UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

AMERICAN PSYCHIATRIC ASSOCIATION (ON BEHALF OF ITS MEMBERS AND THEIR PATIENTS); **CONNECTICUT PSYCHIATRIC SOCIETY, INC.** (ON BEHALF OF ITS MEMBERS AND THEIR PATIENTS); **CONNECTICUT COUNCIL OF CHILD AND ADOLESCENT PSYCHIATRY, INC.** (ON BEHALF OF ITS MEMBERS AND THEIR PATIENTS); **SUSAN SAVULAK, M.D. D/B/A ASSOCIATES IN PSYCHOTHERAPY & PSYCHIATRY, LLC** (ON BEHALF OF HERSELF, HER PATIENTS AND AS ASSIGNEE OF BG AND SM); **THEODORE ZANKER, M.D.** (ON BEHALF OF HIMSELF AND HIS PATIENTS); AND **W.W.** (IN HER INDIVIDUAL CAPACITY)	CIVIL ACTION NO. 3:13-CV-00494 (JBA)
Plaintiffs,	
v.	
ANTHEM HEALTH PLANS, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD AND WELLPOINT, INC	
Defendants.	NOVEMBER 21, 2013

SECOND AMENDED COMPLAINT

Nature of the Action

Plaintiffs – mental health patients, psychiatrists, and professional associations – bring this action to enforce their rights and the rights of their members and their

members' patients under the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). Congress passed MHPAEA to end discrimination in access to health care against patients with mental health and substance use disorders ("MH/SUDs"). The law, along with implementing regulations adopted by the Departments of Labor, Treasury and Health and Human Services expressly prohibits health plan providers and health insurers from adopting or implementing limitations on mental health benefits that are more stringent or restrictive than comparable limitations on other medical and surgical benefits. Among other things, the law prohibits plans and insurers from using methodologies for developing reimbursement rates for mental health treatment that are less favorable than the methodologies used to develop reimbursement rates for other types of medical and surgical treatment.

Defendants provide health plans and other health insurance in Connecticut and set the policies that govern and act as fiduciaries for such plans. Defendants have violated MHPAEA and their contractual obligations to in-network physicians by applying formulas and methodologies for determining reimbursement rates for psychiatric physician services that are not comparable to and are applied more stringently than the formulas and methodologies for determining reimbursement rates for non-psychiatric physician services. In so doing, Defendants have violated their obligations under ERISA as health plan providers and plan fiduciaries, breached their contracts with in-network health care providers, and tortiously interfered with the relationship between psychiatrists and their patients and patients and their health plans.

The importance of this case is acute. In their lifetime, one in five Americans will suffer a mental illness and five percent of Americans will suffer a severe mental illness. 70-90 percent of those who seek treatment will find relief and live normal productive lives. *But less than one third of those who need treatment have access to mental health care.* As a result, millions of Americans suffering from mental illness are denied the treatment to which they are entitled and that would enable them to live healthy and productive lives. Medically necessary MH/SUD services in Connecticut and elsewhere in the United States are inadequate to meet the urgent demand created by patients in need. The number of psychiatrists in networks is insufficient to meet patient needs. While the purpose of health insurance is to facilitate access to medically necessary health care services, Defendants have exacerbated the access crisis by discrimination in payment for psychiatric services which further limits network access and access to the full panoply of benefits to which patients are entitled under their health plans.

Plaintiffs seek a declaration that Defendants have violated MHPAEA and an injunction requiring Defendants to conform their reimbursement rates and policies to the requirements of federal law and their contracts with providers. In the absence of such relief, Defendants will be able to continue violating federal law with impunity, and patients and their families will continue to suffer. Enforcement of Defendants' obligations in this case, by contrast, will be a critical step towards realizing the mandate that Congress adopted to end discrimination against and stigma associated with mental illness

