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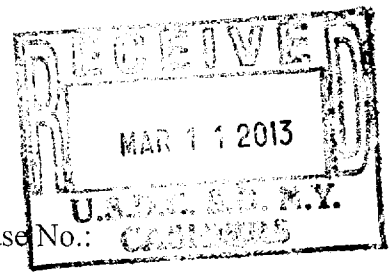
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK



NEW YORK STATE PSYCHIATRIC ASSOCIATION, INC., in a representational capacity on behalf of its members and their patients, 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, JONATHAN DENBO, on his own behalf and on behalf of all other similarly situated health insurance subscribers, and BRAD SMITH, on his own behalf and on behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers,

Plaintiffs,

v.

UNITEDHEALTH GROUP, UHC INSURANCE COMPANY, UNITED HEALTH-CARE INSURANCE COMPANY OF NEW YORK and UNITED BEHAVIORAL HEALTH,

Defendants.

Case No.:

CLASS ACTION COMPLAINT

Demand for Jury Trial

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JURY DEMAND 102

Plaintiff New York State Psychiatric Association, Inc., in a representational capacity on behalf of its members and their patients, Michael A. Kamins, Ph.D., on behalf of himself and his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, Jonathan Denbo, on his own behalf and on behalf of all other similarly situated health insurance subscribers, and Brad Smith, on behalf of himself and his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, bring this Class Action Complaint against Defendants UnitedHealth Group ("UHG"), UHC Insurance Company ("UHC Ins. Co."), United Healthcare Insurance Company of New York, Inc. ("United-NY"), and United Behavioral Health ("UBH") (collectively, referred to herein as "Defendants" or "United"). Plaintiffs hereby allege upon personal knowledge as to themselves and their own 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:

INTRODUCTION

1. Access to mental health care is a critical need in this country. The lack of timely, adequate treatment has exacerbated the unacceptable suffering of untold numbers of individuals with mental illness and their families. Historically, insurers and health plans have discriminated with impunity against the mentally ill, denying them coverage and care necessary to lead healthy and productive lives. To curb these privations, federal and state antidiscrimination laws now mandate coverage of and parity between medical and mental health insurance benefits.

2. United is one of the largest health insurance companies in the United States, issuing policies to and administering benefits on behalf of millions of subscribers nationwide. As such, United is bound by federal and state antidiscrimination laws that protect mental health patients and provide for their access to meaningful care.

3. Despite United's duty to adhere to these antidiscrimination safeguards, United has systematically implemented unlawful and deceptive practices designed to create the illusion of impartiality, fairness, and due process while simultaneously undermining access to treatment for the most vulnerable segment of our society. United's improper conduct is single-minded – to maximize profitability at the expense of disenfranchised beneficiaries whose shame, fear, and fragility it so keenly exploits.

4. Through this action, Plaintiffs seek to expose United's unlawful practices toward mental health claimants and, among other things, compel United's compliance with the laws providing for coverage and parity of mental health care. Plaintiffs also seek to recoup the substantial financial losses they and the Class they seek to represent have sustained from United's unlawful claims practices.

5. This Complaint is lengthy and detailed due to United's comprehensive violations of numerous laws applicable to the Plaintiffs' claims. Because United's systemic abuses apply to all Class Members, treatment of these claims on a class-wide basis, and associational standing permitting the New York Psychiatric Association, Inc. to seek broad injunctive relief on behalf of its members and their patients, is warranted.

PLAINTIFFS AND A SUMMARY OF THEIR ALLEGATIONS

The New York State Psychiatric Association

6. The New York State Psychiatric Association, Inc. ("NYSPA" or the "Association Plaintiff") is the professional medical specialty organization of psychiatrists practicing in New York State and is a division of the American Psychiatric Association. It is headquartered in Garden City, New York. NYSPA's goals are to promote quality mental health care in New York State, to advance psychiatric education and research, to represent the profession of psychiatry,

and to serve the professional needs of its membership. Many of NYSPA's members provide mental health services to patients insured by plans issued or administered by United ("United Insureds"), and are thereby subjected to United's policies and procedures for mental health services. (For convenience, "mental health" and "mental illness" shall collectively refer to mental health and substance use disorders.)

7. As part of its goal of assisting its members in protecting their interests and those of their patients, NYSPA spends substantial time addressing grievances concerning the policies and practices of insurers. In particular, NYSPA has received many complaints concerning United's unlawful policies and practices designed to eliminate, reduce, and discourage the provision of mental health care. NYSPA, in response, has actively challenged United's violations of federal and New York State mental health parity laws arising from, among other things, United's unjustifiably stringent medical necessity criteria and pre-authorization requirements for mental health services not otherwise imposed on primary medical care. Additionally, NYSPA has challenged United's fee schedules for mental health services that are not comparable to and more restrictive than those for medical/surgical procedures as well as United's improper refusal to reimburse evaluation and management ("E/M") codes for mental health services. NYSPA seeks injunctive relief to prevent United's unlawful restrictions on mental health care on behalf of its members and their patients.

Dr. Michael A. Kamins

8. 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 the Empire

Plan, offered by the New York State Health Insurance Program ("NYSHIP"). Defendant United issued the Empire Plan to New York State and insures (through United-NY) and administers (through UBH) its benefits to nearly 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. Dr. Kamins's son, whose mental health treatment is at issue in this litigation, is a beneficiary under Dr. Kamins's plan and resides in California.

9. Among the health benefits provided by the Empire Plan are medically necessary services for mental health and substance use disorders. Dr. Kamins's son suffers from severe mental illness, including psychosis and suicide attempts, requiring him to receive mental health treatments for which Dr. Kamins submitted claims to United for processing and payment. To protect his privacy, Dr. Kamins's son will be referred to herein as "John." The services provided to John entail in- and outpatient treatment, including psychotherapy and psychopharmacology. John continues to suffer from mental illness and will likely require substantial treatment moving forward. 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 and pursue any legal claims on his behalf.

10. From the onset of John's mental illness, United interfered with John's medically necessary care. Using undisclosed algorithms to identify high-use beneficiaries, United flagged John as a beneficiary likely to require significant treatment. United therefore imposed substantial obligations on John's treating providers to obtain preauthorization for services, placing undue burdens and unnecessary restrictions on his care.

11. After having authorized a certain level of care, United prospectively curtailed

coverage for most of John's treatment. In particular, after John's 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. On behalf of Dr. Kamins and his son, the treating physician subsequently pursued the two levels of appeals authorized by the Empire Plan, after which – and with little to any explanation – United reaffirmed its denial of benefits. In doing so, United relied on undisclosed quantitative limits on coverage for outpatient mental health care.

Jonathan Denbo

12. Jonathan Denbo ("Denbo") is the Director of Marketing for CBS Sports Network ("CBS"). As a CBS employee, Mr. Denbo receives health benefits through the large group CBS Medical Plan. The plan is self-funded, such that the benefits are paid from the assets of CBS, the "Plan Sponsor," but claims submitted to the plan are administered by United, which, among other things, has "exclusive authority and sole and absolute discretion to interpret and to apply the rules of the plan to determine claims for plan benefits." The CBS health plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA").

13. For several years, Mr. Denbo has received mental health treatment for chronic depressive and anxiety disorders, exacerbated by the untimely loss of his mother to cancer. Mr. Denbo's treatment is comprised of weekly psychotherapy and periodic medication management. These services are reimbursable by the CBS plan, which specifies that all such outpatient services are covered, subject to retrospective reviews by United for medical necessity. In late 2012, United changed its practice of approving coverage for Mr. Denbo's services and issued a prospective determination that all future psychotherapy would no longer be covered. Such a determination was improper, since it violated the express terms of the CBS plan and was based

on internal policies that violate federal mental health parity laws.

Brad Smith

14. Brad Smith ("Smith" or, with Kamins and Denbo, referred to collectively as "Subscriber Plaintiffs") is a marketing associate at SYSCO Seattle, Inc., a subsidiary of SYSCO Corporation. As a SYSCO employee, Mr. Smith receives health benefits through the SYSCO Corporation Group Benefits Plan. The SYSCO plan, too, is self-funded and benefits are paid from the assets of SYSCO, the "Plan Administrator," while mental health and substance abuse claims submitted to the plan are administered by United (through UBH). Under the SYSCO plan, United is given "discretionary authority to (i) construe and interpret the terms of the Plan, and (ii) determine the validity of charges submitted to [United] under the Plan." Blue Cross Blue Shield of Illinois ("BCBSIL") is the SYSCO plan's Claims Administrator for medical/surgical benefits. The Claims Administrators, including United and BCBSIL, retain full responsibility for the final review of urgent and concurrent care claims and SYSCO retains final oversight for all other types of claims. Furthermore, under the SYSCO plan, "to the extent a third party has agreed to serve as a claims fiduciary or to otherwise have discretionary authority under the Plan, such third party will be the 'named fiduciary' with respect to such claims under the Plan." The SYSCO health plan is governed by ERISA.

15. Among the health care services covered by the SYSCO plan is medically necessary treatment for mental health and substance use disorders. Such services encompass comprehensive, outpatient and inpatient care, both in- and out-of-network. Residential treatment for mental health and substance abuse disorders is a covered benefit. The SYSCO plan does not itself define "medical necessity," vesting such discretion on the Claims Administrators.

16. Mr. Smith's 17 year-old son has been treated for severe mental illness since 2005

and began exhibiting symptoms at an even earlier age. To protect his privacy, Mr. Smith's son will be referred to herein as "William." His treatment over the years has consisted of outpatient psychotherapy and medication management as well as multiple involuntary psychiatric hospitalizations. The mental health care resources available to William and his family are extremely limited on their small island off Washington State. Up through August 2012, William's public school did not offer him meaningful therapeutic services, and historically William had to be transported up to four hours by seaplane or ferry to receive outpatient treatment and schooling outside his district. Over the years, United has had to contract with out-of-network mental health providers to offer services to William due to the absence of any in-network providers within range of his home. William's family has had to travel more than four hours to reach even out-of-network facilities.

17. On March 12, 2012, William was psychiatrically hospitalized for major depressive disorder with suicidality and other major medical and psychiatric comorbidities. Hospital staff unequivocally opined that William required on-going residential treatment, and on March 20, 2012, he was subsequently transported by his mother to a residential treatment center in Utah. United then precertified William's residential treatment for nine days, and thereafter, issued an adverse benefit determination on March 29, 2012, relying on unlawful fail-first policies and step-therapy protocols requiring William to obtain outpatient treatment unavailable in his community. On March 30, 2012, William's provider requested an urgent, concurrent care appeal from United, which subsequently upheld its initial decision on April 2, 2012. United did not pay for any of William's residential treatment pending his urgent, concurrent care appeal or thereafter.

United's Mental Health Care Coverage Policies

18. United's policies, as applied to Dr. Kamins's son, Mr. Denbo, and Mr. Smith's son violate federal and state antidiscrimination laws regarding insurance benefits for mental health and substance use disorders. Federal, New York, and California laws require insurance plans to administer mental health and substance abuse benefits in parity with medical/surgical benefits and prohibit plans from imposing more restrictive quantitative or non-quantitative limitations on benefits for mental health care than they do for other types of health care services. The United policies imposed on the Subscriber Plaintiffs and other insureds that submit claims for mental health care violate these antidiscrimination statutes. Further, United violated New York's unfair business practice statutes protecting the non-ERISA Subscriber Plaintiffs and violated California's comparable statute protecting Dr. Kamins's son (and similarly situated beneficiaries) by imposing restrictions on mental health benefits that are contrary to law and negotiated agreements. United's rampant violations of mental health parity and unfair business practice laws are on a national scale. Its abusive practices are currently being litigated in *Fradenburg v. United Healthcare et al.*, a class action suit brought on behalf of University of California health plan members and beneficiaries.

19. Defendant UHG, through its Health Care segment, offers, underwrites, and administers United Plans, through which healthcare expenses incurred by United Insureds for services and/or products covered by the Plans ("Covered Services") are reimbursed by and/or through United, subject to the Plans' terms, conditions, and limitations. United's mental health coverage, including in the CBS plan, is administered by Defendant UBH, operating under the brand name OptumHealth Behavioral Solutions (or OptumHealth), a wholly-owned United subsidiary. Defendant United-NY – which is also a wholly-owned subsidiary of UHG – insures and administers the mental health provisions of the Empire Plan, along with UBH.

20. Because United's actions were improper and unlawful, Plaintiffs seek, among other things, to enjoin United from engaging in the practices described herein and the Subscriber Plaintiffs seek appropriate damages for themselves and the putative class members for losses suffered therefrom.

THE DEFENDANTS

21. Defendant UnitedHealth Group, headquartered in Minnetonka, Minnesota, is a corporation organized and existing under and pursuant to the laws of Minnesota which issues and administers health care plans around the country through its various wholly owned and controlled subsidiaries, including Defendants UHC Ins. Co., United-NY and UBH.

22. UHC Ins. Co. is one of UHG's wholly owned and controlled subsidiaries, located in Hartford, Connecticut. It is identified in the Summary Plan Description ("SPD") of the CBS plan as the "Claims Administrator" for medical and behavioral health benefits.

23. Defendant United-NY is also one of UHG's wholly owned and controlled subsidiaries, which administers the Empire Plan. It is headquartered in Kingston, New York.

24. Defendant UBH is another one of UHG's wholly-owned and controlled subsidiaries. It is a corporation organized under California law, and its principal place of business is located in San Francisco, California. It operates under the brand name OptumHealth. In administering the Empire Plan with regard to claims submitted by Dr. Kamins, UBH used an OptumHealth address located in Kingston, New York. UBH denied the benefits applicable to Mr. Denbo, as detailed herein, through its Appeals Department located in Philadelphia, Pennsylvania. UBH denied the benefits applicable to Mr. Smith's son, as detailed herein, through its Appeals Department located in Houston, Texas.

JURISDICTION AND VENUE

25. United's actions in administering employer-sponsored healthcare plans, including determining reimbursement for providers of healthcare services to United Insureds pursuant to the terms and conditions of the healthcare plans, are governed by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, ERISA, and the Affordable Care Act. Plaintiffs assert subject matter jurisdiction for their federal parity law claims under 28 U.S.C. § 1331 (federal subject matter jurisdiction). The Court should maintain jurisdiction over the state law claims pursuant to the principles of supplemental jurisdiction.

