SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

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

Plaintiffs,

v.

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

Defendants.

Case No.: 064276/2014
Hon. Jerry Garguilo

AMENDED CLASS ACTION COMPLAINT

(JURY TRIAL DEMANDED)

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

NATURE OF THE ACTION

1. Through this action, Plaintiff challenges Defendants' improper denials of insurance coverage for his son's medically necessary mental health care. In particular, Plaintiff seeks to enjoin and reverse the Defendants' use of restrictive preauthorization and medical necessity requirements as well as their flawed internal appeals procedures for mental health claims that violate various New York statutes, including the New York Parity Law (known as "Timothy's Law") and the Unfair Trade Practices Act. Additionally, Defendants' conduct breaches the terms

of the Empire Plan and their fiduciary duties to Plaintiff's beneficiary son and similar individuals. In asserting his claims, Plaintiff seeks appropriate injunctive relief, payment of improperly denied benefits, and damages compensating for his son's injuries.

2. Dr. Kamins' son (referred to herein as "John") suffers from severe mental illness. While his treating psychiatrist requested preauthorization for two psychotherapy sessions a week for a period of several months, United denied coverage, agreeing only to permit two sessions ***per month*** on an indefinite, prospective basis. In doing so, United relied on unlawful utilization review protocols and medical necessity criteria, as well as on a sham appeal process designed to ration care and rubber stamp denials for the sole purpose of saving costs for United and the Empire Plan.

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

4. The harm Defendants have caused to John is, unfortunately, not unique. According to the National Institute of Mental Health, an estimated 26 percent of American adults suffer from some type of mental health condition each year, with six percent suffering from a severe mental health condition such as schizophrenia or major depression. About 11 percent of adolescents have a depressive disorder by age 18. The seriousness of this problem is highlighted by the fact that suicide consistently ranks as the third leading cause of death for young people ages 15–24. Individuals with borderline personality disorder, who constitute 6 percent of patients in primary care settings, 10 percent of patients in outpatient clinics, and 20 percent of psychiatric inpatients, also face a significant risk of suicide.

5. According to the Substance Abuse and Mental Health Services Administration ("SAMHSA"), an estimated nine percent of Americans twelve or older were classified with a substance use disorder in 2010. Between 2007 and 2010, about 38 percent of Americans twelve or older who needed substance abuse treatment did not receive treatment because they lacked insurance coverage, and could not afford the cost without coverage. The World Health Organization reports that mental health and substance use disorders are among the leading causes of disability in the United States, and the Centers for Disease Control and Prevention reports that 25 percent of all years of life lost to disability and premature mortality are a result of mental illness. When substance use disorders are inadequately treated, they can complicate care for co-occurring mental health disorders and medical conditions.

6. According to the New York State Attorney General, "in any given year, 11%, or 1.8 million, of New Yorkers have a substance use disorder, but only 11% of these individuals receive any treatment for their condition. In contrast, more than 70% of individuals with hypertension and diabetes receive treatment for those conditions."

7. Despite these alarming statistics, Defendants are violating legal duties owed to Empire Plan participants and beneficiaries by improperly restricting the scope of their insurance coverage for outpatient mental health treatment. Defendants have systematically and uniformly applied their overly-restrictive coverage requirements to deny benefits to members of the purported class. As a result, members of the purported class have been denied necessary mental health care and have been injured as a result.

PARTIES

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 Defendant the Empire Plan, offered by the New York State Health Insurance Program ("NYSHIP").

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

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

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

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

JURISDICTION AND VENUE

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

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

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

FACTUAL BACKGROUND

The Mental Health Care Needs of Dr. Kamins' Son

16. 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30. John returned to college in September 2012 in an effort to complete his degree. Although he continued to have serious symptoms resulting from his mental illness, John was unable to receive an adequate treatment dose based on United's continued unwillingness to approve more than two psychotherapy sessions a month. On September 12, 2012, United denied John's written appeals for additional psychotherapy, and thereafter prospectively declined to approve more than 10 visits for his "course of treatment" with his local psychotherapist at college through March 27, 2014. In light of United's restrictions on his treatment, John did not fare well and was required to withdraw once again.

31. John continues to suffer from mental illness and to require ongoing care of an intensity far exceeding what has been approved by Defendants. His difficulties have been exacerbated by improper restrictions on his treatment and the resulting financial pressure placed

on his parents, described below. As a consequence of inadequate access to outpatient mental health care, due to Defendants' denials of coverage as described herein, John was re-hospitalized for two weeks on February 16, 2013.

United's Response to Claims Submitted by Dr. Kamins

32. 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.