The Parties

1. Plaintiff American Psychiatric Association (hereinafter, "APA") is a 501(c)(6) corporation under the Internal Revenue Code that is incorporated in the District of Columbia, with its principal place of business at 1000 Wilson Boulevard, Suite 1825, Arlington, Virginia. The APA is a membership organization with approximately 34,000 member psychiatrists, 750 of whom practice and/or reside in the State of Connecticut and do business with insurance companies including the Defendants on an in-network or out-of-network basis. APA's mission includes promotion of the common professional interests of its members, improving the treatment, rehabilitation and care of persons with mental disorders, advancing standards of psychiatric services and facilities, and promoting the best interests of patients actually or potentially making use of mental health resources. APA brings this Complaint on behalf of: (a) its member psychiatrists in the State of Connecticut who participate in the Defendants' networks or deal with the Defendants on an out-of-network basis; (b) its members outside of the State of Connecticut who treat the Defendants' subscribers with Connecticut-based insurance on an in-network or out-of-network basis; and (c) the patients of its member psychiatrists in the State of Connecticut who are subscribers of and/or beneficiaries covered under the Defendants' health plans.

2. Plaintiff Connecticut Psychiatric Society, Inc. (hereinafter, "CPS") is a 501(c)(6) corporation under the Internal Revenue Code that is incorporated in the State of Connecticut, with a principal place of business at One Regency Drive, Bloomfield, Connecticut. It is a membership organization comprised of approximately

750 psychiatrists practicing and/or residing in the State of Connecticut. CPS is a district branch of the APA. All CPS members are also members of the APA. CPS's mission is to advocate for psychiatric patients and those who care for them, promote and disseminate professional values, and to strengthen the scientific basis of psychiatric diagnosis and treatment. CPS brings this Complaint on behalf of: (a) its member psychiatrists in the State of Connecticut who participate in the Defendants' networks or deal with the Defendants on an out-of-network basis; and (b) the patients of its member psychiatrists in the State of Connecticut who are subscribers of and/or beneficiaries covered under the Defendants' health plans.

3. Plaintiff Connecticut Council of Child and Adolescent Psychiatry, Inc. (hereinafter, "CCCAP") is a 501(c)(6) corporation under the Internal Revenue Code that is incorporated in the State of Connecticut, with its principal place of business at 104 Hungerford Street, Hartford, Connecticut. CCCAP is a membership organization exclusively for psychiatrists who specialize in child and adolescent mental health issues. CCCAP has 225 members in the State of Connecticut. Its mission is to promote the healthy development of children, adolescents, and families through research, training, advocacy, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers. CCCAP brings this Complaint on behalf of: (a) its member psychiatrists in the State of Connecticut who are in the Defendants' networks or deal with the Defendants on an out-of-network basis; and (b) the child and adolescent patients of CCCAP member psychiatrists in the State of Connecticut who are subscribers and/or beneficiaries covered under the Defendants' health plans.

4. Plaintiff Susan Savulak, M.D. d/b/a Associates in Psychotherapy and Psychiatry, LLC (hereinafter, "Dr. Savulak") is a medical doctor certified by the American Board of Psychiatry and Neurology in the practice of psychiatry. Dr. Savulak is licensed to practice and does practice psychiatry in the State of Connecticut. Her principal place of business is at 74 East Street, Suite 304, Plainville, Connecticut. She is a participating provider in the Defendants' insurance plans. Dr. Savulak brings this Complaint on behalf of herself, on behalf of her patients who are insured under plans where Defendants either provide the insurance or exercise discretion to determine provider reimbursement rates and patient coverage, and on behalf of two mental health consumers who have assigned "all right title and interest in and to any claim or cause of action in law or in equity, including but not limited to claims for breach of fiduciary duty, injunctive and declaratory relief, arising out of or relating to any alleged violation of the Mental Health Parity and Addiction Equity Act, the Employee Retirement Income Security Act, or any provision of state law that relates to those claims against [their] plan . . ." to her. Her patients rely upon her to provide diagnosis and treatment of illness (including psychotherapy), to defend their need for treatment when the Defendants inquire, and to correctly bill and code the treatments she provides so that the Defendants will provide coverage and medical records will be accurate.

5. Dr. Savulak's patients and assignors are unwilling to come forward as individual named plaintiffs in this case or to identify themselves to their employers as mental health beneficiaries because of the unjust stigma associated with mental illness, because of their fear that their employers will learn of their illness,

discrimination against them and because acting as a plaintiff in a lawsuit may be stressful and deleterious to their treatment progress.