26. Venue is appropriate in this District for Plaintiff's claims under 28 U.S.C. § 1391 because: (i) the CBS plan, which provides the benefits at issue for Mr. Denbo, is issued in this District, where CBS is headquartered, and Mr. Denbo resides, works, and is treated here; (ii) Dr. Kamins works in a location convenient to this District and many members of the Empire Plan work and reside here; (iii) NYSPA is headquartered in a location convenient to this District and many of its members work and reside here; (iv) UHG, through its wholly owned and controlled subsidiaries, is found, has an agent, and transacts business in this District, where various offices are located; and (v) United conducts a substantial amount of business in this District and insures and administers group health plans both inside and outside this District, including from offices located in this District.

DR. KAMINS'S MENTAL HEALTH INSURANCE ISSUES

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

27. Dr. Kamins' 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.

28. During his first year in college in 2010-2011, John began very successfully, achieving high grades. John then began suffering from severe mental illness, including Bipolar Disorder, ADHD, and polysubstance 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.

29. Upon John's return to Los Angeles, Dr. Kamins considered residential treatment for his son. United, however, dissuaded him from doing so, advising that his health plan does not cover long-term 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 and, in September 2011, 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.

30. 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 determined a bipolar mood pattern and dysregulated personality features had emerged for John, initially masked by intense anxiety and attendant propensity toward angry outbursts.

31. According to Dr. Brod's analysis, John presented with 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, John's moods were unstable and seriously disturbed, and Dr. Brod noted that John appeared to be "rapid-cycling."

32. During treatment, Dr. Brod learned that John also suffered from a secret eating disorder going back to middle school, which continued with new demonstrations of anorexia. John had also 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 difficulty in managing the associated anxiety when his protective rituals were disrupted by his college living environment led to self-destructive social aberrations and drug/alcohol abuse.

33. On December 31, 2011, John became violent during a family argument and was taken by paramedics to the Cedars-Sinai Emergency Room, after which we 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.

34. During this period, John's symptoms were characterized by grave disturbances in thinking, intense anxiety, impaired concentration, and mostly manic mood with some brief, depressive oscillations. From January 25, 2012 through January 31, 2012, John was

rehospitalized involuntarily, after becoming manic and floridly psychotic.

35. By early April, John's agitation diminished, according to Dr. Brod's records, but he remained on fairly high doses of antipsychotic and benzodiazepine medications. By that point, 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 in belligerent, confused, manic or depressed/demoralized states, but psychotherapy was proving effective, and Dr. Brod determined that John's mind and affect were calm by the end his psychotherapy sessions. This clinical achievement therefore weighed in favor of sustaining psychotherapy at the prescribed frequency of three times per week.

36. 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, but he continued 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 at a twice-weekly frequency.

37. As detailed below, United was at this time taking active steps to reduce coverage for John's treatments. Dr. Kamins did not submit claims to United for services provided by Dr. Gerner, concerned that United would use these additional claims to further pressure John to reduce treatment.

38. 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 which 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. Among other things, Dr. Brod concluded that John continued to suffer symptoms causing 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.

39. 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 subjectively the social, occupational, and psychological functioning of patients, *e.g.*, how well or adaptively one is meeting various problems-in-living. The scale is presented 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)."

40. Based on the diagnoses and treatment of John's co-morbid conditions, Dr. Brod, supported by Dr. Gerner, 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.

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

42. After United denied coverage for the number of services sought by Dr. Kamins for John, as detailed further below, Dr. Kamins could not afford to obtain the full scope of services the treating providers had recommended, although he did pay out-of-pocket for a number of services that were not reimbursed.

43. Dr. Kamins's recent inquiries about reimbursement of non-network claims resulted in United informing him that it has 30 days to process claims, a timeframe exceeding the provisions of United's Master Agreement with the State of New York.

44. 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. As a consequence of inadequate access to outpatient mental health care, John was rehospitalized for 12 days on February 16, 2013.

United's Response to Claims Submitted by Dr. Kamins

45. 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.

46. Pursuant to United's policies, Dr. Brod was required to submit preauthorization forms after every 10 sessions in order for subsequent mental health care to be covered. This was through an Outpatient Treatment Form developed by United and submitted to its Kingston, New York address. It was a one page form that only allowed for checking off various factors, including "Symptoms/Functional impairment," as well as "Progress Update."

47. While filling out the form was burdensome, the process was also ineffective. 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 to the plan.

48. 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.

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

50. 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 had been required to submit.

51. On April 24, 2012, Dr. Brod submitted one such form to United, 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, while noting that he was receiving medication management 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 indicating that John would need more than 10 sessions (the maximum number which could be requested on the form) and would require more than one session each week.

52. 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 for May 31, 2012.

53. In the May 31, 2012 concurrent telephonic review, United changed its approach to John's treatment, after the number of psychotherapy sessions exceeded the limit United was willing to cover pursuant to its undisclosed internal policies. In response to Dr. Brod's May 2012 Outpatient Treatment Form, United only approved ***two*** additional outpatient psychotherapy sessions, stating in a June 4, 2012 letter to him 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."

54. This was followed by a letter from United to Dr. Kamins's son, dated June 4, 2012, addressed to his Los Angeles address where lived at the time, disclosing its adverse benefit determination. The decision was reported under the letterhead of OptumHealth, stating that this was "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.

55. 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."

56. 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."

57. 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 . . ."

58. 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 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.

59. Dr. Kamins noted to United 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.

60. 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 David 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.

61. Dr. Kamins ended his letter by asserting that United 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."

62. The appeal was denied in a letter dated July 12, 2012, which was signed by Lee Becker, MD, the Associate Medical Director for OptumHealth and the ***subordinate*** of Dr. Sigler, who issued the initial denial. It was addressed to Dr. Kamins's son, at his Los Angeles address, and not to Dr. Kamins, the insured who had actually written the appeal letter. 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.

63. 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.

64. Notably, United's July 12, 2012 denial letter only provided superficial bases for

its conclusion and failed to address 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.

65. 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 information contained above in paragraphs 27 through 44 was included in this letter. The letter also painstakingly detailed United's violations of federal and state mental health parity laws resulting from United's utilization review procedures.

66. 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 David 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.

67. United responded with a final denial on September 12, 2012 in another boilerplate letter to Dr. Kamins's son on OptumHealth letterhead sent to his Los Angeles address. This letter was again from Dr. Sigler, the United Medical Director who issued the original denial in the June 4, 2012 letter. 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 federal and state laws.

68. 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.

69. The letter 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."

70. Because Dr. Kamins contends that United's policies and practices with regard to mental health coverage violate federal and state laws, as detailed herein, he has elected to bring this lawsuit. The hurdles imposed on subscribers to exercise their mental health benefits, and the limitations placed on such coverage, are unconscionable and should be enjoined.

Coverage Under the Empire Plan

71. 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.

72. 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.

73. 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.**"

74. The Empire Plan provides for the full coverage of hospital, medical, and surgical non-mental health care, subject to network and non-network benefit levels. As a result, coverage for medical/surgical care is broader than for mental illness.

75. Other than the restrictions on Inpatient 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

76. 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."

77. 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.

78. 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 . . .

79. 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.

80. 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.

81. 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.

82. 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.

83. 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

84. 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.

85. "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.

86. 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.

87. 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.

88. 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.

89. 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.

90. 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).

91. 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

92. 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.

93. As with the medical necessity definition discussed above, the preauthorization and concurrent review requirements imposed by United on mental health care violate federal and 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.

94. 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.

95. 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 federal regulations treat mental health providers as comparable to primary care providers, 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.

96. 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

97. 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.

98. 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 federal and state parity laws.

99. 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

100. 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

101. United's appeals processes of adverse benefit determinations regarding mental health care is, likewise, compromised. The 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. This provision specifies that the person making the appeal decision will be different from the person who made the original

denial. The clear import from the statement is also that the person will be ***independent***. In John's case, United violated this provision by allowing a subordinate of the Medical Director who made the original adverse decision to adjudicate his first appeal.

102. With regard to second level appeals of adverse benefit determinations, 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. . . .

This, too, was violated by United in John's case, as the Medical Director who issued the initial benefit denial was on the panel and signed the final denial. Not only do these actions represent a deceptive act or practice under New York law, in that they are contrary to the obligations United assumed with respect to the Empire Plan under the Master Agreement it entered into with the State of New York, but they also violate the rules of the Affordable Care Act, which require appeals to be adjudicated by independent reviewers.

103. Furthermore, the Empire Plan only allows for a 60-day deadline in which to initially appeal denied claims. The Certificate of Insurance states:

> In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 60 days after you receive a notice of denial of the certification or claim . . . .

This restrictive provision violates the Affordable Care Act, which incorporates the Department of Labor ("DOL") ERISA claims rule and allows for at least 180 days for initial appeals.

104. Moreover, whereas the Certificate of Insurance for the Mental Health and Substance Abuse Program provides for only "30 days from the date of your receipt of OptumHealth's written denial notice to request a second level appeal," the Certificate of Insurance for the Basic Medical Program permits a second level appeal "within 60 days after you receive notice of the Level 1 appeal determination." This egregious disparity violates federal

and state parity laws, and in doing so, deprives Empire Plan members with due recourse to properly challenge adverse benefit determinations.

105. Last, although required by the Affordable Care Act to continue to pay for on-going treatment pending final appeals determinations, United fails to do so. In John's case, United immediately curtailed treatment reimbursement when it rendered its initial adverse decision.

MR. DENBO'S MENTAL HEALTH COVERAGE ISSUES

The Relevant Provisions of the CBS Plan

106. Under the CBS plan, which provides health coverage for Mr. Denbo, behavioral health benefits (including mental health and substance abuse) are administered by United. The CBS plan specifies that "Pre-Notification" is required for inpatient services, intensive outpatient program treatment, outpatient electro-convulsive treatment, psychological testing, and "extended outpatient treatment visits beyond 45-50 minutes in duration, with our without medication management." The failure to notify United in advance of such treatment results in a $1,000 penalty adding to any deductibles, copayments, or other coinsurance amounts owed by the subscriber before benefits are due from United.

107. This provision means that standard "outpatient treatment visits" that do not exceed 45-50 minutes in duration do ***not*** require that pre-notification be provided to United.

108. The CBS Plan further provides that for an office visit to a Network Provider for mental health care services, the subscriber is responsible solely for a $25 per office visit copayment, with the remaining charge covered in full. In contrast, a deductible off $400 per person is applied to Non-Network providers (referred to in the CBS plan as an Out-of-Network ("ONET") provider). After the deductible is satisfied, the plan will pay 70% of the reasonable

and customary ("R&C") charge. The subscriber is responsible for "the deductible, the remaining 30% of the Plan's R&C Charge, and any amount in excess of the R&C Charge," as well as "the cost of any treatment that does not meet UBH's criteria for Clinical Necessity."

109. The CBS plan includes the following warning:

> Out-of-Network care will not automatically be deemed Clinically Necessary by UBH standards even if ordered or recommended by a Physician. Out-of-Network claims are subject to a retrospective Clinical Necessity review prior to the reimbursement of claims.

This means that, for Non-Network or ONET services, United is not permitted to conduct concurrent or prospective medical necessity (defined in the CBS plan as "Clinical Necessity" or "Medical Appropriateness") reviews of mental health treatment, but only reserves the right to conduct "retrospective" reviews of such prior to paying benefits.

110. According to the terms of the CBS plan, subscribers or their treating providers are entitled to pursue internal appeals in the event of benefits denials based on lack of necessity of the services at issue. As the plan states:

> If you or your Physician disagrees with UHC's denial of benefits based on lack of Medical Appropriateness, you may request a review of your claim. To appeal a denial of benefits, you or your Physician should contact UHC's Medical Management Department or send a written request to the Medical Management Department within 180 days. Include with your request any additional documentation in support of your review.
>
> UHC's Medical Management Department will review your records and any new information you or your Physician submits in support of your case. If your first level appeal is denied, you may appeal a second time to the Medical Management Department.

111. The CBS plan reiterates that "the Covered Person's first level appeal request must be submitted to the Claims Administrator," in this case, United, "within 180 days after the Covered Person receives the claim denial." It adds that "a qualified person who was not involved in the decision being appeal will be appointed to decide the appeal," and that, if the appeal "is

related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination."

112. If the subscriber or treating physician disagrees with the "Level 1 appeal decision," a "Level 2 appeal" may be pursued by sending a request within 60 days of the initial decision. That second decision will be "final and binding, and no further appeal is available." The CBS plan specifies that decision-making authority on appeals has been delegated to United, as the Claims Administrator, adding that United's decisions "are conclusive and binding."

113. Finally, the CBS plan provides that, upon exhausting the internal appeals, the subscriber "may choose to participate in the external review program," to the extent the adverse benefit determination was based on, among other things, clinical reasons. Alternatively, ERISA provides that once the internal appeal process is completed, the subscriber may sue for relief in court. As described below, Mr. Denbo elected to forego the external review program after having exhausted the administrative appeals of United's adverse benefit determination, and has filed this lawsuit instead.

The Claims Process Applicable to Mr. Denbo

114. Due to various symptoms, Mr. Denbo sought treatment from an ONET provider, Phyllis Urman-Klein, Ph.D., who diagnosed him with, among other things, Dysthymic Disorder and Generalized Anxiety Disorder. She began treating him with weekly psychotherapy sessions and having him evaluated for medication management. Following the untimely death of Mr. Denbo's mother, session frequency at times increased to twice weekly. These services were consistent with generally recognized medical standards for Mr. Denbo's symptoms and conditions. Upon receiving the bills for such treatments, Mr. Denbo submitted claims to United for processing. As stated above, Mr. Denbo had no obligation to pre-notify United of these

services and United had no right to require preauthorization or to prospectively review his claims.

115. On May 9, 2012, a psychologist affiliated with United, Dr. Kelly McPfimeloronti, who identified herself as a "UBH peer reviewer," contacted Dr. Urman-Klein by phone to review Mr. Denbo's out-of-network, routine mental health treatment. Two days later, a phone message was left for Dr. Urman-Klein, informing her that Mr. Denbo's on-going treatment would no longer be reimbursed by United. This decision was confirmed in a letter dated May 18, 2012 from Dr. PcPfimeloronti under the letterhead of UBH's Appeals Department in Philadelphia, Pennsylvania. In the letter, United informed Mr. Denbo of its decision denying further mental health coverage:

> I have reviewed the plan for your outpatient ongoing treatment with Phyllis Urman-Klein, PhD. Based on my review of the available documentation and all information we have received to date, I have determined that the plan does not meet UBH criteria for benefit coverage at this time. Coverage is available for an additional three (3) sessions from 05/11/2012 in order to provide an opportunity for you to terminate treatment should you so desire. After these three (3) sessions, benefit coverage will no longer be available for this service for the following reason(s):
>
> Based upon review of the available information, it appears that there has been an adequate reduction/resolution in clinical symptoms and behaviors that necessitated treatment and that you are generally functioning well. It has been determined that the remaining treatment goals can be self-managed or managed with peer support and/or community resources. Despite marked improved clinical improvement, you continued to be seen twice weekly in outpatient psychotherapy since 2007 without a discharge plan in place. The use of multiple weekly therapy sessions is limited to acute exacerbations of illness or in the context of a clinically urgent situation in order to prevent a higher level of care. As such, it has been determined that the services you are receiving are not consistent with generally accepted national standards of medical practice for the outpatient treatment of Generalized Anxiety Disorder (GAD).

