsel fees, in amounts to be determined by the Court;

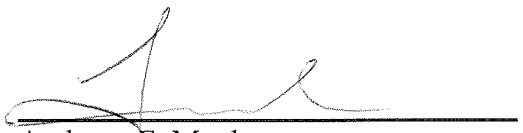
Awarding taxable costs, as the law allows, and interest from the date of initial benefit reductions for Plaintiff and members of the Class for all improperly denied amounts; and

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

JURY DEMAND

Plaintiffs demand trial by jury on all issues so triable.

Respectfully submitted,
June 4, 2014



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