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

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

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

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

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

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

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

38. In the May 31, 2012 telephonic review, United dramatically changed its approach to John's treatment. In response to Dr. Brod's May 2012 Outpatient Treatment Form, which requested twice weekly sessions, United only approved additional outpatient psychotherapy sessions ***every other week***, stating in a June 4, 2012 letter that "[i]n order to ensure that services

are medically necessary and will be covered, you should submit the attached Outpatient Treatment Report before the end of the certification period."

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

40. 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."

41. 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."

42. 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 . . ."

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

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

- Rothbaum, B.O., and Astin, M.C. (2000), "Integration of Pharmacoptherapy and Psychotherapy for Bipolar Disorder," *Journal of Clinical Psychiatry*, 61 (Supplement 9), pp. 67-75;

- Miklowitz, D.J. (2006), "A Review of Evidence Based Psychosocial

Interventions for Bipolar Disorder," *Journal of Clinical Psychiatry*, 67 (Supplement 11), pp. 28-33.

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

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

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

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

> into action without having fully recovered from the injury. Your prescription is best considered as something that would be characterized as "maintenance" it is clearly not prescriptive.

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

47. The appeal was denied in a letter dated July 12, 2012. The letter was signed by Lee Becker, M.D., the Associate Medical Director for OptumHealth and thus a ***subordinate*** of Dr. Sigler, the Medical Director who issued the initial denial.

48. In explaining the basis for the denial, United 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. 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 your NYSHIP General Information Book and Empire Plan Certificate.
>
> 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.

49. While Dr. Becker's letter did not reference that United relied on its internally-developed Level of Care Guidelines for Outpatient Mental Health Treatment to deny John's prescribed care, United's case files indeed confirm that to have been the case. Contrary to generally accepted standards of care promulgated by physician specialty associations (such as the American Psychiatric Association), United's internally-developed level of care guidelines restrict even the lowest level of mental health care, outpatient treatment, to acute symptoms or crises and fail to account for chronically severe conditions and relapse prevention.

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

51. 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 review. In that letter, Dr. Brod, in collaboration with Dr. Gerner, submitted a detailed, single-space 10-page letter that provided specific information about John's condition, his treatment history, his diagnosis, and the providers' rationales for John's continued need for psychotherapy at least two times per week. The letter also painstakingly detailed United's violations of federal and state mental health parity laws resulting from United's utilization review procedures.

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

> Given that the patient's chronic Axis I, II and III conditions cannot be treated with medications alone, are prone to relapse and invariably affect each other, on-going

> psychotherapy at a rate of two to three times weekly is necessary to prevent further escalation of symptoms and deterioration of functioning, as evidenced by less intensive and/or interrupted treatments in the past.
>
> I am confident the proposed treatment plan is consistent with prevailing treatment standards and the OHBS 2012 Level of Care Guidelines: The general focus and goals of [John's] outpatient treatment are to reduce and alleviate his symptoms, to improve his level of functioning, and to prevent deterioration. We are actively engaged in mobilizing his strengths, building upon his existing coping strategies, and helping him utilize available support systems as appropriate. Interventions are interactive, requiring John to cooperate with and be actively involved in establishing clearly defined treatment objectives and identifying ways to measure improvement. The types and degrees of the patient's functional impairments are reflected in the treatment plan highlighted above.
>
> Because the patient's psychiatric conditions are biologically-based, impact day-to-day functioning, relationships, work performance, and cannot be alleviated on their own, however, it is expected both psychopharmacologic and psychotherapeutic treatment will be long-term. Moreover, there is clear and compelling factual and scientific evidence (cited above) that continued treatment at the frequency of multiple sessions a week is both the treatment of choice for comorbid disorders and required to prevent acute deterioration or exacerbation of symptoms.
>
> Though tempered by experience with OHBS, it is my hope that appropriate examination of [John's] case will ensure the health plan adheres to legal mandates for parity, honors its contractual obligations to the patient, respects my good faith determination of medical necessity based upon current standards of practice and the Guidelines, and facilitates payment for psychotherapy at a frequency of three (3) times a week until such a time as treatment can be properly tapered.

53. On or about October 15, 2012, in another boilerplate letter dated September 12, 2012, United responded with a final denial to Dr. Kamins' son on OptumHealth letterhead sent to his Los Angeles address. This letter was again from OptumHealth Medical Director Liviu Sigler, the same Medical Director who initially rationed John's care on June 4, 2012. As discussed herein, United's use of the same personnel to issue clinical denials and adjudicate subsequent appeals violates state law, the January 1, 2009 Master Agreement between United and the Empire Plan, and the Certificate of Insurance issued by United.

54. In summarizing the basis for the final appeals denial, United 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. 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 your NYSHIP General Information Book and Empire Plan Certificate.
>
> 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.