116. After informing Mr. Denbo of the basis for its decision denying further coverage for outpatient mental health office visits, United informed him of his "right to request an appeal review of any decision not to provide you a benefit or pay for an item or service (in whole or in

part)." In this denial, United failed to provide the full disclosures and explanations required for an adverse benefit determination under ERISA.

117. The May 9, 2012 UBH adverse benefit determination represented a prospective denial of coverage, following a concurrent review of Mr. Denbo's ongoing mental health treatment. Such a decision was contrary to the express provisions of the CBS plan, which only allows for ***retrospective*** review of such treatments and not for concurrent or prospective reviews.

The Appeals Process Concerning Mr. Denbo

118. By letter dated May 22, 2012, Mr. Denbo requested an appeal of the coverage denial.

119. By letter dated May 30, 2012 from Krista Olex, Psy.D., identified as a Licensed Psychologist and Neuropsychologist, under the same UBH letterhead from the Appeals Department in Philadelphia, Pennsylvania, United responded with a denial of the appeal:

> Coverage was not available for the service(s) or procedure(s) because UBH determined that it did not meet the criteria for approval. . . .
>
> * * * *
>
> After fully investigating the substance of the appeal, including all aspects of clinical care involved in the treatment episode, I have determined that benefit coverage is not available for the following reason(s):
>
> Notification was given to United Behavioral Health (UBH) for continuing weekly outpatient therapy services with Phyllis Urman Klein, Ph.D. It is my determination the benefit coverage is not available for outpatient therapy sessions beginning 05/11/2012 and forward; therefore, it is my determination that the non-coverage determination regarding outpatient therapy sessions effective 05/11/2012 is upheld. . . . Based on my review of all available information, the services provided do not appear to be consistent with generally accepted standards of practice based upon the Coverage Determination Guideline for Outpatient Treatment of Generalized Anxiety Disorder. Services that are not consistent with UBH Guidelines and with generally accepted standards of practice are not considered covered health services.

120. Although the May 22, 2012 letter was only a denial of Mr. Denbo's Level 1

appeal, United did not offer him the right to pursue a Level 2 appeal, as required by the express terms of the CBS plan. Instead, United asserted in its denial letter that "this is the Final Adverse Determination of your internal appeal," and "all internal appeals through UBH have been exhausted." Rather than offering a further internal appeal, as provided by the CBS plan, United only referenced a right to pursue an independent external review. United further stated:

> When all applicable appeal options have been exhausted, you may have the right to file a civil action under section 502(a) of the Employee Retirement and Income Security Act (ERISA), or any applicable federal or state law.

121. This final statement suggests that a subscriber must pursue an external review prior to pursuing litigation under ERISA, which is false. The external review is optional under the CBS plan and the Affordable Care Act, but is not required before relief may be sought in court. Moreover, ERISA limits the appeal process to no more than two levels. Thus, after a Level 1 and Level 2 appeal are completed, as provided by the CBS plan, litigation may be pursued. United misled Mr. Denbo concerning his rights in its May 22, 2012 denial.

122. Although United did not offer a Level 2 appeal to Mr. Denbo, he nevertheless exercised his rights to pursue a second level appeal under the CBS plan, through Dr. Urman-Klein. Before submitting a Level 2 appeal, Mr. Denbo also requested copies of all underlying plan documents relating to the CBS plan, including "the CBS Health and Welfare Benefits Plan" and contract between CBS and United, as the Claims Administrator. These documents were necessary since the SPD, which was the only document accessible to Mr. Denbo, stated that "should there be a discrepancy between the terms of this booklet and the official plan document, the terms of the plan document shall govern," and that, if there was a conflict between the SPD and "the terms contained in the Company's contract with the applicable Claims Administrator, the terms of the contract will control." Mr. Denbo was never provided a copy of the underlying plan documents, as he had requested on multiple occasions.

123. By letter dated July 27, 2012, Dr. Urman-Klein filed a second-level appeal with United on behalf of Mr. Denbo, claiming that United's denial of benefits should be reversed due to its violations of ERISA, the federal mental health parity law, and the Affordable Care Act. As part of the appeal, Dr. Urman-Klein explained United's violations of the Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act" or "MHPAEA"), 29 U.S.C. § 1185a(a)(3), as follows:

> Because the patient's (medical) health plan, administered by United Healthcare, does not require preauthorization for out-of-network, routine outpatient medical office visits, any preauthorization for out-of-network, routine mental health office visits is an unlawful nonquantitative treatment limitation. UBH's Case File and Dr. McPfimeloronti's May 18, 2012 letter restricting the patient's access to future out-of-network, routine mental health office visits clearly reference "pre-service review" and the "dates of service" for "May 11, 2012 forward."
>
> Furthermore, because substantially all out-of-network, outpatient medical claims are not subjected (in policy or practice) to utilization reviews of any sort by the patient's plan, any utilization reviews of out-of-network, routine outpatient mental health office visits are impermissible nonquantitative treatment limitations under the [Federal Parity] Act.
>
> Even, *arguendo*, if the patient's medical plan subjected substantially all out-of-network, outpatient medical claims to retrospective ("post-service") medical necessity reviews, the May 9, 2012 peer review by UBH would still amount to an unlawful, asymmetric, non-quantitative treatment limitation in that it subjected Jonathan Denbo to a concurrent review for out-of-network, routine outpatient mental healthcare. While the CBS Medical Plan allows for concurrent utilization reviews of inpatient (facility-based) care, the use of concurrent review for out-of-network, routine outpatient mental health office visits creates unlawful deterrence and violates the Act.
>
> Moreover, not only did UBH's May 9, 2012 peer review violate the Act's prohibition against asymmetric, non-quantitative treatment limitations, UBH's utilization review procedures also violate the Act's prohibition against quantitative treatment limitations. The UBH Case File provided to Jonathan Denbo is replete with references to quantitative treatment limitations such as: "Alert claims information indicates utilization review needed for 12 or more visits within the last 6 weeks" and "[i]t has again triggered for FOV review as PROV continues to see MBR twice weekly." Because the UBH-administered portion of the health plan does not have numeric benefit caps triggering concurrent utilization reviews for out-of-network, routine outpatient medical/surgical office visits, the UBH-administered policy fails to withstand the federal litmus test for

parity.

> Given that out-of-network, routine outpatient medical office visits are not subject to preauthorization pursuant to the CBS Medical Plan and at most could be subject to (unapplied) retrospective reviews, it stands that out-of-network medical providers of routine, outpatient services are exclusively charged in good faith with the task of ascertaining medical necessity pursuant to any (currently unknown) medical guidelines (presumably but no means conclusively) proffered by the plan. Application of the Act necessitates the same with respect to Jonathan Denbo's out-of-network, routine outpatient mental health benefits.

124. In addition to asserting violations of the Federal Parity Act, the appeal letter further argued to United that it had breached the contractual obligations of the CBS plan (in violation of ERISA) by imposing concurrent and prospective reviews on Mr. Denbo's outpatient mental health treatment. In addition, the appeal letter stated that United failed to provide a full and fair review of its denial of benefits by failing to offer Mr. Denbo a second level appeal, in violation of the Affordable Care Act and ERISA.

125. Aside from challenging the procedural aspects of United's appeal, the appeal also challenged the substance of United's determination that the mental health services rendered by Dr. Urman-Klein were not medically necessary. First, the letter explained that United had misrepresented and misapplied generally accepted standards of care applicable to Mr. Denbo's conditions:

> Given that clear and compelling scientific evidence published in the *Harvard Review of Psychiatry*, *JAMA*, and *JAPA* has established enduring, frequent psychodynamic psychotherapy as the **superior, first-line** standard of care for the patient's particular conditions, it is unconscionable for UBH to expect patients with mental illness not to access clinically recognized modalities, including frequent outpatient psychotherapy, to treat debilitating conditions that Congress has recognized as worthy of codified parity protections. Though sustained treatment may be more costly to the plan, please note that "fail first policies" or "step-therapy protocols" designed to restrict access to psychodynamic psychotherapy are unlawful non-quantitative limitations under the Act.
>
> Moreover, the UBH 2012 Level of Care Guidelines in no way suggest that "the use of multiple weekly therapy sessions is limited to acute exacerbations of illness or in the context of a clinically urgent situation in order to prevent a higher level

> of care." Such a misrepresentation of standards by the reviewers is part of UBH's systematic effort to deprive patients of access to routine, outpatient mental health care.

126. In addition to United's application of improper clinical standards as a basis for its denial of benefits, the appeal letter also noted that United's denial letters had limited their analysis solely to Generalized Anxiety Disorder, ignoring "the patient's comorbid mood disorder." As Dr. Urman-Klein's letter states, "this glaring omission conveniently minimizes the complexity of the patient's psychiatric profile and bypasses acknowledgment of biweekly psychodynamic psychotherapy as the preferred treatment modality in multifaceted cases."

127. In the appeal letter, Dr. Urman-Klein provided a detailed analysis of Mr. Denbo's symptoms and conditions, detailing the medical necessity of ongoing outpatient psychotherapy pursuant to generally accepted standards of care. In doing so, Dr. Urman-Klein described United's denials as having utterly distorted the facts communicated by her, including omitting evidence that "the patient's symptoms have fluctuated in severity over time, and despite periods of improvement, the patient's symptoms are chronic and cyclical," thereby requiring ongoing treatment.

128. After detailing Mr. Denbo's condition, Dr. Urman-Klein presented the following conclusion:

> Given that the patient's chronic Axis 1 conditions cannot be treated with medications alone, are prone to relapse and invariably affect each other, on-going psychotherapy at a rate of twice (2) 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.
>
> * * * *
>
> 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 a treatment of choice for comorbid mood and anxiety disorders and required to prevent acute deterioration or exacerbation of symptoms.

129. In this action, Plaintiffs incorporate by reference all of the allegations and claims asserted by Dr. Urman-Klein in her appeal letter, as they appropriately identify United's pattern of misconduct and the invalid bases for its denial of benefits.

130. United refused to consider Dr. Urman-Klein's detailed and well-analyzed appeal letter submitted on behalf of Mr. Denbo. Instead, United sent a letter to Mr. Denbo dated August 1, 2012, from UBH "Clinical Appeals Specialist" DaWanda R. Watson:

> On 07/30/2012 United Behavioral Health received a request for a second appeal review. According to our records an initial review was completed on 05/11/2012 by Kelly McPfimeloronti, PhD and a Non-Urgent Appeal was completed on 05/30/21-2 by Dr. Krista Olex, PhD. A determination letter was mailed on 05/31/2012 with final internal appeal rights. Therefore, no additional reviews are available through UBH. All internal appeals through UBH have been exhausted.

131. In response, Dr. Urman-Klein faxed a letter to UBH on behalf of Mr. Denbo, dated August 10, 2012, reiterating Mr. Denbo's right to a Level 2 appeal under the CBS plan:

> Please take note that UBH Appeal Specialist DeWanda Watson's August 1, 2012 letter to the patient improperly denied him a Level 2 Appeal.
>
> To date, the patient has only had the benefit of a Level 1 Appeal by Dr. Krista Olex. Dr. McPfimeloronti's May 11, 2012 involvement in this case was a UBH-initiated peer review – not an appeal.
>
> Accordingly, we must insist on UBH allowing the patient to exhaust his appeals. If we do not receive a Level 2 Appeal decision from UBH within thirty (30) days of July 30, 2012, we will deem a non-response as a continued denial and an exhaustion of Jonathan Denbo's internal administrative remedies.
>
> The July 27, 2012 Level 2 Appeal is re-attached for consideration.

132. As of the date of filing of the Class Action Complaint ("Complaint"), United has never responded to the August 10, 2012 letter, nor has it provided a substantive response to Dr. Urman-Klein's detailed July 27, 2012 Level 2 Appeal letter. Instead, United has implemented its

prospective denial of care by denying coverage for ongoing mental health claims submitted by Mr. Denbo. This is reflected in a January 25, 2013 EOB sent to Mr. Denbo from United's Greensboro Service Center in Atlanta, Georgia, which denied all of his claims for mental health services. To explain the denial, United used Remark Code "S8," which states: "Your plan provides benefits for services that are determined to be covered health services. The information received does not support measurable progress toward defined treatment goals for these services. Therefore, additional benefits are not available." The decision leaves Mr. Denbo responsible for the entire $1,500 statement.

133. The EOB further states: "You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed." Because United's decision was based solely on its previously issued prospective denial of benefits, for which Mr. Denbo had exhausted his appeals, no further reviews are needed here. Mr. Denbo is therefore entitled to assert his ERISA claims. Alternatively, further appeals would be futile, given: (1) the decision United has already reached; (2) United's failure to comply with the terms of the CBS plan; (3) United's refusal to offer a full and fair review process as required by ERISA and the Affordable Care Act; and (4) United's violations of the Federal Parity Act. Any potential appeals of United's benefit denials should therefore be "deemed exhausted" under ERISA.

134. United's practice of contacting Mr. Denbo's treating provider for a concurrent review of his care, and its subsequent decision to deny further authorization of coverage, was improper under the CBS plan, which only permits retrospective review of submitted claims for outpatient mental health care services. Moreover, for the reasons detailed in the undisputed appeal letter, and due to the improper reduction in reimbursement rates prior to the outright denial of benefits, United has violated the Federal Parity Act, the Affordable Care Act and

ERISA.

135. In addition to denying benefits improperly based on a prospective review that was not permitted by the CBS plan and the Federal Parity Act, United also altered the terms of health services reimbursement under the CBS plan, in violation of ERISA.

136. The SPD, the only plan document provided to Mr. Denbo despite repeated requests for the official plan documents and contract with United, states:

> Out-of-Network benefit reimbursement is based on the Plan's Reasonable and Customary ("R&C") Charge for the service and not on a discounted Allowance amount since UHC cannot negotiate discounts with Out-of-Network Providers.