6. Plaintiff W.W. (hereinafter, "W.W.") is an individual who is insured by the State of Connecticut under a plan administered by Anthem. The State elected to be compliant with MHPAEA. The State has given Anthem broad discretion under this plan to administer benefits and to determine the payment of benefits and reimbursement rates for providers in compliance with MHPAEA. W.W. has elected to pay additional amounts of money for her insurance in order to secure an out-of-network benefit option in her health plan. She is a resident of the State of Connecticut and accesses mental health benefits in her Point of Service Anthem Blue Cross Blue Shield Plan. W.W.'s psychiatrist does not participate in Anthem's networks. W.W. sees her treating physician for psychotherapy and psychopharmacological management, pays the doctors' fees, and then seeks reimbursement from Defendant Anthem using her out-of-network benefit.

7. Plaintiff Theodore Zanker, MD is a medical doctor certified by the American Board of Psychiatry and Neurology in the practice of psychiatry and child psychiatry. Dr. Zanker is licensed to practice and does practice psychiatry in the State of Connecticut. His principal place of business is at 315 Whitney Avenue, New Haven, Connecticut. Through his hospital employment, Dr. Zanker was formerly a participating provider in Anthem's network, but no longer participates in the network. He brings this Complaint on behalf of himself and his patients who received insurance through Defendants or through plans administered by Defendants under which Defendants have complete discretion in setting provider reimbursement rates. Child

and adolescent patients and their families rely upon their psychiatrists to provide diagnosis and treatment of illness, to defend their need for treatment when the Defendants inquire, and to correctly bill and code the treatment provided so that coverage and medical records will be accurate. Dr. Zanker's patients on whose behalf this claim is brought are fully insured by Defendants, or are insured by their employer's self-funded plan which gives Defendants unfettered discretion to determine coverage, medical necessity and reimbursement rates.

8. Defendant Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem") is a Connecticut corporation with a principal place of business at 108 Leigus Road, Wallingford, Connecticut. Anthem offers several health plans in Connecticut. Anthem also administers health plans in Connecticut and is given unfettered discretion in administration of those plans regarding setting of rates for providers and on determination of coverage, benefits and medical necessity. On information and belief, Anthem is a subsidiary of WellPoint, Inc. and gets its instruction for the operation on these plans, including provider reimbursement rate determinations, from WellPoint.

9. Defendant WellPoint, Inc. (hereinafter "WellPoint") is an Indiana corporation, with its principal place of business at 120 Monument Circle, Indianapolis, Indiana. WellPoint directly or indirectly owns 100% of the stock of Anthem. WellPoint reports that it is one of the largest health benefits companies in the United States and, in 2012, posted net profits of over $2.6 billion. In the first six months of 2013, while the events described herein occurred, WellPoint and its subsidiaries posted net profits of nearly $1.7 billion. On information and belief, WellPoint sets policies across its

Anthem subsidiaries, including coverage polices and national policies for the methodologies WellPoint subsidiaries use to set provider reimbursement rates and apply medical necessity standards. To set these polices, WellPoint employs a "Chief Medical Officer," Vice President of Patient Innovation, Enterprise Execution and Efficiency and Clinical Health Policy Officer to set policies, including policies for mental health care and provider reimbursement rates for all companies in the WellPoint family. Through the setting of these policies, WellPoint exercises discretionary authority and control respecting the health plans offered by Anthem and Anthem's decisions with regard to administration of self -funded plans.

Jurisdiction and Venue

10. Jurisdiction in this Court is appropriate under 28 U.S.C. §1331 and 29 U.S.C. §1132(e)(1) as this case arises under a federal statute, the Employee Retirement Income Security Act ("ERISA") including the Mental Health Parity and Addiction Equity Act (MHPAEA) and seeks declaratory and injunctive relief pursuant to section 502(a)(3) of ERISA. The complaint alleges a system-wide violation of a statute (MHPAEA) through the manner in which Defendants set reimbursement rates for mental health providers and seeks a declaration from this Court that Defendants conduct violates MHPAEA and injunctive relief precluding such future violations.

11. This Court has supplemental jurisdiction under section 28 U.S.C. § 1367 over the claims arising under state law as the claims arise out of the same set of operative facts and the same transaction or occurrence as the claims under ERISA.