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

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

Continued Treatment Denials

57. In September 2012, in an effort to complete his degree, John returned to school. Because United had already expressly limited John's psychotherapy to twice a month and affirmed its unwillingness to change course as late as September 12, 2012, John was unable to receive suitable treatment while at college. As a result of the steady deterioration of his condition, John was re-hospitalized for two weeks on February 16, 2013.

58. Perversely, United recognized the medical necessity of John's two week hospitalization and covered its costs. Yet, once John was discharged and resumed outpatient treatment, United continued to restrict such services prospectively, despite the fact that his re-hospitalization so plainly demonstrated his need for more frequent psychotherapy. In a letter issued by OptumHealth's Kingston, New York office John on March 28, 2013, one month after his psychiatric hospitalization, United confirmed that only a total of 10 sessions through March 27, 2014 (the entire coming year) were preauthorized. United did not offer any appeals rights when making this benefit decision, but only gave a telephone number "if [United] can be of any further assistance."

Coverage Under the Empire Plan

59. The Certificate of Insurance for the Empire Plan, which provides the mental health benefits for Plaintiff Kamins and his son, was prepared by United and "has been updated to include the Amendments through January 1, 2013." It specifies that UHIC-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 UHIC-NY will pay any claims authorized by Optum.

60. 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.

61. Other than the non-network restrictions on residential care for mental illness, services under the Empire Plan are covered when rendered by providers who are part of United's network ("Network Provider") or by ones 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."

Utilization Review Under the Empire Plan

62. Utilization review is the process by which a health plan examines plan members' requests or claims for health care services to determine whether the services are medically necessary, and thus eligible for coverage. Utilization review procedures can encompass preauthorization (or prior authorization) before services are initiated, concurrent reviews (which typically impose forward-looking restrictions on services already in progress and thus amount to preauthorization), and retrospective reviews of services already received.

63. "In order to receive network coverage" for mental health and substance abuse services under the Empire Plan, the Certificate of Insurance issued by United 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.

64. Under United's 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.

65. Similarly, preauthorization is required for Non-Network Providers, as stated in the Certificate of Insurance:

> 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.

66. United's utilization review requirements with respect to both Network and Non-Network, outpatient mental health and substance abuse services are far more stringent than

United's utilization review requirements with respect to both Network and Non-Network, outpatient medical services. Whereas United requires preauthorization for outpatient mental health and substance abuse treatment, the United-issued Certificate of Insurance for the Basic Medical Program under the Empire Plan requires prior authorization only for infertility benefits and diabetic supplies, which (unlike psychotherapy, the mainstay of outpatient mental health and substance abuse treatment) facially constitute a *de minimis* share of all outpatient medical services. While, effective January 1, 2012, United stopped requiring preauthorization exclusively for psychiatric medication management ***without*** psychotherapy, United does not differentiate between the types of treatments offered by non-psychiatric medical providers (*i.e.*, medication versus other routine, office-based services) for purposes of requiring preauthorization – and in fact, does not require preauthorization for routine, office-based medical care.

67. Additionally, through its proprietary ALERT program, UBH identifies chronically mentally ill patients whose treatment needs exceed United's tolerance for liability and subjects their outpatient care to concurrent reviews with prospective treatment limitations (amounting to preauthorization) that are not comparably imposed on chronically ill patients with non-psychiatric conditions.

68. Moreover, United's utilization reviews of Non-Network outpatient mental health and substance abuse services are actually inconsistent with the January 1, 2009 Master Agreement between United and the New York State Department of Civil Service concerning the administration of the Mental Health and Substance Abuse Program under 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."*** Thus, when not requested by the provider and the insured, United is ***not*** to perform concurrent review for Non-Network services.

69. The contractual intent is further confirmed in the February 15, 2008 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 and Substance Abuse Program. 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."

70. United's policies are contrary to that instruction despite confirming in its Technical Proposal submitted to the New York Department of Civil Service as part of its 2008 Request for Proposal: "As noted in the RFP requirements, we will also provide review of non-network care ***when requested by the member or provider***."

71. In anticipation of the Empire Plan's mental health program converting to self-funded status on January 1, 2014, however, the Empire Plan issued "Official Answers to Offeror Questions" on March 11, 2013, stating that "In addition to the Contractor's standard concurrent review procedures, the Contractor must also perform concurrent review of Outpatient and Inpatient Services rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider." Thus, while the Empire Plan did not require preauthorization or concurrent reviews for Non-Network benefits under the Mental Health and Substance Abuse Program while insured and administered by United, since the Program converted to self-funded status in January 1, 2014 the Empire Plan continues to violate the New York Parity Law by authorizing disparate utilization review procedures for outpatient mental health and medical office visits.