Yet as of the beginning of 2013, United changed its payment for out-of-network providers from "reasonable and customary" charges to the "Maximum Non-Network Reimbursement Program" ("MNRP"). According to a CBS brochure, United will now "base reimbursement for out-of-network care on the MNRP amount, which is set at 140% of the Medicare allowable charge." Moreover, based on information and belief, United actually reimburses mental health care services at levels below the amount it pays for comparable medical services rendered by non-mental health providers. Thus, not only is United violating ERISA by paying less than the amount required by the CBS plan, but it is also violating the Federal Parity Act by using a compensation schedule for mental health services that is not on par with the schedule used to reimburse medical/surgical procedures rendered by non-mental health providers.

MR. SMITH'S MENTAL HEALTH COVERAGE ISSUES

The Mental Health Needs of Mr. Smith's Son

137. William Smith's childhood has been fraught with academic struggles and progressively intensifying emotional disturbances. His family history is positive for ADHD and Bipolar Disorder. When William was twelve, his parents divorced, and familial dynamics have

not been harmonious. Over the years, William has received special education services and has been placed in increasingly restrictive educational settings. Because his family resides on a small island off the Washington coast, his parents have had to transport him vast distances by ferries and seaplanes to obtain outpatient mental health treatment for him.

138. William's case is well known to United. William's psychiatrist since 2005, Dr. Norman Hale, has been required by United to seek out-of-network, outpatient treatment precertifications on William's behalf for many years. At a certain point, Dr. Hale requested a single-case agreement with United given the lack of available (in- and out-of-network) mental health resources in William's community.

139. To obtain second opinions and more intensive outpatient services, William's parents have contacted United on many occasions, only to be informed there were no in-network providers within 100 miles of their home.

140. In November 2007, at age 11, Children's Hospital and Regional Medical Center, some four hours from William's home, called United to precertify an involuntary psychiatric admission after William threatened to kill his mother and a psychiatric interviewer. United informed hospital staff that an out-of-network accommodation would be sought due to the lack of in-network facilities. Unfortunately, reimbursement of William's involuntary hospitalization was subsequently denied by United for lack of authorization due to United's failure to properly enter treatment certification into its systems.

141. Following William's hospital discharge in 2007, he was seen by an outpatient psychotherapist, Barbara Starr, LCSW, for a number of years. As with Dr. Hale, United agreed to a single-case accommodation for Ms. Starr due to the lack of in-network, mental health providers in William's community.

142. Unfortunately, by incorrectly logging Ms. Starr's business address and therefore not sending her Outpatient Treatment Report forms to precertify William's on-going visits, United delayed payments and written communications to Ms. Starr about the need for additional precertifications of his treatment. This delayed reimbursements for William and repeatedly resulted in gaps in coverage. Despite many attempts by Ms. Starr to address payment concerns with United, they remained unresolved for years.

143. By June 2011, Ms. Starr reported to United that William had periods of severe depression with suicidal ideations and was very impulsive and labile. She again expressed willingness "to do whatever Optum require[d]" but repeated she was not receiving any mail from United. Upon further research, United determined that Ms. Starr's address was still incorrectly listed in their systems.

144. In December 2011, Dr. Hale requested continued authorizations to treat William for ADHD, Generalized Anxiety Disorder, and Obsessive Compulsive Disorder. He reported William's then current GAF score as 50, representative of "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)."

145. By January 2012, Mr. Smith requested referrals from United for residential treatment, pursuant to Dr. Hale's urging. Mr. Smith reported that the family could not control William, that William could not control himself, and that William had not attended school for a semester.

146. In February 2012, William assaulted Ms. Starr during a psychotherapy session and was subsequently terminated from her care with misdemeanor charges pending.

147. Subsequently, Dr. Hale contacted United to request residential treatment center

referrals for William. William's mother also explained to United that referrals to residential treatment were meaningless in Washington, where William, an adolescent, could voluntarily refuse inpatient treatment. She inquired about referrals to facilities in Idaho or Montana.

148. On March 6, 2012, William was involuntarily admitted to Eastern Idaho Regional Medical Center, where he remained until March 20, 2012. During his psychiatric hospitalization, he was diagnosed by Dr. Susan Bunnell, Board Certified in Child and Adolescent Psychiatry, with Major Depressive Disorder, Type II Diabetes, morbid obesity, and recent self-harm by pick lesions. United's records also reflect that William exhibited "[g]lobal lack of functioning, mbr unable to complete intake admission due to sobbing in his room and not wanting to come out." Eastern Idaho Regional Medical Center treatment staff unequivocally urged on-going residential treatment for William following his psychiatric hospital discharge. This was explicitly noted in a March 15, 2012 psychological assessment conducted by John E. Landers, Ph.D. during William's hospitalization:

> It would appear that he is not manageable in the home environment . . . The patient has a history of failure to attend school and only do[es] so under very rich environmental reinforcers for minimal compliance. Additionally, he has failed to comply with basic rules at home, preferring to spend his time binging on food, playing video games, and sleeping rather than engage in more goal-directed long-term oriented behaviors . . . Additionally, he is judged to be gravely disabled due to lack of insight and his history of binge eating with unmanaged developing diabetes . . . his poor insight indicates that his perceptions may in fact be quite distorted from reality . . . He does have a significant history of acting out and no apparent ability to conceptualize his role in past difficulties nor his role in alleviating future conflict in the home . . .
>
> It is the opinion of this writer that the patient would be most likely to benefit from a residential psychiatric treatment program that can address the behavioral, psychiatric, and academic symptoms at once. He will be unlikely to benefit from outpatient individual therapy or psychosocial rehabilitation, as these have not been successful in the past, and they lack the complete environmental control that would be afforded to a residential program.

149. On March 16, 2012, United's reviewer, Sally Kroner, M.D., noted the following:

> [William] won't participate in outpt treatment at all because he won't go. He is improved but the AP thinks he needs a longer term more structured approach. They would like him to go to RTC and then step down . . . They don't have services available in their community--they live on an island and have to be transported to care via seaplane . . . I discussed with the AP that I do think he meets RTC LOC.

150. On March 20, 2012, William's mother transported him to a residential treatment center for struggling adolescents in Utah. Upon admission, William's GAF score was assessed as 25, reflective of: "Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR Inability to function in almost all areas (e.g., stays in bed all day, no job, home or friends)."

151. Despite the above, on March 30, 2012, United terminated William's coverage for residential treatment, concluding he can receive outpatient treatment in his community. William has remained in residential treatment since his admission at great financial expense to his family.

The Relevant Provisions of the SYSCO Plan

152. The SYSCO Corporation Group Benefit Plan was last amended and restated effective as of January 1, 2005. Under the plan terms, "'Plan' means the SYSCO Corporation Group Benefit Plan, as set forth herein together with the insurance policy(ies) providing any insured benefits under the Plan and the SPDs." The Plan adds: "'SPD' means each summary plan description for the benefits available under the Plan as designated by the Company from time to time and as communicated to Employees which are hereby incorporated by reference. If there is a conflict between the terms of an SPD and the terms in the Plan document, the terms of the Plan document will control." There are three SPD documents issued by the Plan, the SYSCO Healthcare Program Summary of Benefits, the SYSCO Administrative Information Summary of

Benefits, and an annually updated Group Benefits Summary. There are also administrative services agreements between SYSCO and the Claims Administrators, BCBSIL (for medical/surgical benefits) and United (through UBH, for mental health and substance abuse services).

153. The self-funded SYSCO plan provides for comprehensive medical/surgical as well as mental health and substance abuse benefits. The United Behavioral Health Administrative Services Agreement with SYSCO includes a Case Management Services Product Schedule that calls for "[s]ervices, supplies and/or accommodations provided by a Provider for diagnostic or therapeutic purposes in the treatment of a Behavioral Disorder or Substance Abuse." The Case Management Services Product Schedule defines "Behavioral Disorder" as a "pathological state of mind producing clinically significant psychological (including but not limited to, affective, cognitive, and behavioral) or physiological symptoms (illness) together with impairment in one or more major areas of functioning (disability)."

154. Benefits under the SYSCO plan are payable upon submission of claims to and approval by the relevant Claims Administrators. The SYSCO plan confers full responsibility for the final review of urgent and concurrent care claims to the respective Claims Administrators, and reserves full responsibility for all other types of claims for SYSCO, the Plan Administrator.

155. The SYSCO Healthcare Program Summary of Benefits requires precertification of confinement in a hospital, convalescent, extended care or hospice facility, as well as home health care and private duty nursing services by the Claims Administrators. Routine medical/surgical services as well as chiropractic care and speech therapy do not require precertification, which is contrary to the following restrictions on mental health coverage: "All mental health and/or substance abuse treatment must be approved . . . Any expenses for services

or materials that have not been precertified will not be covered."

156. According to the SYSCO Administrative Information Summary of Benefits, "there is only one level of appeal for an adverse benefit determination of an urgent care or concurrent care claim." These appeals are fully adjudicated by the Claims Administrators. An urgent care claim is defined by the SYSCO Healthcare Program Summary of Benefits as:

> any pre-service claim or concurrent care decision (described below) that must be reviewed quickly in order to avoid jeopardizing your life, health, or ability to regain maximum function or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim . . . The Medical Plans allow a health care professional with knowledge of your medical condition to act as your authorized representative in claims involving urgent care.

157. A concurrent care claim is defined by the SYSCO Healthcare Program Summary of Benefits as:

> A concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment that is to be provided over a period of time or for a specified number of treatments (a "course of treatment"). A concurrent care claim may be reconsidered after an initial approval is made and results in a reduced or terminated benefit.

The Plan adds: "You will be notified of a decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow you to appeal this adverse decision before the benefit is reduced or terminated."

158. According to the SYSCO Administrative Information Summary of Benefits, all other claims than those for urgent and concurrent care provide for one mandatory level of appeal to the Claims Administrator and one voluntary level of appeal to the SYSCO Appeals Committee. The Plan then provides:

> This [second] level of appeal is voluntary, and you are not required to undertake it before pursuing legal action. If you choose not to file for a voluntary review but you have exhausted the required appeals process, the plan will not assert you have failed to exhaust your administrative remedies.

Medical Necessity Under the SYSCO Plan

159. The SYSCO plan does not define "medical necessity," but conditions coverage for all services on medical necessity as determined by the respective Claims Administrators.

160. BCBSIL does not publicly post a definition of medical necessity, but is bound by a January 21, 2009 settlement agreement in *Love et al. v. Blue Cross Blue Shield Association, et al.* to employ the following:

> "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

161. United, like BCBSIL, does not publicly post a definition of medical necessity for self-funded plans that do not contain their own definitions, but in a 2000 consent agreement with the Maine Bureau of Insurance, United unveiled the following definition:

> Medical Necessity—health care services and supplies that are determined by the Plan to be medically appropriate, and (1) necessary to meet the basic health needs of the covered person; (2) rendered in the type of setting appropriate for the delivery of the health service; (3) consistent in type, frequency, and duration of treatment with United Behavioral Health guidelines; (4) consistent with the diagnosis of the condition; (5) required for reasons other than the comfort or convenience of the covered person or his or her physician; and (6) of demonstrated medical value.

162. United's definition of medical necessity, therefore, confers upon it far greater

discretion to deny care than the corresponding BCBIL definition of medical necessity. This is because United's definition allows it to review mental health claims pursuant to its own, internally-developed guidelines, whereas BCBIL must review medical/surgical claims pursuant to "generally accepted standards of medical practice" that are "based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors." Thus, BCBIL claimants are accorded far greater latitude to rely on clinical standards of care deferential to their medical/surgical conditions.

163. For example, United's Level of Care guidelines for Residential Treatment Center: Mental Health Conditions, which were used to deny William's care after only nine days of residential treatment, contain the following criteria:

> 1. The member's psychosocial functioning has deteriorated to the degree that the member is at risk for being unable to safely and adequately care for themselves in the community.
>
> 2. The member is experiencing a disturbance in mood, affect or cognition resulting in behavior that cannot be safely managed in a less restrictive setting. (This criterion is not intended for use solely as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)
>
> 3. There is an imminent risk of deterioration in the member's functioning due to the presence of severe, multiple and complex psychosocial stressors that are significant enough to undermine treatment at a lower level of care. (This criterion is not intended for use as a long-term solution to maintain stabilization acquired during treatment in a residential facility/program.)
>
> 4. A lower level of care in which a member may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for Residential Treatment are unavailable, insufficient or inadequate.

164. These criteria not only empower United's clinical reviewers to routinely require

its members and their beneficiaries to first fail treatment at lower levels of care, thereby compromising their safety, stability, and morale, but they also empower United's clinical reviewers to deny treatment in contravention of "generally accepted standards of medical practice" that are "based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors."

165. Examples of prevailing, accepted standards of medical practice are guidelines promulgated by the American Psychiatric Association ("APA"), American Academy of Child & Adolescent Psychiatry ("AACAP"), and American Association of Community Psychiatrists ("AACP").

166. AACAP's Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers unequivocally indicate: ***"The best intervention for serious mental health issues that cannot be treated in the child's home environment is a facility that has a multidisciplinary treatment team providing safe, evidence-based care that is medically monitored"*** (2010, p. 2).

167. Furthermore, the Child and Adolescent Level of Care Utilization System (CALOCUS, version 1.5), developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association of Community Psychiatrists (AACP), raises its recommendation for residential treatment with corresponding levels of treatment-obstruction/resistance by adolescent patients.