12. Venue is appropriate in this District under 28 U.S.C. §1391(b)(1) and (2) and 29 U.S.C. §1132(e)(2) as Anthem resides in this District, other Defendants do

business in this District and substantially all of the actions and omissions committed by the Defendants which give rise to the complaint and injury alleged occurred in this district.

13. This Court has personal jurisdiction over the Defendants because Anthem resides in this District, other Defendants do business in this District, and because substantially all of the actions giving rise to this Complaint occurred in this District, or had a substantial impact in and have caused injury within this District.

14. Plaintiffs APA, CPS, and CCCAP have standing to bring this Second Amended Complaint on behalf of their members. The associations' members have standing in their own right in that they have suffered injury and will continue to have patient relationships threatened by Defendants' conduct unless this Court intervenes. The interests the associations seek to protect are germane to their missions. Neither the claims asserted nor the declaratory and injunctive relief requested require the participation of any individual member of the associations in the lawsuit.

15. Drs. Savulak and Zanker have standing to bring claims on behalf of their patients. Their respective patients have standing in their own right because those patients have suffered or will suffer discrimination and injury caused by Defendants' unlawful conduct, and the declaratory and injunctive relief requested herein would redress that injury. Drs. Savulak and Zanker have standing to bring those claims on their patients' behalf because the unique and intimate doctor-patient relationship between a psychiatrist and a patient aligns their interests in litigating the claims, and psychiatric patients face substantial obstacles in bringing and litigating claims on their own behalf, both because of the unjust stigma associated with mental illness and

because of the inherent challenges of their condition. Dr. Savulak also has standing as assignee of BG's and SM's claims.

16. APA, CPS, and CCCAP have standing to bring claims on behalf of their members' patients. These associations' members, like Drs. Savulak and Zanker, have standing to bring claims on behalf of their patients because the nature of the relationship between a psychiatrist and his or her patient aligns their interests in litigation, and because those patients face substantial obstacles in bringing and litigating a case on their own behalf. The associations in turn have standing to litigate these claims on behalf of their members because those members have standing in their own right, the interests the associations seek to protect are germane to their missions, and neither the claims asserted nor the declaratory and injunctive relief requested require the participation of any individual members of the associations or patients in the lawsuit.

17. The Parties are engaged in a real and justiciable controversy concerning the legality of the Defendants' actions described herein and seek the Court's intervention to resolve the dispute and declare the rights of the Parties.

Background Facts

A. BG's Company Plan

18. Susan Savulak, MD is the assignee of BG who is a participant of a self-insured health plan, Lumenos Health Savings Account ("LHSA") provided by her employer, "BG's Employer".[1] The Plan covers more than 50 employees and is subject

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[1] Plaintiffs concurrently filed a motion to hold the name of the employer and the name of the plan participant who assigned the claim in confidence to avoid

to MHPAEA. BG has assigned "all right title and interest in and to any claim or cause of action in law or in equity, including but not limited to claims for breach of fiduciary duty and for injunctive and declaratory relief, arising out of or relating to any alleged violation of the Mental Health Parity and Addiction Equity Act, the Employee Retirement Income Security Act, or any provision of state law that relates to those claims against the health plan . . ." to Dr. Savulak. The LHSA is an Anthem product. Anthem and WellPoint are fiduciaries of this Plan under ERISA because they have and exercise discretionary authority and/or discretionary responsibility in administering the Plan. 29 USC §1002(21)(A)(iii). Specifically, Anthem has "complete discretion to determine the administration of the Covered Person's benefits. Anthem BCBS' determination shall be final and conclusive and may include, without limitations, a determination of whether the services, care, treatment, or supplies are Medically Necessary . . . whether [provider] charges are consistent with its Maximal Allowable Amount." Anthem also has the sole authority to construe the contract and to establish and amend rules, regulations and procedures regarding interpretation and administration of the plan, and to determine reimbursement rate for providers. Upon information and belief, WellPoint sets corporate policy for determination of provider rates which is followed and executed by Anthem in servicing its contract.

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public disclosure of the Assignors' condition and to prevent Assignors' employer from becoming aware of it or the Assignee's complaint.