72. While unlawful, Defendants' disparate utilization review requirements for mental health and substance abuse treatment are certainly not unique and, in fact, bear striking resemblance to those cited by the New York State Attorney General ("NYAG") in a July 2014 Assurance of Discontinuance Under Executive Law against New York City-based insurer, EmblemHealth:

> Persons with mental health and substance use disorders comprise a vulnerable population, and may be reluctant to seek care. Frequent and time-consuming utilization review may pose obstacles preventing them from accessing or completing treatment.
>
> * * *
>
> Emblem requires behavioral health providers – even at the outpatient level – to develop treatment and discharge plans, denying coverage if such plans are not filed. In contrast, Emblem does not typically require medical/surgical providers to develop treatment plans or to demonstrate discharge planning.
>
> * * *
>
> Emblem applies a utilization review tool for outpatient behavioral health benefits known as the Outpatient Outlier Model, under which a certain number of member outpatient psychotherapy visits triggers a special form of intensive utilization review whereby additional treatments are more deeply scrutinized, and are often denied. For example, after a member with major depression – a chronic, often lifelong, biologically based illness – submits claims for a certain number of psychotherapy visits, Emblem places that member in the Outpatient Outlier Model, with the expectation that the member will soon terminate treatment. Emblem has never discussed basing the Outpatient Outlier Model on clinical evidence or research regarding length of treatment for particular mental health conditions.
>
> Once Emblem places a member in the Outpatient Outlier Model, it may request extensive records from the member's provider, including progress notes, a treatment plan, a discharge plan, and other information, before it will authorize further coverage. Emblem will also recommend a lower frequency of visits as a strategy of working towards treatment termination, even though it cannot point to any literature or evidence supportive of session frequency as a treatment variable. Emblem does not implement a utilization review tool equivalent to the Outpatient Outlier Model in administering medical/surgical benefits.

73. Defendant the Empire Plan was initially represented in this action by the NYAG's office. However, in November 2014, the NYAG's office informed Plaintiff's counsel that due to

an unspecified conflict of interest, the NYAG's office would be withdrawing from such representation.

74. Though unlawful utilization review procedures are not unique to Defendants, their disregard of the New York Parity Law (New York Insurance Law § 3221(l)(5), also known as "Timothy's Law"), is particularly alarming given the express covenant in the January 1, 2009 Master Agreement between the New York Department of Civil Service and United:

> 6.15.1. The Insurer must provide all aspects of claims processing. Such responsibility shall include, but not be limited to:
>
> 6.15.6. Maintaining a claims processing system capable of ensuring that claims are processed in accordance with Program requirements and all applicable laws including but not limited to Chapter 748 of the Laws of 2006 known as "Timothy's Law," as amended.

75. Defendants cannot claim ignorance of their obligations to insureds (or the import of such) pursuant to Timothy's Law given the Master Agreement and United's representations in the Technical Proposal submitted to the New York Department of Civil Service as part of its Request for Proposal:

> 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).

76. 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.

77. As detailed herein, Plaintiff's experiences with United exemplify Defendants' improper 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, ***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.

Medical Necessity under the Empire Plan

78. Under the Certificate of Insurance issued by United, 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."

79. Unbeknownst to Empire Plan members, Defendants interpret this definition as allowing them to adopt internal standards for the "appropriate level of care," that are more restrictive than what is "generally accepted" in the mental health and substance abuse treatment professional community.

80. Even setting aside Defendants' dubious interpretation of the "appropriate level of care" provisions, this definition is more restrictive than the definition of "Medical Necessity" applicable to health care services in general under the United's 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 . . .

81. 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.

82. In comparing the three definitions, it is self-evident that the definition used by Defendants 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.

83. 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." As noted above, Defendants interpret this to mean 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 would give United carte blanch to deny coverage for mental health services.

84. 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 unambiguously provides 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.

85. 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.

UBH's Medical Necessity Guidelines

86. While UBH recognizes the generally accepted standards of care established by non-profit, national physician-specialty organizations such as the American Psychiatric Association ("APA"), American Association of Addiction Medicine ("ASAM"), American Association of Child and Adolescent Psychiatry ("AACAP"), and the American Association of Community Psychiatrists ("AACP") in multiple sources such as its own Coverage Determination Guidelines,

Guideline Evidence Base for Level of Care Guidelines, and *Guideline Evidence Base for Coverage Determination Guidelines*, and while UBH "maintains that treatment should be consistent with nationally recognized scientific evidence," UBH has instead developed its own medical necessity guidelines that are much more restrictive than the generally accepted standards of care in the mental health community. In fact, since UBH assumed administration of the Mental Health and Substance Abuse Program under the Empire Plan, it has amended its Level of Care Guidelines ("LOC") and Coverage Determination Guidelines ("CDG") to make them even more focused on the presence of acute symptoms (and therefore more restrictive), despite the fact that generally accepted standards of care highlight prevention of relapse and chronic considerations. As detailed herein, whereas UBH's guidelines restrict coverage for outpatient mental health and substance abuse treatment to "acute" situations that can be addressed quickly, such restrictions on outpatient treatment are not found in any of the generally accepted standards of care.