The Claims Process Applicable to Mr. Smith's Son

168. Within just nine days of his admission to residential treatment, which by

definition is intended to offer longer-term rehabilitation than psychiatric hospitalization, United Medical Director, Dr. Nelson Gruber, determined "the member's condition does not meet United Behavioral Health Level of Care Guidelines for the Mental Health Residential Treatment." Although United's own records are replete with references to inadequate outpatient (or inpatient) resources within William's community, and although Dr. Gruber noted William's current GAF remained at 25, and although United's own records revealed William's GAF had been 50 in December of 2011, Dr. Gruber logged in his notes, "The member is near / at his baseline with no expectation of further improvements in the shorter term . . . The member can reside in a safe, structured, supervised setting if return home at this time is not pursued." A letter to this effect was generated by Dr. Gruber from United to William's parents on April 2, 2012:

> United Behavioral Health (USH) is responsible for making benefit coverage determinations for mental health and substance abuse services that are provided to UBH members. The availability of benefit coverage for a service is determined by the terms of your benefit plan. To review information about your specific plan coverage, please refer to the benefit information provided by your employer group.
>
> I have reviewed the plan for your child's ongoing treatment . . . Based on my review of the available documentation and all information we have received to date, I have determined that coverage is not available under your benefit plan for the following reason(s):
>
> Issue an Adverse Benefit Determination from 3/29/12 forward, and recommending the Mental Health Outpatient Level of Care, which is locally available and a covered benefit. The Attending Physician was notified of the Adverse Benefit Determination and Appeal options. The member's condition does not meet United Behavioral Health Level of Care Guidelines for the Mental Health Residential Treatment Level of Care as evidenced by the following: The member is generally cooperative, compliant, and participating in treatment; his behavioral health condition is improving and stabilizing. Admitting symptoms of severe depression, self injurious behavior, physical assaultiveness, and noncooperation are all improving. The member has no suicidal or homicidal ideations, no threatening - aggressive -destructive ideations or behaviors, no self injurious Ideations or behaviors, and no psychosis. There is no report of the member presenting major behavioral management challenges at this time. He is physically stable. He is functional. Medications have recently been adjusted and

are tolerated and appear helpful. Given this stabilization, there is limited risk of regression requiring inpatient care. The member is near / at his baseline with no expectation of further improvements in the shorter term. The member's mother is supportive and involved his care. There is no longer a clinical need for the 24-hour structure, supervision, and active treatment of the Residential Treatment setting. Active treatment could be safely and effectively delivered at a lower level of care. The member can reside in a safe, structured, supervised setting if return home at this time is not pursued.

The following United Behavioral Health Level of Care Guidelines for the Mental Health Residential Treatment Level of Care was considered:

1. The member's psychosocial functioning has deteriorated to the degree that the member is at risk for being unable to safely and adequately care for themselves in the community.

2. The member is experiencing a disturbance in mood, affect or cognition resulting in behavior that cannot be safely managed in a less restrictive setting. (This criterion is not intended for use solely as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)

3. There is an imminent risk of deterioration in the member's functioning due to the presence of severe, multiple and complex psychosocial stressors that are significant enough to undermine treatment at a lower level of care. (This criterion is not intended for use as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)

4. A lower level of care in which a member may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for Residential Treatment are unavailable, insufficient or inadequate.

This determination does not mean that your child does not require additional health care, or that your child needs to be discharged. Decisions about continuation of treatment should be made by you and your child's provider. The purpose of this letter is to inform you that based on my review of the available information it has been determined that benefit coverage is not available for your child's ongoing treatment . . .

169. In violation of the Federal Parity Act, ERISA, and the ACA, the letter omitted a crucial component of United's Level of Care Guidelines for Mental Health Residential Treatment by failing to disclose that only ***one*** of the four criteria enumerated above must be met

for residential coverage to apply.

170. Furthermore, not a single "supervised setting" or outpatient treatment resource was identified by Dr. Gruber in his April 2, 2012 denial letter to William's parents.

171. William's attending physician promptly requested an urgent, concurrent care appeal, which was decided on April 2, 2012 by United Medical Director, Edwards U. McReynolds, M.D. In upholding its initial denial on the same grounds, United responded with the following letter to William's parents:

> United Behavioral Health (UBH) is responsible for making benefit coverage determinations for menial health and substance abuse services that are provided to UBH members. The availability of benefit coverage for a service is determined by the terms of your benefit plan. To review information about your specific plan coverage, please refer to the benefit information provided by your employer group.
>
> Coverage was not available for the service(s) or procedure(s) because UBH determined that it did not meet the criteria for approval.
>
> As requested, I have completed an urgent appeal review on 4/2/2012 on a request we received on 3/30/2012. This review involved a telephone conversation with your child's provider. After fully investigating the substance of the appeal, including all aspects of clinical care involved in this treatment episode, I have determined that benefit coverage is not available for the following reason(s):
>
> I am upholding the Adverse Benefit Determination from 3/29/12 forward, and recommending the Mental Health Outpatient Level of Care, which is locally available and a covered benefit, while residing in an alternative living situation, such as a group home or other placement , if a return to the home environment is not deemed clinically appropriate at this time. The member's condition does not meet United Behavioral Health Level of Care Guidelines for the Mental Health Residential Treatment Level of Care as evidenced by the following:
>
> The member is no longer manifesting symptoms of severe depression, self-injurious behaviors or physical assaultiveness that were the symptoms that lead to his admission. The member is generally cooperative and following the daily routine. The member is not at high risk for a regression that would require an inpatient hospitalization. There appears to no longer be a need for the structure and intensity of service found in a 24 residential level of care. The member appears to need a placement outside the home that could provide the necessary the core structure if a return to the home is not deemed clinically appropriate at this

time.

The following United Behavioral Health Level of Care Guidelines for the Mental Health Residential Treatment Level of Care was considered:

1. The member's psychosocial functioning has deteriorated to the degree that the member is at risk for being unable to safely and adequately care for themselves in the community.

2. The member is experiencing a disturbance in mood, affect or cognition resulting in behavior that cannot be safely managed in a less restrictive setting. (This criterion is not intended for use solely as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)

3. There is an imminent risk of deterioration in the member's functioning due to the presence of severe, multiple and complex psychosocial stressors that are significant enough to undermine treatment at a lower level of care. (This criterion is not intended for use as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)

4. A lower level of care in which a member may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for Residential Treatment are unavailable, insufficient or inadequate.

This determination does not mean that your child does not require additional health care, or that your child needs to be discharged. Decisions about continuation of treatment should be made by you and your child's provider. The purpose of this letter is to inform you that based on my review of the available information it has been determined that benefit coverage is not available for your child's treatment . . .

Under federal law, you have a right to request the diagnosis and diagnosis code provided to us by your provider. Alternately, you may request this information from your provider.

Contact UBH if you need the diagnosis and/or treatment code information regarding the services referenced in this communication.

This is the Final Adverse Determination of your internal appeal. All internal appeals through UBH have been exhausted.

172. In violation of the Federal Parity Act, ERISA, and the ACA, this letter also omitted a crucial component of United's Level of Care Guidelines for Mental Health Residential

Treatment by failing to disclose that only ***one*** of the four criteria enumerated above must be met for residential coverage to apply.

173. The April 2, 2012 United Final Adverse Determination letter again failed to identify a single "supervised setting" or outpatient treatment resource for William.

174. To date, United has not reimbursed William's family for the residential treatment William received pending the final disposition of his appeal. This failure to cover such treatment is a violation of federal law, as detailed herein.

NYSPA'S MENTAL HEALTH INSURANCE ISSUES

175. NYSPA's members include many psychiatrists who have been confronted with United's improper and overly restrictive policies applied to deny or reduce coverage for mental health care, in violation of federal and state parity and related laws. On behalf of these members, and their patients, NYSPA brings this action to enjoin United's illegal conduct.

176. On February 14, 2012, after having received complaints from members and engaging in a series of email correspondence with United, NYSPA wrote United (through OptumHealth) concerning violations of the Federal Parity Act, specifically, that United, through the Empire Plan, continued to require "submission of outpatient treatment reports (OTRs) in connection with ongoing treatment of mental illness." While United had asserted that the requirements imposed on mental health care services were comparable to what it required for other medical/surgical services "'which involve on-going treatment with regular frequency, such as physical therapy,'" NYPSA argued that United's policies nonetheless violated the federal parity law.

177. In rejecting United's theory, NYSPA explained that subjecting ***all*** mental health services to concurrent reviews and OTRs cannot be compared with subjecting a *de minimis*

portion of medical/surgical benefits to such reviews by United. This is particularly so, given that "physical therapy is not a physician service and cannot properly be characterized as 'comparable to' behavioral health services provided by a psychiatric physician." By imposing nonquantitative treatment limitations ("NQTLs") on mental health services far in excess of those imposed on medical/surgical treatments, United's policies violate the Federal Parity Act. United did not respond to NYSPA's letter or change its policies and practices. NYSPA has since received additional complaints about United delaying preauthorizations for treatments in progress that require continued approvals, thereby leading to gaps in coverage.

178. In an August 8, 2012 letter, NYSPA wrote United again with regard to other policies it had applied in violation of the parity laws. First, NYSPA challenged United's policy rejecting two outpatient therapy sessions per week, even for severe mental illness, as expressed in the following statement in a denial letter issued by United:

> There is no clear and compelling evidence, nor any prevailing national standards of clinical practice, that indicate that continued treatment at the frequency of two (2) times a week is required to prevent acute deterioration or exacerbation that would then require a higher level of care of your symptoms and contradictions.

179. NYSPA properly argued that United's policy was based on a flawed interpretation of "prevailing national standards," citing to the American Psychiatric Association's Practice Guidelines for the Treatment of Patients with Major Depressive Disorders ("APA Practice Guideline") as the only national standard known to it for MDD. The APA Practice Guidelines identified "depression-focused psychotherapy" as the treatment of choice, concluding that it was "Recommended with Substantial Clinical Confidence" based on the "best evidence available." They further found that, "for many patients, particularly for those with chronic and recurrent major depressive disorder or co-occurring medical and/or psychiatric disorders, some form of maintenance treatment will be required indefinitely." At the same time, according to NYSPA,

there was no basis for United's rejection of two sessions per week as it was without support:

> The Practice Guideline makes no mention of any recommended minimum or maximum frequency of visits necessary to achieve established treatment goals. Rather, frequency of treatment must be based on an individual assessment of the acuity and severity of the patient's symptoms and the specific factors and circumstances present. . . . There is no clinical basis whatsoever in UBH's assertion that one visit per week is sufficient to prevent acute deterioration or exacerbation of symptoms. It seems clear that UBH's determination to cover only one visit per week is based solely on cost considerations rather than long term patient care goals.

180. To date, NYSPA has received numerous member complaints about United's restrictions on psychotherapy. NYSPA members have reported United fully curtailing psychotherapy for patients requiring long-term treatment, allowing no more than weekly psychotherapy for patients who have attempted suicide and have been hospitalized (in one case, a patient attempted suicide five times and was hospitalized 10 times), and refusing to cover more than one weekly psychotherapy session for actively suicidal patients.

181. NYSPA members have also complained about United's plan members having extreme difficulty obtaining initial and continued authorizations for intermediate levels of care, such as intensive outpatient treatment and partial hospitalization services for mental health and substance use disorders.

182. Another issue raised by NYSPA with United is a pattern of denying coverage for out-of-network mental health services, due to purported failures by providers to respond to requests for back-up clinical information when, in fact, such inquiries are never made:

> This is not an isolated incident. Other NYSPA members have reported similar situations with an identical fact pattern. In each of the cases, UBH or OptumHealth asserts either in writing or over the telephone that it has repeatedly contacted either the beneficiary or the provider to obtain additional information regarding out-of-network claims, yet none of the parties report receiving any such requests for information. As a result of the alleged failure to respond to information requests, the patient's out-of-network claims are then denied. Several patients have even received very troubling warnings that their psychiatrist's failure to respond to these "phantom" requests for information will result in

suspension or termination of all of their out-of-network mental health benefits.

> . . . The UBH and OptumHealth actions described above are clearly creating significant obstacles to access to mental health care and treatment and are having a chilling effect on the submission of legitimate claims for out-of-network mental health benefits.

183. This practice represents a further example of an effort by United to disrupt and discourage mental health care and treatment, in this case by out-of-network providers, in violation of the parity and unlawful business practice laws as well as ERISA.

184. Another issue with which NYSPA had been involved, as a result of member complaints, is United's refusal to pay for CPT evaluation and management ("E/M") claims submitted by psychiatrists, in violation of the parity laws. As NYSPA reported in a January 9, 2013 letter to the New York State Department of Financial Services, United "has been regularly denying coverage for E/M claims submitted by psychiatrists for the treatment of mental illness." Sometimes E/M claims have been rejected using the denial code "96 – not covered service," while frequently United uses an invalid excuse for the denial:

> UBH reviewers also regularly disallow E/M claims on the basis that documentation fails to include the required elements necessary to support the E/M code billed, i.e., two of three key components: history, examination and medical decision making. Yet, in every case, the claims were documented using time as the determining factor where counseling and/or coordination represent more than 50% of time spent face-to-face with the patient. This alternative method is set forth explicitly in both CPT and the American Medical Association 1997 Documentation Guidelines for Evaluation and Management Services. . . . Regardless of these policies, UBH continues to disallow E/M claims submitted by psychiatrists where counseling and/or coordination of care represents at least 50% of face-to-face time. . . . Despite adequate documentation that meets all the requirements of CPT and the Documentation Guidelines, these claims continue to be denied.

185. The failure to authorize coverage for E/M services rendered by psychiatrists, when such services are covered for surgical/medical care rendered by non-psychiatrists, is a violation of the Federal Parity Act and New York Parity Law. In addition, since there is no basis

under United's health care plans to deny such coverage, United's policy also violates ERISA.

186. NYSPA has also received complaints from members over reduced reimbursement rates. Members have complained that when United does choose to reimburse E/M claims, for Current Procedural Terminology ("CPT") code 99213, rates have dropped from $60 in 2012 to $51.25 in 2013. Furthermore, members have complained that combination CPT codes that include medical evaluation and management, along with psychotherapy, have been reduced well below Medicare benchmarks, and in some instances, below what was paid for the predecessor codes (90805 and 90807), while Medicare has actually increased its payment levels for such services. Since many United plans tie reimbursement levels, particularly for out-of-network services, to Medicare (as is now true for the CBS plan), it appears that United is using more stringent reimbursement practices for mental health benefits than for medical/surgical benefits. This, too, violates the parity laws and ERISA.

187. NYSPA has also recently received member complaints about UMR, a division of United, charging double co-pays for the combination CPT codes introduced by the American Medical Association in 2013.

188. Finally, United frequently delays payments of clean claims beyond the time required by the Master Agreement with the State of New York and by the New York State prompt pay law. Members have complained to NYSPA regarding such delayed payments, with one member reporting that interest was not paid on claims processed a full year following their initial submission. Another member complained about submitting over 100 clean claims for January 2013 and still not receiving payments.

189. Because any disallowed E/M codes should have been reimbursed when initially submitted, United's failure to do so similarly violates the prompt pay requirements.

190. Through this action, NYSPA seeks injunctive relief on behalf of its members and their patients to address these numerous violations of federal and state law. NYSPA seeks judicial intervention to compel United to alter its practices to comply with legal requirements as detailed herein.