B. SM's Company Plan

19. SM is a beneficiary under an Anthem insured Lumenos Health Savings Plan provided by SM's spouse's employer, "SM's Spouse's Company". The Plan covers more than 50 employees and is subject to MHPAEA. SM has assigned "all right title and interest in and to any claim or cause of action in law or in equity, including but not limited to claims for breach of fiduciary duty and for injunctive and declaratory relief, arising out of or relating to any alleged violation of the Mental Health Parity and Addiction Equity Act, the Employee Retirement Income Security Act, or any provision of state law that relates to those claims against the health plan . . . "to Dr. Savulak. SM uses in network benefits for treatment of SM's mental health condition.

20. Under SM's Spouse's Company Plan, Anthem has unfettered discretion to set provider reimbursement rates, make medical management decisions and to determine coverage under the Plan. Upon information and belief, WellPoint sets corporate policy for determination of provider rates which is followed and executed by Anthem in servicing its contract.

21. Defendants have set those rates in violation of MHPAEA causing network providers to leave the network, services to be reduced and discrimination against mental health patients.

C. W.W.'s Plan

22. W.W. is a participant in the State of Connecticut Point of Service Health Benefit Plan.

23. The State of Connecticut is the Plan Sponsor. The Plan covers more than 50 employees.

24. Anthem is the Plan Administrator and provides health insurance under this Plan.

25. Under the Plan, W.W.'s mental health treatment services obtained outside the network are reimbursed at 80% of the allowable cost (after payment of the annual deductible). She also pays 100% of the amount that the Out-of Network Provider bills above the Maximum Allowable Amount.

26. The Plan Document gives Anthem complete discretion in determining whether services are medically necessary.

27. Anthem determines the rates paid to in and out of network providers. Upon information and belief, WellPoint sets corporate policy for determination of provider rates which is followed and executed by Anthem in servicing its contract.

28. The Plan provides that mental health conditions will be covered to the same extent as the medical/surgical coverage described in the Plan.

29. Pursuant to MHPAEA, sponsors of self-funded, nonfederal governmental plans, like the State of Connecticut, are permitted to elect to exempt those plans from ("opt out of") compliance with MHPAEA.

30. The State of Connecticut has not opted out of the MHPAEA.

31. Accordingly, W.W.'s Plan is subject to MHPAEA's requirements.

D. All Other Plans Defendants Insure, Administer or For Which Defendants Act as A Fiduciary.

32. In every situation where Defendants act as the insurance issuer, Plan Administrator or as a fiduciary under any health plan, they maintain sole discretion to set provider reimbursement rates and, upon information and belief, does so pursuant to a formula established by WellPoint for its subsidiaries.

33. Anthem and WellPoint determine the rate they will pay for a specific service or procedure and dictate that rate across the board to any psychiatrist in its network, across all plans. While some large groups have the ability to negotiate provider rates, Anthem will not negotiate rates with small groups or individual practitioners – which comprise a significant part of its provider network. Accordingly, whether the plan is self-insured with Defendants acting in a fiduciary capacity or fully insured by Defendants, Defendants use the same network of providers and pay them the same reimbursement rates regardless of the particulars of the individual plan. Accordingly, any health plan for which Defendants provide the network of physicians violates MHPAEA and the particulars of a given plan are inconsequential to this conduct.

E. <u>Mental Health Facts</u>

34. Psychiatrists are medical doctors who specialize in the prevention, diagnosis and treatment of MH/SUDs. Psychiatrists treat the biological, psychological and social components of mental illness and substance use disorders. As medical doctors, psychiatrists are trained and qualified to provide basic medical evaluation and management services identical to other physicians. They attend the same medical school programs as other physicians and, in addition, complete at least another four-year residency program after medical school that focuses on the prevention, diagnosis and treatment of MH/SUDs.

35. A psychiatrist who participates in a Defendants' network is an "in-network" or "participating" provider and contracts with Defendants. The patients pay only an agreed upon co-payment and/or deductible and Anthem or the insurer pays

the doctor an "agreed-upon" fixed fee for service dictated by the provider's contract with Anthem. In most cases, Defendants dictate the fees and will not negotiate them. In-network psychiatrists often take on the responsibility of all administrative services involved in a patient's access to care, including billing, appealing claim denials, and applying for pre-authorizations for treatment because this complex and tedious process often proves daunting for patients with MH/SUDs. Psychiatrists are not compensated for this time.