87. UBH's guidelines for mental health and substance abuse services recognize that individuals who pose an imminent or current risk of harm to self or others should be hospitalized. Thus, as a precondition to all levels of mental health and substance abuse services other than psychiatric hospitalization, including outpatient treatment, the guidelines require that members should ***not*** be "in imminent or current risk of harm to self or others and/or property."

88. In its 2013 (and preceding) guidelines such as the LOC for Continued Service Criteria, applicable to all levels of care for both mental health and substance abuse and incorporated by reference into all UBH condition-specific Coverage Determination Guidelines, UBH specified that coverage should be denied for any level of care absent "evidence that relapse or a significant deterioration in functioning would be ***imminent*** if the member was transitioned to a lower level of care or, in the case of outpatient care, was discharged." This requirement was

reinforced by UBH's 2013 (and preceding) Coverage Determination Guidelines for all mental health and substance use disorders, which required "***compelling evidence*** that continued treatment in the current level of care is required to prevent ***acute*** deterioration or exacerbation of the member's current condition."

89. These requirements do not reflect generally accepted standards of care. In fact, the Level of Care Utilization System (CALOCUS) developed by AACAP and AACP, and recognized as a generally accepted standard of care by UBH, expressly notes that "it may be desirable for a child or adolescent to remain at a higher level of care to preclude relapse and unnecessary disruption of care, and to promote lasting stability. A child or adolescent may make the transition to another level of care when, ***after an adequate period of stabilization and based on the family's and treatment team's clinical judgment***, the child or adolescent meets the criteria for the other level of care." Further, both CALOCUS and the Level of Care Utilization System for Psychiatric and Addictive Services ("LOCUS"), developed by AACP for use in adult populations, note that ***"In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise."***

90. Similarly, in its patient placement criteria for all levels of care, ASAM notes:

> Given the current understanding of substance use disorders as having a ***chronic, long-term, remitting and relapsing course, it should be expected that effective treatment should match this chronic course.*** In fact, treatment should be regarded as a dynamic, longitudinal process, rather than as a discrete episode of care. While it may encompass one or several acute episodes, it also must endure over the long term. ***A now outdated approach viewed discrete time-limited episodes of program enrollment as adequate "doses" of treatment. In that view, any further care, also typically time-limited, was regarded as "aftercare" rather than ongoing care—as though the active part of treatment had ended.***
>
> The current view of addiction as a chronic disorder supports a stance of therapeutic optimism and an attitude of persistence toward the treatment-refractory patient. It also reinforces the need for chronic attention and vigilance in response to a chronic vulnerability, even in the improved patient.

91. Ironically, while UBH's CDGs direct that "[t]he treatment plan should always address co-occurring behavioral and medical conditions including substance use disorders" and "maintain[] that treatment should be consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines," UBH's CDGs for Personality Disorders, which are covered conditions under the Empire Plan, indicate that:

> Treatments for the primary diagnosis of a Personality Disorder are excluded. Indications for coverage are limited to circumstances where:
>
> • The Personality Disorder is a secondary diagnosis; and
> • The primary diagnosis is a covered conditions; and
> • Treatment is principally focused on the primary diagnosis.

92. Recognized by the APA as "the most common personality disorder in clinical settings," Borderline Personality Disorder ("BPD") "causes marked distress and impairment in social, occupational, and role functioning, and it is associated with high rates of self-destructive behavior (e.g., suicide attempts) and completed suicide." The APA notes in its *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder* that:

> There is a large clinical literature describing psychoanalytic/psychodynamic individual therapy for patients with borderline personality disorder. Most of these clinical reports document the difficult transference and countertransference aspects of the treatment, but they also provide considerable encouragement regarding the ultimate treatability of borderline personality disorder. Therapists who persevere describe substantial improvement in well-suited patients. Some of these skilled clinicians have reported success with the use of psychoanalysis four or five times weekly.
>
> * * *
>
> There are no studies demonstrating that brief therapy or psychotherapy less than twice a week is helpful for patients with borderline personality disorder.