VIOLATION OF THE FEDERAL PARITY ACT

191. The Federal Parity Act requires health care plans issued by employers with more than 50 employees, including the Empire Plan, CBS and SYSCO, that choose to provide mental health and substance abuse benefits, to cover them, as written and applied, in parity with medical/surgical benefits offered within the same classifications. The Federal Parity Act allows for only six types of benefit classifications: in-network, inpatient; in-network, outpatient; out-of-network, inpatient, out-of-network, outpatient; emergency care; and prescription drugs. The Federal Parity Act specifies that "all medical care benefits provided by an employer or employee organization constitute a single group health plan."

192. As explained in the Frequently Asked Questions ("FAQs") About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, jointly issued by the Departments of Health and Human Services, Labor, and the Treasury (collectively, the "Departments"), the Federal Parity Act provides as follows:

> Generally, MHPAEA specifies that the financial requirements and treatment limitations imposed on mental health and substance abuse disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. MHPAEA also prohibits separate financial requirements or treatment limitations that are applicable only to mental health or substance use disorder benefits.

193. The Departments' FAQs further describe that the interim final rules implementing MHPAEA on February 2, 2010, established that a group health plan or insurer issuer "generally cannot impose a financial requirement (such as a copayment or coinsurance) or a quantitative

treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance abuse disorder benefits . . . that is more restrictive than the financial requirements or quantitative treatment limitations that apply to at least 2/3 of medical/surgical benefits . . ."

194. The interim final rules by the Departments also require parity with regard to "nonquantitative treatment limitations," such as "medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness," "plan methods for determining usual, customary, or reasonable charges," and "refusal to pay for higher-cost therapies until it can be shown that a lower cost therapy is not effective (also known as fail-first policies or step therapy protocols)." Here, according to the FAQ, the rules provide that, "under the terms of the plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference." The latter exception is not authorized under the statute, but only included in the regulations. It is inapplicable here in any event, as "clinically appropriate standards of care" do not justify a difference in utilization management between mental health care and other types of health care services. Moreover, United has not advanced any such arguments in support of its discriminatory policies in asserting its statutorily required rationales for claims denials to its beneficiaries.

195. In explaining the purpose underlying the Federal Parity Act and the implementing regulations, the Departments stated:

> Allowing plans to provide less favorable benefits with respect to services for these providers than for services by providers of medical/surgical care that are classified by the plan as primary care providers would undercut the protections that the statute was intended to provide.

196. The Federal Parity Act expressly provides that medical management standards, such as medical necessity, must be in parity. Therefore, the non-clinically-based disparities between definitions of medical necessity in the Empire Plan and SYSCO plan as applied to mental health versus medical/surgical treatments are impermissible. The mental health medical necessity definitions improperly bestow United with greater leeway to deny benefits than the definitions applied to medical care in general. United should therefore be precluded from applying its more restrictive definitions in making medical necessity decisions.

197. The FAQs also expressly state that the Federal Parity Act requirements apply to preauthorization requirements, as the following question and answer demonstrates:

> Q2: For all mental health and substance abuse disorder benefits, my group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary, but the plan does not require such prior authorization for any medical/surgical benefits. Is this permissible?
>
> No. The plan is applying a nonquantitative treatment limitation to mental health and substance use disorder benefits that is not applied to medical/surgical benefits. This violates MHPAEA's prohibition on separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

198. Moreover, the FAQs also specify that the Federal Parity Act is violated where an insurer applies more stringent interpretations to preauthorization requirements for mental health care services than for medical/surgical treatments:

> Q3. My group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance abuse disorder benefits, routine approval is given for only one day, after which a treatment plan must be submitted by the patient's

> attending provider and approved by the plan. Is this permissible?
>
> No. The plan is applying a stricter nonquantitative treatment limitation in practice to mental health and substance disorder benefits than is applied to medical/surgical benefits. While some differences might be permissible based on recognized clinically appropriate standards of care, the interim final regulations do not permit a plan to apply stricter nonquantitative treatment limitations to all benefits for mental health or substance use disorders than those applied to all medical/surgical benefits. The application of nonquantitative treatment limitations – both with respect to the plan's benefits and its care management practices – must comply with the nonquantitative treatment limitation rules.

United's preauthorization and concurrent review requirements for mental health care violate these requirements.

199. The Federal Parity Act, without exception, prohibits separate treatment limitations that apply only with respect to mental health and substance use disorder benefits. The implementing regulations under the Federal Parity Act further require plans that provide any benefits for mental health conditions or substance use disorders to provide benefits for such conditions or disorders in each classification for which any medical/surgical benefits are provided. "A plan must apply these terms uniformly for both medical/surgical benefits and mental health or substance use disorder benefits." 75 Fed. Reg. 5410, 5413 (Feb. 2, 2010). Though the Empire Plan indisputably covers mental health and substance use disorders, and though the Empire Plan offers coverage for all out-of-network, inpatient medical/surgical services, United categorically excludes coverage for out-of-network mental health and substance use residential treatment, an inpatient benefit. This limitation applies only with respect to mental health and substance use disorder benefits and therefore violates the Federal Parity Act.

200. The Federal Parity Act similarly precludes United from imposing separate deductible and copayment requirements for mental health care and substance abuse services from deductibles and copayment requirements for medical/surgical treatments. The Federal Parity Act requires that group health plans must ensure that:

> the financial requirements applicable to such mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are not separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

201. The implementing regulations under the Federal Parity Act then detail this requirement with regard to copayments, stating:

> [T]he Departments' view is that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA. Consequently, these regulations provide . . . that a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance use disorder benefits in a classification that accumulate separately from any such cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification.

The copayment requirements imposed by United violate these provisions as well.

202. The Federal Parity Act further specifies that "[t]he reason for any denial under the plan ... with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator ... to the participant or beneficiary in accordance with regulations." This requirement is repeated and strengthened in the Interim Final Regulations, at 75 Fed. Reg. 5410, 5417(D)(1) and (2):

203. In other words, the Regulations make it mandatory that plans disclose the "reasons for denial," even without a request from the beneficiary, and further require compliance with the detailed disclosure requirements of the ERISA regulations, which provide as follows:

> (g) Manner and content of notification of benefit determination.
>
> (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination .... The notification shall set forth, in a manner calculated to be understood by the claimant-
>
> (i) The specific reason or reasons for the adverse determination;

> (ii) **Reference to the specific plan provisions on which the determination is based;**
>
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; ...
>
> (v) In the case of an adverse benefit determination by a group health plan ...
>
> (A) **If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion**; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
>
> (B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

United fails to comply with these requirements by citing incomplete portions and omitting key elements of its internally developed guidelines, thereby misleading beneficiaries and providers about the standards applicable to denied claims.

204. As detailed above, United, as insurer and administrator of the Empire Plan, and as claims administrator of the SYSCO plan, violates the Federal Parity Act in numerous ways. It does so by applying vastly different medical necessity definitions to mental health care than to medical/surgical care. It also imposes preauthorization and concurrent review requirements on mental health services that are not imposed on analogous medical/surgical services. Furthermore, United applies proscribed fail first policies and step therapy protocols to mental health treatments at all levels of care. With respect to the Empire Plan, United applies a categorical exclusion of out-of-network residential treatment for mental health and substance abuse, when the medical/surgical portion of the plan provides for the full scope of out-of-network, inpatient services to treat medical/surgical conditions. Last, United allocates disparate financial requirements to mental health and substance use disorder benefits.

205. With respect to the CBS plan, United similarly violates the Federal Parity Act due to its precertification policies applied to outpatient mental health services that are not comparable to and are more stringent than the policies United applies to medical/surgical services.

206. United's violation of the Federal Parity Act is further illustrated by its published mental health treatment protocol and non-adherence thereto. In its protocol, United acknowledges that mental illness can be long-term and that psychotherapy is a significant component of treatment. Yet, United nonetheless applies restrictive policies that improperly limit access to psychotherapy, thereby interfering with the ability of mental health care providers to appropriately treat patients. Not only does this approach contradict generally accepted medical standards, but it also imposes limits on mental health care that are not comparable to and are more stringent than United's limitations on analogous medical/surgical services.

207. In United's 2012 Supplemental and Measurable Guideline for the Treatment of Adults Diagnosed with Bipolar Disorder, United acknowledges the significance of bipolar disorder as a serious medical condition, as well as the fact that non-medication treatment approaches are a critical part of medically necessary treatment:

> Bipolar disorder is a serious, lifelong medical condition that affects over 2 million adults ages 18 and older in the United States in any given year. Due to misdiagnosis, the incidence of bipolar disorder may be even higher than current estimates. . . . Bipolar disorder is the sixth leading cause of disability in the United States and results in suicide in nearly one in five cases. Bipolar disorder is associated with a higher suicide rate post hospitalization. Bipolar disorder is found in combination with both medical and other psychiatric disorders. Sixty percent (60%) of people with bipolar disorder have alcohol or other substance abuse problems.
>
> Goldberg and Hoop (2004) point out the importance of engaging with bipolar patients early in the treatment process, especially when they are seeking help in the depressed stage of the disorder. They also emphasize the criticalness of getting the patient on a mood stabilizer and the need to balance effective acute treatment with longer term maintenance care. . . . He also point out that as bipolar patients improve, they resist maintenance or longer term treatment. Pomerantz (2005) highlights a number of important factors regarding bipolar disorder

> including the fact that early intervention can help prevent hospitalizations and that bipolar disorder is a chronic illness which requires ongoing maintenance treatment. Furthermore, successful management of these patients should include psychopharmacologic treatment and supportive psychotherapy.
>
> The American Psychiatric Association has developed a guideline for the treatment of bipolar disorder which emphasizes adequate maintenance treatment for the bipolar patient in order to enhance treatment adherence, especially through a maintenance regimen of medication as well as offering the patient a variety of psychosocial interventions. The guidelines call for continued longer term treatment for the bipolar patient in order to prevent relapse.

208. In United's 2012 Supplemental and Measurable Guideline for the Treatment of Major Depressive Disorder, United further highlights the importance and effectiveness of psychotherapy as an essential part of the treatment regimen:

> The efficacy of psychotherapy and antidepressant medications for the treatment of adults with Major Depressive Disorder (MDD) has been established in the literature. Guidelines and quality measures for treatment of the acute phase of MDD in adults recommend psychotherapy and, if prescribed as an antidepressant, medication management with frequent visits by the patient with a clinician for the first 12 to 16 weeks following diagnosis.
>
> Psychotherapy alone is commonly an effective treatment for MDD of mild to moderate severity, whereas vegetative, somatic and psychotic symptoms often occurring with severe MDD may require the use of medication. When using medication to treat MDD, treatment outcomes for depression are generally better when combining medication treatment and psychotherapy. The APA guidelines recommends a minimum of weekly psychotherapy for acute phase treatment.

209. As reflected in these policies, United has recognized both that Bipolar Disorder and MDD are serious medical conditions in which non-medication treatments, including psychotherapy, are a critical component, and also that these conditions are generally chronic and require long-term care to treat symptoms and protect patients from deterioration.

210. In effect, however, United's concerns with cost trump accepted clinical standards of care. In particular, United has adopted internal and undisclosed policies limiting coverage to no more than two sessions per month for patients not in the midst of acute episodes or otherwise in the throws of crises, and limiting sessions to no more than one per week even for suicidal

patients. This is irreconcilable with the Master Agreement and RFP issued for the mental health care portion of the Empire Plan, which require adherence to best clinical practices as well as transparency and consistency in claims adjudication. United has also adopted practices and standards inconsistent with prevailing clinical standards of care for inpatient (ie. residential) treatment of severe mental illnesses.

211. United's inconsistent and devious claims adjudication practices are demonstrated in the July 12, 2012 letter of Dr. Kamins' first level appeal of denied care recommended by Dr. Brod. In its denial, United stated that it was limiting care to two psychotherapy sessions based on its finding that John had purportedly "not deteriorated," was "not in the middle of a crisis," and was "not displaying any acute symptoms." That finding was further upheld in the September 12, 2012 final denial, which confirmed the two sessions per month limit without any analysis, other than that John had shown "improvement." Notably, United didn't even consider the lengthy and detailed analysis provided by Dr. Brod concerning the need for ongoing care. United similarly refused to consider the detailed analysis provided by Mr. Denbo's provider in her unsuccessful effort to appeal United's denial of benefits.

212. Significantly, while United cites and relies on APA guidelines in describing the type of mental health care that is medically necessary for Bipolar Disorder and MDD, its limitation to two sessions per month in the absence of "acute" symptoms or "deterioration" is not a recommendation of the APA. To the contrary, APA guidelines call for case-by-case determinations, with active consideration of the treating providers, since individualized needs with regard to mental health care are paramount.

213. As applied by United, its coverage policies for mental health care are effectively based on a "wait to see if it fails" approach. In other words, United calls for severely limited

treatment until and unless this fails, resulting in acute episodes or deterioration of functioning, in which case further care may be authorized. Yet, this approach ignores the accepted standard of care where ongoing treatment is recommended to ***sustain*** the gains achieved by a patient with chronic mental illness and to ***prevent*** deterioration. Moreover, such fail first policies and step therapy protocols are impermissible under the Federal Parity Act.

214. Further, the policy applied by United in materially reducing coverage for John, William, and Mr. Denbo is based on restrictions to "acute" episodes or conditions, a limitation on coverage that is found nowhere in the Empire Plan, SYSCO, CBS, or other similar plans insured and/or administered by United. Such a limitation violates the Federal Parity Act since is it is not, likewise, applied to medical/surgical care.

215. United's own written policies for the continuation of mental health care coverage are inconsistent with the actual policies it imposes in restricting care. United's 2012 Level of Care Guidelines for mental health conditions summarize the following standards for determining the frequency and duration of outpatient visits:

> The frequency and duration of outpatient visits should allow for safe and timely achievement of treatment goals, and should support the member's recovery. Multiple factors should be considered when determining the frequency and duration of treatment including the objectives of treatment, the member's preferences, evidence-based guidance regarding the frequency and duration of treatment, and the degree of intensity needed to monitor and address imminent risk to the member. Initially, the frequency of outpatient visits generally varies from weekly in routine cases to as often as several times a week. In the later stages of treatment, the frequency of visits may decrease further.

216. As this provision establishes, the number of sessions which should be authorized depends on the unique circumstances of each patient, which the treating provider is in the best position to determine. Only "in the later stages of treatment" does this policy refer to the possible "decrease" of the frequency of visits, but there is no definition of "later stages," since that depends on the needs and symptoms of the patient. Applying a two session per month limit or, in

Mr. Denbo's case, declining all further coverage altogether, solely because there do not appear to be "acute" conditions or "deterioration," is inconsistent with the above United continued care standard.