36. Many psychiatrists will not participate in the Defendants' networks because they refuse to accept the fees that Defendants dictate. Defendants generally reimburse psychiatrists less than they reimburse non-psychiatric physicians who provide comparable medical services. Further, Defendants impose onerous administrative requirements on psychiatrists which can interfere with the doctor's ability to provide quality care. If patients possess the financial resources, they can see these "out-of-network" or "non-participating" physicians and pay the psychiatrist's fees directly out of their own pocket. If patients pay additional premiums for an "out-of-network benefit" in their plan, they may be reimbursed for the amount that Defendants would have paid an in-network doctor, or another rate determined by Defendants. In the vast majority of circumstances, it is much more expensive for patients to see out-of network psychiatrists, because patients must pay the difference between what Defendants have agreed to pay and the doctor's market fee. Seeing an out-of network psychiatrist costs disproportionately more than seeing out-of-network, non-psychiatric physician because Defendants reimburse psychiatric patients less for MH/SUD visits than it does for non-psychiatric physician visits.

37. Many mental health patients in Connecticut, and throughout the country, must see out of network psychiatrists because Defendants' network of psychiatrists is insufficient to meet the demand for psychiatric care. If Defendants' network were adequate, there would be no need for patients to seek out of network service at higher personal cost or to forego medically necessary treatment.

F. Insurance Coding Facts

38. CPT, which stands for Current Procedural Terminology, is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical (mental health and non-mental health related), surgical, and diagnostic services in order to facilitate an effective means for reliable nationwide communication among physicians and other healthcare providers, patients and third parties, such as insurance companies. CPT is the federally mandated procedure code set, and all health care plans and providers who transmit information electronically are required by federal law to use these established national standards in their business practices.

39. Each psychiatric diagnosis is represented by a diagnostic code on insurance forms and in patients' medical records. Each treatment or procedure provided in connection with a diagnosis of an illness is represented on insurance forms, including billing forms, and in the patient's medical records by a CPT code.

40. Effective January 1, 2013, the federal government adopted changes to certain CPT codes including that psychiatrists who perform or provide medical services similar to other non-psychiatric physicians bill the same CPT codes as their non-psychiatric physician counterparts. In addition, as a result of these changes,

psychiatrists were instructed to use "add-on" procedure codes to insure that other services provided by psychiatrists in the same visit as, and in conjunction with, medical services, such as psychotherapy, would be formally and properly documented and compensated.

41. In psychiatry, during a patient visit, the psychiatrist may provide primary medical evaluation and management ("E/M") services, which include a medical evaluation of the patient's condition and review of the patient's medications and/or other medical conditions that may relate to the patient's psychiatric illness. During this same visit, the psychiatrist may also provide other services (e.g., psychotherapy). Prior to January 1, 2013, psychiatric physicians used different codes that combined the values for E/M and psychotherapy services into one code. Under current federal guidelines, the psychiatrist records the CPT code for the E/M service and the additional service and bills the patient or the insurance company for each service (i.e., the E/M service plus the psychotherapy). Non-psychiatric physicians also bill and are paid in this manner, i.e., for a primary medical code and for work in addition to the primary visit/medical service that is reflected in "add-on" codes.

42. A separate process exists to determine the value of the service reflected by each primary and add-on CPT code. The Centers for Medicare and Medicaid Services ("CMS") establish a total value, including a physician work value for each relevant CPT code. The factors used to determine physician work value include the time required to perform the services; the technical skill and physician effort required; the mental effort and judgment required; and the stress due to the potential risk to the patient. Thus, the value ascribed to the CPT code that represents a more difficult case

is generally more than the value ascribed to the more common illnesses. The physician work value for a given CPT code remains the same regardless of the physician's specialty. In other words, the federal government recognizes that all physicians billing the same code provide a specific service that has the same value. The Medicare Fee schedule established by CMS is based upon these work values and ascribes the same payment to all physicians who bill the same code (i.e., equal pay for comparable work).