93. Despite generally accepted standards of care recognizing BPD as a severe mental illness clearly treatable in its own right, UBH's CDGs pay lip service to such by relegating BPD to, at most, a "secondary diagnosis" that is effectively not eligible for coverage. In John's case,

UBH didn't even consider his BPD as a "secondary diagnosis." Even when BPD is comorbid with other psychiatric illnesses, UBH's CDGs artificially attempt to distinguish between "primary" and "secondary diagnoses" to circumvent coverage. This artifice directly contradicts the APA's DSM, which notes that "[t]he multiaxial distinction among Axis I, Axis II [personality], and Axis III [medical] disorders does not imply that there are fundamental differences in their conceptualization."

94. Thus, in developing its guidelines, UBH had a fiduciary duty to Plaintiff and members of the putative class to promulgate and apply medical necessity guidelines that are consistent with the Empire Plan and generally accepted standards of care. UBH breached this duty by supplanting generally accepted treatment standards in the mental health field with standards that promote its self-serving, cost-cutting preferences. By adopting guidelines that are inconsistent with, and much more restrictive than, those that are generally accepted in the medical community, UBH breached its fiduciary duty to act solely in the interests of participants and beneficiaries for the "exclusive purpose" of "providing benefits" with reasonable "care, skill, prudence, and diligence" and in accordance with the Empire Plan.

Summary of Ways in Which UBH's Guidelines Violate Generally Accepted Standards of Care

95. For the reasons discussed herein, UBH's LOCs and CDGs related to outpatient treatment are inconsistent with generally accepted standards of care (and therefore Plaintiff's Plan) in four key respects. First, UBH's guidelines require patients to demonstrate by "compelling evidence" that treatment is necessary to prevent "acute" deterioration of their conditions. Generally accepted standards of care, in contrast, call for treatment unless there is "clear and compelling" evidence that a lower level of care is more appropriate (i.e., the burden of proof is reversed), do not condition treatment on the acute risk of deterioration, and instead focus on long-term recovery,

recognizing that extended and intensive outpatient treatment is often necessary to address chronic conditions and promote lasting stability. Second, UBH's guidelines require patients to demonstrate "acute changes" in their conditions or circumstances that now warrant treatment, even though generally accepted standards articulate no such requirement and call for treatment when chronic symptoms are present. Third, UBH's guidelines ignore patient motivation and clinician assessments of patients' readiness and ability to benefit from reduced levels of care. Fourth, UBH's guidelines call for the denial of claims seeking treatment for borderline personality disorder when that diagnosis is primary, despite the fact that generally accepted standards of care do not contain such a restriction.

96. The fact that UBH's guidelines are more restrictive than its plans or generally accepted standards of care is not particularly surprising. As early as 2009, ASAM cautioned in its *Public Policy Statement on Managed Care, Addiction Medicine, and Parity* that when an insurer like UBH "develops its own treatment level of care and continuing stay guidelines for authorizing or denying requested treatment rather than adhering to nationally validated, reliable, and accepted guidelines, it may appear that decision-influencing factors such as cost considerations outweigh valid evidence-based authorization requests for medically necessary treatment."

Denials Under the Empire Plan Mental Health And Substance Abuse Program

97. Although New York Insurance Law § 4903(e) requires that "Notice of an adverse determination made by a utilization review agent shall be in writing and must include: (1) the reasons for the determination including the clinical rationale," and although United represented in its Technical Proposal submitted to the New York Department of Civil Service as part of its 2008 Request for Proposal (both incorporated into the January 1, 2009 Master Agreement) that "When an authorization for care is denied, a non-certification letter is sent to the member that ***thoroughly***

explains the reasons for the non-certification," United's adverse determination letters contain nothing more than boilerplate language that fails to meaningfully explain denial rationales.

98. For example, United's June 4, 2012 denial letter to John merely indicated, "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."

99. In similar conclusory fashion, United's September 12, 2012 denial letter to John merely stated, "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."

100. In fact, United's boilerplate denial letters bear striking resemblance to those sent by EmblemHealth and cited as materially defective by the New York State Attorney General in July 2014 Assurance of Discontinuance Under Executive Law (Assurance No. 14-031):

> Emblem's adverse determination letters denying behavioral health claims are generic and lack specific detail explaining why coverage was denied for particular members. The letters also fail to explain adequately the medical necessity criteria used in making the determinations and why members failed to meet such criteria. For example, each of the denial letters contain boilerplate language such as:
>
> ☐ ["T]he information indicates the patient has made progress toward treatment goals and no longer requires the same frequency of treatment."
>
> ☐ ["T]he review indicates that the treatment plan goals and objectives have been attained and that the signs and symptoms that brought the patient into the treatment have been stabilized."