217. With regard to John, Dr. Brod, in collaboration with Dr. Gerner, carefully described John's ongoing treatment needs in his September 11, 2012 second level appeal letter. There he described John's diagnosis, including, among other things, Bipolar 1 Disorder, Recurrent, Most Recent Episode Depressed, Severe with Psychotic Features. This condition is one of the most severe forms of mental illness and is characterized by recurrent episodes of mania and depression. It also has a high rate of recurrence, with a significant risk of suicide. It is the third leading cause of death among young people (age 15-24) and the 6th leading cause of disability for people from 14-44. Dr. Brod and Dr. Gerner therefore concluded that John's conditions "cannot be treated with medications alone," and "are prone to relapse," such that "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." The analysis provided by John's seasoned and highly respected treating providers established a clear basis for the continued level of care, consistent with generally accepted medical standards in the mental health community.

218. Similarly, the detailed analysis offered by Mr. Denbo's treating clinician, Dr. Urman-Klein, provides ample support for continued, medically necessity care. Yet United failed not only to consider the merits of her explanation, but categorically denied all future coverage to Mr. Denbo due solely to financial considerations and lucrative incentives as Claims Administrator.

219. United's denials result from its internal policies which are designed to enhance

profitability and cost-savings by limiting care and imposing restrictions on mental health treatment that exceed those applied to medical/surgical care. As such, United has violated the Federal Parity Act.

220. United's policies, including those which impose pre-authorization and concurrent review requirements on non-medication therapy, but not on medication management, reflect United's goal of funneling mental health beneficiaries to pharmacologic treatment. Such an approach is not only inconsistent with generally accepted medical practices, but it also risks the health of its insureds, including Mr. Denbo and the sons of Dr. Kamins and Mr. Smith.

221. The problem is highlighted by a recent article in *The New York Times,* published on February 2, 2013, entitled "Drowned in a Stream of Prescriptions." The story describes the life of a successful college graduate who began suffering from mental illness and was prescribed large doses of medication for ADHD. According to the story, "after becoming violently delusional and spending a week in a psychiatric hospital in 2011," he received further prescriptions for medication and hung himself two weeks after his prescription expired. The story exemplifies the need to balance medication with careful follow-up and, when necessary, non-medication therapy, an approach United actively discourages through its policies.

222. United's policies with respect to residential care is similarly improper. Its 2012 Level of Care Guidelines for Residential Treatment for both mental health and substance abuse, for example, specify that residential treatment is precluded unless the patient's condition "cannot be safely managed in a less restrictive setting" or the there is an "imminent risk" that the patient's condition will "undermine treatment in a lower level of care." In practice, these "step-therapy" or "fail first" requirements force patients, regardless of need, to first attempt and fail potentially unsuitable outpatient treatments so as to subsequently be eligible for residential care.

Such policies should be enjoined, as they are ***only*** applicable to mental health and substance abuse treatments. These types of inconsistent restrictions are expressly prohibited under the Federal Parity Law.

VIOLATION OF ERISA

223. United is a fiduciary under ERISA due to its role in making benefit determinations and processing claims for its health care plans. As such, United must comply with the terms and conditions of its health care plans, and must comply with its fiduciary obligations in processing claims.

224. The CBS plan and other similar ERISA plans do not permit United to conduct concurrent or prospective reviews of outpatient mental health care services. Instead, United is permitted only to apply retrospective reviews when evaluating such mental health claims for coverage based on medical necessity.

225. As detailed herein, United imposes precertification and concurrent review requirements on ERISA plans, utilization review practices which are not permitted under such plans. As a result, United has violated the terms of its self-funded and fully-insured ERISA plans and its obligations as insurer and administrator under ERISA.

226. Many, if not most, of United's ERISA plans also define "medical necessity" or "medically necessary" services as consistent with generally accepted standards in applicable medical communities. By applying more restrictive guidelines and standards for mental health care that are contrary to generally accepted standards, United violates the terms of its ERISA plans and its obligations under ERISA.

227. United further violates ERISA by failing to provide group plan beneficiaries with "full and fair reviews" conducted by independent reviewers, by failing to allow group plan

beneficiaries to exhaust their internal appeals (as, for example, required by the CBS plan), and by failing to fully and accurately reference clinical standards and rationales in adverse benefit determinations (such as those issued to William's parents under the SYSCO Plan).

VIOLATION OF THE AFFORDABLE CARE ACT

228. The Affordable Care Act requires insurers and health plans to strictly follow specific rules prior to rendering adverse benefit determinations. The DOL's regulations state:

> [T]hese interim final regulations provide additional criteria to ensure that a claimant receives a full and fair review . . . The plan or issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

75 Fed. Reg. 43330, 43333 (July 23, 2010).

229. This is consistent with the regulations issued under ERISA, which provide as follows:

> The proposal adopted new standards for a full and fair appeal of an adverse benefit determination. The proposal required that the review be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party; that the review not afford deference to the initial adverse benefit determination; and that the review take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

65 Fed. Reg. 70246, 70252 (Nov. 21, 2000).

230. Under the Affordable Care Act regulations, all plans subject to that Act must comply with these procedural protections under ERISA:

> A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under the DOL claims procedure regulation. Therefore, for purposes of compliance with these interim final regulations, a health insurance issuer offering health insurance coverage in connection with a group health plan is subject to the DOL claims procedure regulation to the same extent as if it were a group health plan.

75 Fed. Reg. 43330, 43332 (July 23, 2010). Thus, United has violated the Affordable Care Act by failing to use suitable, independent personnel to render appeal decisions, by improperly granting deference to initial denials, by failing to take into account information provided by subscribers and their providers (such as Drs. Kamins, Brod, Gerner, and Urman-Klein in their exhaustive appeals), and by failing to fully and accurately represent clinical standards and rationales as contemplated by the DOL claims rule.

231. United further violates the Affordable Care Act by terminating coverage for ongoing treatment and by failing to continue to pay for such treatments during the course of internal appeals. The Affordable Care Act regulations provide:

> [T]he statute and these interim final regulations require a plan and issuer to provide continued coverage pending the outcome of an internal appeal. For this purpose, the plan or issuer must comply with the requirements of the DOL claims procedure regulation, which, as applied under these interim final regulations, generally prohibits a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review.

Id. at 43334.

232. The DOL regulations with regard to continued coverage, and which are incorporated by reference into the Affordable Care Act, provide:

> Any decision to terminate or reduce benefits that have already been granted will cause disruption and potential harm to patients receiving the ongoing care. In our view, claimants faced with such a disruption should be afforded an adequate opportunity to contest the termination or reduction of already granted benefits before it takes effect. Accordingly, subparagraph (f)(2)(ii)(A) retains the basic protection provided in the proposal as to the termination or reduction of previously granted benefits, but expands its scope to encompass any termination or reduction of already granted benefits.
>
> If a plan approves a course of treatment that has no finite termination date, such as treatments to be provided "as long as medically necessary," a reduction or termination of that course of treatment is considered a concurrent care decision under the regulation.

65 Fed. Reg. 70246, 70248-70249 & fn. 11 (Nov. 21, 2000).

233. Under these regulations, United was therefore required to continue paying for the accepted course of treatments previously approved for John, William, and Mr. Denbo until their final appeals had been exhausted. United failed to do so. In John's case, United immediately applied its decision in June 2012, after its initial denial, rather than in September, when John's appeals had been exhausted. In William's case, United immediately applied its decision on March 30, 2012, after its initial denial, rather than on April 2, 2012, when William's urgent, concurrent care appeal had been exhausted. In Mr. Denbo's case, United terminated his benefits without even allowing for his right to appeal.

234. United also violated the Affordable Care Act by intentionally declining to provide a proper appeal process for Mr. Denbo despite his request and insistence on such. Instead, United relied on a prospective review process that is not permitted by the CBS plan or the Federal Parity Act and then failed to provide the requisite, full and fair review processes guaranteed by the CBS plan.

235. Furthermore, United violates the Affordable Care Act by requiring its Empire Plan members and subscribers to submit initial appeals of adverse benefit decisions within 60 days. The DOL regulations, which are incorporated by reference into the Affordable Care Act, require group health plans to provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. By failing to allow for an adequate time to appeal initial adverse benefit decisions, United prevents Empire Plan beneficiaries from challenging claims denials and meaningfully participating in the appeals process.

VIOLATION OF NEW YORK'S PARITY LAW

236. The Federal Parity Act does not preempt similar state parity laws, but expressly

permits states to adopt stricter mental health parity laws applicable to health care plans issued or health care services provided in the states. New York's mental health care parity law, known as Timothy's Law, therefore applies here.

237. Under 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).

238. 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.

239. 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.

240. 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.

241. Despite United's material inducements, its practices fall far short, and each of the United policies and practices described above which violate the Federal Parity Act similarly 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

242. 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.

243. United has violated this provision by administering its mental health insurance policies in a manner violating the Federal Parity Act and 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 federal and state parity laws. 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.

244. United's practices are further deceptive with regard to how it handles appeals of its mental health care claims. 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.

245. Contrary to the provisions of the Affordable Care Act, 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.

246. 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.

247. 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

248. 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.

249. 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.

VIOLATION OF CALIFORNIA LAW

250. While Dr. Kamins and his son are insured under the Empire Plan, issued in New York, John was treated in California by Dr. Brod and Dr. Gerner, and United conducted its preauthorization and concurrent review of his care which was provided in California, while John was a resident there. As a result, United's actions are also covered by California's Unfair Competition Law (Business and Professions Code § 17200 *et seq.*), as well as California's Unruh Civil Rights Act, Civil Code § 51. Dr. Kamins seeks relief on behalf of a proposed class of

individuals who have submitted claims for treatment of any one of the diagnoses listed in California's Parity Act.

251. Under the Unruh Civil Rights Act, Civil Code § 51(b), all persons within California "are free and equal," regardless of, *inter alia*, "medical condition," and are "entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever."

252. Under California's Parity Act, introduced in Assembly Bill 88 and incorporated into Health & Safety Code § 1374.72, every health insurance plan covering services in California which provides "hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses . . . under the same terms and conditions applied to other medical conditions . . .," including "outpatient services" and "inpatient hospital services." The "severe mental illnesses" enumerated by this provision include, but are not limited to, bipolar disorder (manic-depressive illness) and major depressive disorders.

253. While the California Parity Act does not preclude an insurer from utilizing "case management" or "utilization review techniques" when providing insurance coverage, such procedures must be applied "under the same terms and conditions" governing non-mental health conditions.

254. Due to the administration of the United policies described herein, United has violated the California Parity Act, and therefore discriminated against California residents based on their "medical condition" under the Unruh Act. These violations further constitute a violation of California's Unfair Competition Law, § 17200.

CLASS CLAIMS

255. Dr. Kamins brings this action on behalf of the following classes of similarly

situated subscribers under United Plans: Dr. Kamins brings this action on behalf of the following classes of similarly situated subscribers under United Plans:

> The "Federal Class," defined as: All United Insureds who, from inception of the statute of limitations period applicable to this claim until the final termination of this action ("Federal 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) denial of benefits pending appeals determinations.
>
> The "New York Class," defined as: All United Insureds in ERISA-exempt or fully-insured plans who reside in New York and, from inception of the statute of limitations period applicable to this claim until the final termination of this action ("New York 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; 4) denial of benefits pending appeals determinations; and 5) did not receive payment of benefits within the time frame required under the New York prompt pay statute.
>
> The "California Class," defined as: With the exception of class members included by and subject to *Fradenburg v. United Healthcare et al.*, all United Insureds in ERISA-exempt or fully insured plans who, from inception of the statute of limitations period applicable to this claim until the final termination of this action ("California Class Period"), submitted health insurance claims to United for mental health care services in California and 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) denial of benefits pending appeals determinations.

256. Mr. Denbo and Mr. Smith also bring this action on behalf of members of the Federal Class. In addition, Mr. Denbo and Mr. Smith bring this action on behalf of the following class of similarly situated subscribers under United Plans:

> The "ERISA Class," defined as: All United Insureds in ERISA plans who, from inception of the statute of limitations period applicable to this claim until the final termination of this action ("ERISA 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) preauthorization or concurrent review

requirements and appeals; and 3) denial of benefits pending appeals determinations.

257. The Individual Plaintiffs bring claims against Defendants on their own behalf and on behalf of the putative Classes (1) to enjoin Defendants from engaging in the improper conduct allegedly here or otherwise relying on the internal policies which are challenged in this action; and (2) to reverse the adverse benefit determinations which were made as a result of Defendants' application of improper policies.

COMMON CLASS CLAIMS, ISSUES AND DEFENSES FOR THE CLASS

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

1. Whether United violated the Federal Parity Act by applying preauthorization and concurrent review requirements for mental health services as well as medical necessity definitions and guidelines that were not comparable to or more stringent than policies and definitions applied to medical/surgical services;
2. Whether United violated ERISA by altering express or implied utilization review terms and claims reimbursement schedules of its administered or fully insured health plans;
3. Whether United violated the Affordable Care Act by failing to ensure independence in appeal adjudications of mental health benefit claims, by failing to offer and process timely appeals, by failing to offer requisite time frames for appeals, and by failing to provide continued benefit payments during the pendency of appeals;
4. Whether United violated Timothy's Law by applying preauthorization and concurrent review requirements as well as medical necessity definitions and guidelines for mental health services that were not comparable to or more stringent than policies and definitions applied to medical/surgical services;
5. Whether United violated New York's GBL § 349 by violating the New York Parity Act in applying preauthorization and concurrent review requirements as well as medical necessity definitions and guidelines for mental health services that were not comparable to or more stringent than policies and definitions applied to medical/surgical services;
6. Whether United violated New York's GBL § 349 by violating the Federal Parity Act in applying preauthorization and concurrent review requirements as well as medical necessity definitions and guidelines for mental health services

that were not comparable to or more stringent than policies or definitions applied to medical/surgical services;

7. Whether United violated New York's GBL § 349 by violating the Affordable Care Act in failing to ensure independence in appeal adjudications of mental health care claims, by failing to offer and process timely appeals, by failing to offer requisite time frames for appeals, and by failing to provide continued benefit payments during the pendency of appeals;

8. Whether United violated the New York prompt pay statute by failing to pay clean claims in a timely fashion;

9. Whether United violated the California Mental Health Parity Act by applying preauthorization and concurrent review requirements as well as medical necessity definitions and guidelines for mental health services that were not comparable to or more stringent than policies and definitions applied to medical/surgical services;

10. Whether United violated California's Unruh Civil Rights Act by applying preauthorization and concurrent review requirements as well as medical necessity definitions and guidelines for the treatment of severe mental illnesses that are not comparable to or more stringent than policies and definitions applied to medical/surgical services, in violation of the California Parity Act;

11. Whether United violated California's Unfair Competition Law by violating the Federal Parity Act or the California Mental Health Parity Act in applying preauthorization and concurrent review requirements as well as medical necessity definitions and guidelines for mental health services that are not comparable to or more stringent than policies or definitions applied to medical/surgical services;

12. Whether United violated California's Unfair Competition Law by violating the Affordable Care Act in failing to ensure independence in appeal adjudications of mental health care claims, by failing to offer and process timely appeals, by failing to offer requisite time frames for appeals, and by failing to provide continued benefit payments during the pendency of appeals;

13. If United violated the statutes identified herein, what relief is appropriate;

14. Are members of the proposed Classes entitled to an injunction prohibiting United from applying the policies identified herein for reducing coverage for mental health care services;

15. What is the statute of limitations for the various statutes identified herein.

ADDITIONAL CLASS ACTION ALLEGATIONS

259. The members of the Classes are so numerous that joinder of all members is impracticable. Upon information and belief, the Classes consist of thousands of subscribers who

are subject to United's 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 number of ERISA plan members easily dwarf the number of Empire Plan subscribers. The precise number of members in the Classes is within United's custody and control. Based on reasonable estimates, the numerosity requirement of Rule 23 is easily satisfied for the Class. 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.