G. Defendants' Conduct

43. The Defendants have used the CPT code changes as a platform to limit and distort services provided by psychiatrists, to reduce the fees paid to psychiatrists, to impose a greater burden and expense upon patients receiving psychiatric treatment than they impose upon patients seeking non-psychiatric medical services, and to further hinder access to medically necessary psychiatric care through further reduction in network adequacy.

44. The manner in which Defendants have accomplished this has varied since January of 2013, but has never been in compliance with the law. For example, Anthem originally told psychiatrists that they could not bill or code via an "add-on" for psychotherapy on the same day in which they provided medical services. This required doctors to either provide a time consuming service, such as psychotherapy, without charge or code, or to ask the patient to come back for psychotherapy on another day thereby making access to needed psychiatric services more restrictive than allowable by law because patients would be required to visit twice for a service that should be provided in one visit and incur more costs associated with another visit.

Moreover, medical records need to be accurate so all treatments need to be coded and noted in the record.

45. Later, Anthem required psychiatrists to make a note of the psychotherapy Defendants service in the patient record, but the Defendants still would not pay for the psychotherapy provided in the same visit. Notwithstanding the fact that no value was assigned to the psychotherapy add-on code when payment to the physician was considered, Defendants charged the patient a co-payment for each service, increasing the out-of-pocket cost to patients who receive two services in one visit.

46. Through manipulation of the reimbursement schedules, Defendants have limited the scope of the benefits provided by discouraging psychiatrists from providing an appropriate scope of service where indicated as medically necessary (i.e., psychotherapy in addition to basic E/M in the same visit) because payment for a 45 minute visit that includes psychotherapy and medical evaluation and management is not noticeably more than payment for a 15 minute visit that provides medical evaluation and management alone. Where psychiatrists do not provide psychotherapy, the patient is required either to see a second provider for that service or to return to the same psychiatrist on a different day for psychotherapy services. Either way, the patient is required to pay additional co-payments and experiences additional time burdens that should not be necessary and are not required of medical/surgical benefit recipients. Many patients will forgo medically necessary psychotherapy because they cannot afford the expense or the additional time and inconvenience of receiving it.

47. W.W.'s out-of-network provider sees her for psychotherapy, medical evaluation and management and/or psychopharmacologic management. The psychiatrist's fees have remained constant in 2012 and 2013. Yet, in 2013, when Defendants changed the fee schedule, the amount that Defendants reimbursed for the identical services was almost 50% less than in 2012, causing W.W. to incur out-of-pocket costs that she could not afford to pay, thereby reducing her treatment options and frequency.

48. Dr. Savulak complained to the Connecticut Insurance Department and APA, CPS, and CCCAP asked Defendants to address these issues. Defendants refused. Plaintiffs filed their Original Complaint.

49. After Plaintiffs filed the Original Complaint, Anthem sent psychiatrists in Connecticut another new fee schedule which they dictated would be effective almost immediately. That fee schedule *dramatically reduced* the amount Defendants would pay for some E/M services and provided some fees for psychotherapy that were so low that there was no financial incentive to provide that service. In some instances, if a psychiatrist were to provide both E/M services and psychotherapy in one visit, Defendants would pay that provider 45.5% *less* for providing both services than it originally offered for E/M service alone. Under the current fee schedule, a psychiatrist will earn a higher fee for psychotherapy if he/she does not offer medical services in the same visit. Indeed, Defendants pay for psychotherapy *without* medical evaluation and management at a rate that is approximately 66% *more* than when a psychiatrist does the same amount of psychotherapy but also provides medical services in the same visit.

50. Upon information and belief, many psychiatrists dropped out of the Defendants' network, or refused to take on new patients insured by the Defendants as a result of the Defendants' actions. The cost to the patient of out-of-network care also increased because the Defendants reimbursed patients at lower rates for the same services in 2013 than they had in 2012. In short, access to MH/SUD treatment has been made more complicated and costly than treatment for medical surgical care in any plan in which Anthem has discretion over provider reimbursement rates to the detriment of patient access and medical care.