☐ "[T]he review does not indicate the presence of biomedical or psychological impairment, or the likelihood of relapse requiring treatment at the acute inpatient hospitalization with 24 hour medical supervision level of care. An appropriate level of care to the current needs of the patient is intensive outpatient services."

Without details of the denial or the criteria used in making the determination, members are without the means to lodge a meaningful appeal of Emblem's denials.

Emblem has admitted that, in its denial letters, "[c]linical rationales primarily state in general rather than specific terms why the member's condition does not meet medical necessity criteria." Emblem has also admitted that the boilerplate denial reasons in the letters are not sufficient and that denial letters often mischaracterize the level of treatment requested. Such flawed letters call into question the accuracy of Emblem's adverse decisions. Emblem's letters denying coverage for medical/surgical conditions, however, are more detailed.

Appeals Under the Empire Plan Mental Health and Substance Abuse Program

101. New York Insurance Law § 4904(d) requires that "appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination."

102. Pursuant to the January 1, 2009 Master Agreement between United and the State of New York Department of Civil Service, United was required to ensure the following with respect to appeals of adverse benefits determinations:

> 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.

103. In its Technical Proposal submitted to the Department of Civil Service (and incorporated by reference into the Master Agreement), United confirmed that:

> The Program's dedicated clinical team will work under the supervision of an experienced leadership team, including an Executive Director, ***two Medical Directors*** (1.5 FTE), and three Clinical Program Managers, all dedicated to serving Program members. We will recruit behavioral health professionals, licensed to practice in the State of New York, who have experience and understanding of the local provider community.
>
> * * *
>
> 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 . . .

104. Thus, United's Certificate of Insurance provides for two levels of internal appeals and specifically states that "another OptumHealth peer advisor will review your case and make a determination" subsequent to any initial, clinical claims denials. The clear import from the statement is that the reviewer will be ***independent***. With regard to second level appeals, United's 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. . . .

105. Despite its promises to insureds, however, United's appeals process systematically fails to ensure reviewer independence due to structural defects. Under United's flawed staffing arrangement, while initial denials are issued by one of OptumHealth's Medical Directors, OptumHealth's practice (as confirmed by its Technical Proposal and Certificate of Insurance) is to assign first level appeals either to: 1) "off-site Peer-Advisors" whose recommendations must be approved or rejected by ***OptumHealth*** "Associate Medical Directors" (who are subordinates of its Medical Directors and are by definition not "independent"); or 2) UBH's second Medical Director. Additionally, to the degree that first level appeals are not fatally adjudicated by UBH subordinates of the two Medical Directors and are instead assigned to the second UBH Medical Director, any

second level appeal must necessarily make use of either Medical Director who previously denied the claim.

106. That is exactly what happened in John's case. As detailed above, United's initial denial of John's care was decided by Dr. Sigler, a Medical Director. Dr. Kamins' first-level appeal was then decided by Dr. Becker, an Associate Medical Director *and thus a subordinate of Dr. Sigler*. Finally, Dr. Kamins' second-level appeal was decided by a three-doctor panel *that again included Dr. Sigler*. In other words, none of Dr. Kamins' appeals were reviewed under even a minimum standard of independence or due process.

VIOLATION OF NEW YORK'S PARITY LAW

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

108. In order to provide mental health coverage that is "at least equal" to coverage for other health conditions or constitutes "comparable coverage," Defendants 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.

109. Despite United's material inducements, its practices fall far short, and each of the United policies and practices described above which violate Timothy's Law. Because of the limitations placed on mental health care coverage, Defendants fail 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

110. 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.

111. Defendants have violated this provision by administering mental health insurance policies in a manner violating the New York Parity Law. Its disparate medical necessity definitions for mental health conditions, disparate financial requirements, misrepresentation of covered benefits to insureds, and utilization review policies with respect to the Empire Plan all violate the New York Parity Law. While some of these disparate policies are disclosed in the documents provided to Empire Plan members, others (as detailed above) were applied pursuant to secret and

undisclosed internal policies. 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.

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

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

> 8.1.3 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.

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

115. As detailed herein, 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.

CLASS CLAIMS

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

All persons receiving health insurance coverage under the Empire Plan who, from inception of the statute of limitations period applicable to this claim until the final termination of this action ("Class Period"), submitted health insurance claims for mental health care services for coverage under the Empire Plan which were 1) subjected to disparate medical necessity definitions, treatment criteria or utilization review procedures for mental health and substance use disorders, or 2) adversely adjudicated through United's appeal processes.