260. The claims of the Individual Plaintiffs, as the proposed Class Representatives, are typical of the claims of the Class members because, as a result of the conduct alleged herein, United has violated the various federal and state statutes as detailed herein, and provided improper coverage of mental health care services.

261. The Individual Plaintiffs will fairly and adequately protect the interests of the members of the Classes, are committed to the vigorous prosecution of this action, have 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 have no interests antagonistic to or in conflict with those of the Class. For these reasons, the Individual Plaintiffs are adequate class representatives.

262. The prosecution of separate actions by individual members of the Classes would create a risk of inconsistent or varying adjudications that could establish incompatible standards of conduct for United.

263. 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 Classes 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 FEDERAL PARITY ACT
(on behalf of the Individual Plaintiffs and the Federal Class and NYSPA in a representational capacity on behalf of its members and their patients)

264. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count I is brought under the MHPAEA, 29 U.S.C. § 1185a(a)(2).

265. Through the preauthorization and concurrent review policies applied to mental health claims, medical necessity definitions and guidelines, coverage determination practices, and disparate fee schedules for reimbursement of mental health claims, United has failed to provide quantitative or nonquantitative parity between coverage for mental health services and medical/surgical services.

266. United's policies impose quantitative limits on mental health benefits that are more restrictive than those placed on non-mental health benefits. Moreover, United's processes, strategies, evidentiary standards and other factors used in applying nonquantitative treatment limitations to mental health care claims are applied only with respect to mental health/substance abuse claims, are not comparable to, and are more restrictive than, such factors as written and applied to analogous medical/surgical services. This includes, but is not limited to, United's

improper use of medical necessity definitions, coverage/medical necessity guidelines, refusal to reimburse mental health services with E/M codes, and reimbursing services rendered by mental health professionals at lower rates than identical services rendered by non-mental health providers.

267. During the Class Period, Plaintiff and the members of the Federal Class have been harmed by United's violations of the Federal Parity Act. The Individual Plaintiffs, on their own behalf and on behalf of the members of the Federal Class, seek to enjoin United's policies and practices that violate the Federal Parity Act, as detailed herein, request that United reprocess and reimburse benefits denied or reduced as a result of such policies, and request that United pay appropriate interest back to the date such claims were originally submitted to United. The Individual Plaintiffs, as well as NYSPA, an Association Plaintiff acting on behalf of its members and their patients, also sue for declaratory and injunctive relief related to enforcement of the Federal Parity Act, and further request attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT II

CLAIM FOR RELIEF UNDER ERISA

(on behalf of Plaintiffs Denbo and Smith and the ERISA Class and NYSPA in a representational capacity on behalf of its members and their patients)

268. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count I is brought under 29 U.S.C. § 1132(a)(1)(B) and (a)(3).

269. Under ERISA, United must comply with the terms and conditions of its health care plans in making benefit determinations and processing health care claims on behalf of its Insureds.

270. Under the CBS plan and similar plans issued or administered by United, ERISA Class members are entitled to obtain outpatient mental health services without being subjected to concurrent or prospective reviews. Instead, United may only apply retrospective reviews of such services to determine their medical necessity, as defined by the plans.

271. In administering its ERISA plans, United acts as a fiduciary and must comply with its fiduciary obligations toward the participants and beneficiaries of the ERISA plans.

272. United has violated the terms and conditions of its ERISA plans, and, hence, has violated ERISA by imposing preauthorization and concurrent review requirements for outpatient mental health services, by denying coverage for E/M codes for health care services, and by reimbursing mental health services below the levels authorized by the plans. Such actions similarly represent breaches of fiduciary duties by United.

273. United has also violated the terms and conditions of its health care plans, and violated ERISA, by applying processes, strategies, evidentiary standards and other factors to deny or reduce benefits for mental health services that are inconsistent or in conflict with generally accepted medical standards.

274. During the Class Period, Plaintiff Denbo and the members of the ERISA Class have been harmed by United's violations of ERISA. Plaintiff Denbo, on his own behalf and on behalf of the members of the ERISA Class, seeks to enjoin United's policies and practices that violate ERISA, as detailed herein; requests that United reprocess and reimburse benefits denied or reduced as a result of such policies; requests that United pay appropriate interest back to the date such claims were originally submitted; and seeks appropriate equitable relief arising from United's misconduct, including an award of a surcharge to compensate him and other members of the ERISA Class for United's ERISA violations. Plaintiff Denbo, as well as NYSPA, an

Association Plaintiff acting on behalf of its members and their patients, also sue for declaratory and injunctive relief related to enforcement of ERISA, and further request attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT III

CLAIM FOR RELIEF UNDER THE AFFORDABLE CARE ACT
(on behalf of the Individual Plaintiffs and the Federal Class and NYSPA in a representational capacity on behalf of its members and their patients)

275. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count III is brought under the Affordable Care Act.

276. United has violated the Affordable Care Act by adjudicating appeals of adverse benefit determinations relating to mental health services contrary to the requirements of the Act and ERISA regulations incorporated by reference.

277. During the Class Period, the Individual Plaintiffs and the members of the Federal Class have been harmed by United's violations of the Affordable Care Act, and United's misconduct was a substantial factor in causing such harm.

278. The Individual Plaintiffs, on their own behalf and on behalf of the members of the Federal Class, and NYSPA, in a representational capacity, seek to enjoin United's policies and practices that violate the Affordable Care Act, as detailed herein. Plaintiffs further request attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT IV

CLAIM FOR RELIEF UNDER THE NEW YORK PARITY ACT
(on behalf of Dr. Kamins and the New York Class and NYSPA in a representational capacity on behalf of its members and their patients)

279. The allegations contained in this Complaint are realleged and incorporated by

reference as if fully set forth therein. Count IV is brought under Timothy's Law, N.Y. Ins. Law § 3221(l)(5), *et seq.*

280. Through the preauthorization and concurrent review policies applied to mental health claims, medical necessity definitions and guidelines, coverage determination practices, and disparate fee schedules for reimbursement of mental health claims, United has failed to provide quantitative or nonquantitative parity between coverage for mental health services and medical/surgical services.

281. United's policies and practices impose limits on mental health benefits that are more restrictive than those placed on non-mental health benefits, employ medical necessity criteria not otherwise applied to non-mental health benefits, and enforce utilization review requirements that are not applied in a consistent fashion to mental health and other health conditions. This had led to disparate coverage of mental health benefits in violation of Timothy's Law.

282. During the Class Period, Dr. Kamins and the members of the New York Class have been harmed by United's violations of Timothy's Law. Dr. Kamins, on his own behalf and on behalf of the members of the New York class, seeks to enjoin United's policies and practices that violate Timothy's Law, as detailed herein, requests that United reprocess and reimburse benefits which were denied or reduced as a result of such policies, and requests that United pay appropriate interest back to the date such claims were originally submitted. Dr. Kamins and NYSPA, in a representational capacity as the Association Plaintiff, also sue for declaratory and injunctive relief related to enforcement of Timothy's Law, and further request attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT V

CLAIM FOR RELIEF UNDER NEW YORK GBL § 349
(on behalf of Dr. Kamins and the New York Class and NYSPA in a representational capacity on behalf of its members and their patients)

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

284. By applying preauthorization and concurrent reviews of mental health services, providing sham appeals processes to claimants, devising unlawful definitions of medical necessity for mental health services, implementing disparate, unsound coverage guidelines for mental health services, and establishing fee schedules that circumvent federal and state parity laws to restrict mental health benefits, United has engaged in deceptive acts and practices in the conduct of its health insurance business in this State, in violation of GBL § 349.

285. During the Class Period, Dr. Kamins and the members of the New York Class have been harmed by United's violations of New York's Unfair Trade Practices Act. Dr. Kamins, on his own behalf and on behalf of the members of the New York Class, seeks to enjoin United's policies and practices that violate GBL § 349, as detailed herein, requests that United reprocess and reimburse benefits which were denied or reduced as a result of such policies, and requests that United pay appropriate interest back to the date such claims were originally submitted. Dr. Kamins and NYSPA also sue for declaratory and injunctive relief related to enforcement of the Federal Parity Act, and further request attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT VI

CLAIM FOR RELIEF UNDER N.Y. INS. LAW § 3224-a

(on behalf of Dr. Kamins and the New York Class and NYSPA in a representational capacity on behalf of its members and their patients)

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

287. 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, United is 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, United has failed to make timely payments, in violation of this Law.

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

COUNT VII

CLAIM FOR RELIEF UNDER THE CALIFORNIA UNFAIR COMPETITION LAW

(on behalf of Dr. Kamins and the California Class)

289. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count VII is brought under the California Unfair

Competition Law, Business and Professional Code § 17200 *et seq.*

290. By applying preauthorization and concurrent reviews of mental health services, providing sham appeals processes to claimants, devising unlawful definitions of medical necessity for mental health services, implementing disparate, unsound coverage guidelines for mental health services, and establishing fee schedules that circumvent federal and state parity laws to restrict mental health benefits, United has engaged in deceptive acts and practices in the conduct of its health insurance business and in this State, in violation of California's Unfair Competition Law.

291. During the Class Period, Plaintiff and the members of the California Class have been harmed by United's violations of California's Unfair Competition Law. Dr. Kamins, on his own behalf and on behalf of the members of the California Class, seeks to enjoin United's policies and practices that violate Business and Professions Code § 17200, as detailed herein, requests that United reprocess and reimburse benefits which were denied or reduced as a result of such policies and pay appropriate interest back to the date such claims were originally submitted to United. Dr. Kamins also sues for declaratory and injunctive relief related to enforcement of the California Unfair Competition Law, and further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

COUNT VIII

CLAIM FOR RELIEF UNDER THE CALIFORNIA UNRUH ACT

(on behalf of Dr. Kamins and the California Class)

292. The allegations contained in this Complaint are realleged and incorporated by reference as if fully set forth therein. Count VIII is brought under the California Unfair Competition Law, Business and Professions Code § 17200 *et seq.*

293. By applying preauthorization and concurrent reviews of mental health services,

providing sham appeals processes to claimants, devising unlawful definitions of medical necessity for mental health services, implementing disparate, unsound coverage guidelines for mental health services, and establishing fee schedules that circumvent federal and state parity laws to restrict mental health benefits, United has denied Dr. Kamins (and his son whom he represents in this action) and the members of the California Class full and equal benefits under the United Plans. United has also discriminated against or made a distinction that denied these Class Members full benefits under their health insurance plans. United imposed restrictions on benefits for Dr. Kamins's son and other Class Members with severe mental illness that were not imposed on other claimants with regard to non-mental health care services.

294. The California Class Members' mental disabilities, resulting from severe mental illnesses, were a motivating reason for United's misconduct. The Class Members' mental disabilities were the reason for the discriminatory restrictions that United placed on the benefits of Dr. Kamins's son and other members of the California Class.

295. During the Class Period, Plaintiff and the members of the California Class have been harmed by United's violations of the Unruh Act, and United's misconduct was a substantial factor in causing such harm.

296. Dr. Kamins further seeks to recover the $4,000 per person per violation statutory minimum damages that Civil Code § 52 imposes for violations of the Unruh Act. He is not seeking any other individual damages for United's violation of the Unruh Act.

297. Dr. Kamins, on his own behalf and on behalf of the members of the California Class, seeks to enjoin United from pursuing the policies that violate the Unruh Act, as detailed herein. Dr. Kamins further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against United.

WHEREFORE, Plaintiffs demand judgment in their favor against United as follows:

Certifying the above defined Classes and their claims for class treatment;

Appointing the Individual Plaintiffs as Class Representative for the respective proposed Classes, as detailed herein;

Designating Pomerantz Grossman Hufford Dahlstrom & Gross LLP and Meiram Bendat as class counsel for the respective Classes;

Declaring that United's 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 federal and state laws, including the mental health parity laws, as detailed herein;

Issuing a permanent injunction ordering United 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 United's actions as detailed herein;

For the ERISA class, award a surcharge of an amount to be determined at trial to compensate Class members for Defendants' ERISA violations;

For the California Class, award statutory minimum damages of $4,000 per person per violation for each of United's violations of the Unruh Act, with the total number of violations to be determined at trial;

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

Awarding allowable taxable costs and interest from the date of initial benefit reductions for Plaintiffs and members of the Classes for all improperly denied amounts; and

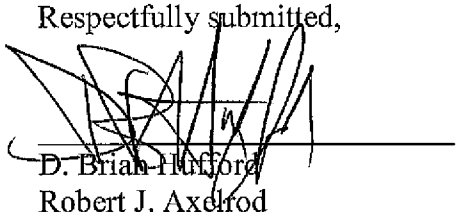
Granting such other and further relief as is just and proper.

JURY DEMAND

Plaintiffs demand trial by jury on all issues so triable.

Dated: March 11, 2013

Respectfully submitted,



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