COMMON CLASS CLAIMS, ISSUES AND DEFENSES FOR THE CLASS

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

1. Whether Defendants violated Timothy's Law by applying medical necessity definitions, treatment criteria or utilization review guidelines for mental health services that were not comparable to or were more stringent than policies applied to medical/surgical services;
2. Whether Defendants violated New York's GBL § 349 by applying medical necessity definitions, treatment criteria or utilization review guidelines for mental health services that were not comparable to or were more stringent than policies applied to medical/surgical services;
3. Whether Defendants violated New York's GBL § 349 by failing to assure independence in appeal adjudications of mental health care claims;
4. Whether Defendants breached the terms of the Empire Plan by applying restrictive coverage policies for mental health care;
5. Whether Defendants breach their fiduciary duties to Empire Plan members by applying restrictive coverage policies for mental health care;
6. Whether members of the proposed Class are entitled to an injunction prohibiting Defendants from applying the policies identified herein for reducing coverage for mental health care services;
7. Whether members of the proposed Class are entitled to an injunction mandating re-adjudication of appeals previously adjudicated without sufficient independence.
8. Whether members of the proposed Class are entitled to payment of benefits improperly denied as a result of Defendants' restrictive coverage policies.
9. Whether members of the proposed Class are entitled to payment of damages for injuries suffered as a result of Defendants' use of illegal coverage policies;
10. What is the statute of limitations for the various statutes identified herein.

ADDITIONAL CLASS ACTION ALLEGATIONS

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

119. 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.

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

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

122. A class action is superior to other available methods for the fair and efficient adjudication of this controversy because joinder of all members of the Class is impracticable.

Further, the expense and burden of individual litigation make it impossible for the Class members individually to redress the harm done to them. Notably, many members might be too ashamed or intimidated to prosecute their individual claims. Given the uniform policy and practices at issue, there will also be no difficulty in the management of this litigation as a class action.

COUNT I

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

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

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

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

126. During the Class Period, Dr. Kamins and the members of the putative Class have been harmed by Defendants' violations of Timothy's Law. Dr. Kamins, on his own behalf and on behalf of the members of the putative class, seeks to enjoin Defendants from pursuing policies that violate Timothy's Law, as detailed herein, requests that Defendants reprocess and reimburse benefits which were denied or reduced as a result of such policies, and requests that Defendants

pay appropriate interest back to the date such claims were originally submitted. Dr. Kamins also sues for declaratory and injunctive relief related to enforcement of Timothy's Law, and further requests attorneys' fees, costs, prejudgment interest and other appropriate relief against Defendants.

COUNT II

CLAIM FOR RELIEF UNDER NEW YORK GBL § 349

(on behalf of Plaintiff and the putative Class)

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

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

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

COUNT III

CLAIM FOR BREACH OF CONTRACT

(on behalf of Plaintiff and the purported Class)

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

131. As detailed herein, Defendants breached the terms of the Empire Plan by applying level of care standards more restrictive than those mandated by the Plan terms.

132. As further detailed herein, Defendants violated the terms of the Empire Plan by failing to comply with applicable laws, including the New York Parity Law, incorporated therein.

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

134. As a result of Defendants' breach of the terms of terms of the Empire Plan, Plaintiff was denied benefits and due process rights to which he was entitled. Plaintiff was thus injured by Defendants' depravation of benefits owed to him, as well as his opportunity to challenge Defendants' benefit determinations as provided by the terms of the Empire Plan.

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

COUNT IV

CLAIM FOR BREACH OF FIDUCIARY DUTY

(on behalf of Plaintiff and the putative Class)

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

137. Plaintiff and the members of the putative Class entrusted Defendants with authority to make coverage and benefit determinations and to apply appellate procedures consistent with the terms of the Empire Plan. To those ends, Plaintiff and the members of the putative Class reposed trust and confidence in the Empire Plan to select a worthy and reputable claims administrator to carry out such coverage, benefit and appellate functions. Plaintiff and the members of the putative Class similarly reposed trust and confidence in United to promulgate and carry out internal claims adjudication policies in compliance with Empire Plan terms and applicable laws. As a result, Defendants owed fiduciary duties to Plaintiff and the members of the putative Class.

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

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

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

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

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

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

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

Issuing a permanent injunction ordering Defendants to cease imposing preauthorization and concurrent review requirements with regard to outpatient mental health care services, to cease relying on the medical necessity definition for mental health care services as incorporated into the Empire Plan or plans with similar definitions, and to cease adjudicating appeals in a manner that fails to meet required standards of independence and due process;

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

Ordering Defendants to re-adjudicate appeals that failed to meet required standards of independence and due process;

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

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

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

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

JURY DEMAND

Plaintiffs demand trial by jury on all issues so triable.

Respectfully submitted,
February 6, 2015

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