51. Approximately 50% of Dr. Savulak's patients are covered by Defendants' rates. Dr. Savulak cannot continue to remain a provider in Defendants' network under the circumstances and her patients who cannot pay out of network rates or who do not have an out of network benefit, will have to seek care from another psychiatrist in Defendants' network. Because the network is already inadequate to meet demand, these patients' conditions will deteriorate. BG and other patients will no longer have access to their long term physician with whom she has a productive relationship.

52. The Defendants' discrimination against psychiatric patients threatens the availability of in-network psychiatrists, thereby making affordable psychiatric treatment beyond the reach of many insured patients. Discouraging providers from providing psychotherapy and E/M in the same session increases patient costs and discourages them for seeking care. Continued discrimination against patients with MH/SUDs exacerbates stigma. Damages are not adequate to remedy these wrongs because most patients cannot access out of network physician services and many do not have

that benefit. Therefore those with a mental illness or substance use disorder will not have access to care.

H. Mental Health Parity and Addiction Equity Act

53. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is codified in ERISA at 29 U.S.C. §1185a. MHPAEA is an antidiscrimination statute designed to ensure that mental health insurance benefits are treated no differently than benefits available for medical and surgical claims.

54. MHPAEA prohibits group health plans and health insurance issuers that cover more than 50 employees and offer mental health and substance abuse disorders ("MH/SUD") benefits from imposing financial requirements or treatment limitations on MH/SUD benefits that are more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits covered by the health plan or health insurance issuer. MHPAEA also prohibits group health plans and health insurance issuers from imposing separate financial requirements or treatment limitations that are applicable only with respect to MH/SUD benefits. 29 U.S.C. §1185a(3).

55. MHPAEA defines two key concepts important to compliance with the law – "financial requirements" and "treatment limitations". Financial requirements set forth the cost sharing between the plan and the participant/beneficiary of a Plan, including co-payments, coinsurance, deductibles, and out-of-pocket limits. 29 U.S.C. §1185a(3)(B)(i). Treatment limitations set limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. 29 U.S.C. §1185a(3)(B)(iii).

56. The United States Departments of Labor, Treasury and Health and Human Services ("the Departments") issued Interim Final Rules ("IFR") (effective for plan years effective before July 1, 2014).[2] and the Final Rules ("FR") (effective for plan years beginning on or after July 1, 2014) to implement MHPAEA. Treatment limitations are either quantitative or non-quantitative. Quantitative treatment limitations ("QTLs") constitute treatment limitations that are "expressed numerically" (such as calendar year limits on the number of office visits or inpatient hospital days, or lifetime limits on the coverage of benefits). Non-quantitative treatment limitations, or NQTLs, are treatment limitations, which are not expressed numerically, but "otherwise limit the scope or duration of benefits for treatment under the plan."

57. Financial requirements, QTLs, and NQTLs that apply only to MH/SUD benefits are separate treatment limitations. Separate treatment limitations are a per se violation of MHPAEA.

58. The IFR explicitly states that standards for provider admission to participate in a provider network, including reimbursement rates; and plan methods for determining usual and customary rates are NQTLs that must meet MHPAEA requirements.

59. The Final Rule confirms that provider reimbursement rates are non-quantitative treatment limitations subject to the strictures of MHPAEA.

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[2] The Departments on November 8, 2013 issued the Final Rules implementing MHPAEA. These rules become effective for plan years beginning July 1, 2014 but are informative about the intended interpretation of the IFR which in many cases did not change in the Final Rule.

60. The IFR provides a test, which allows plans to equalize, for comparison sake, the NQTL applied to the MH/SUD benefit and the NQTL applied to the medical surgical benefit. If a health plan imposes an NQTL on MH/SUD benefits, the plan must demonstrate that: (1) the NQTL is comparable to the NQTL for medical/surgical benefits; and (2) the NQTL is applied no more stringently to MH/SUD benefits than to the medical/surgical benefits; or (3) there is a recognized clinically appropriate standard of care that permits an exception (i.e., more stringent or non-comparable application) to parts (1) and (2) to the NQTL comparability test above. (The Final Rule eliminated the exception after finding that there probably are no exceptions that would justify different application of standards to MH/SUD and medical surgical benefits.)

61. Under MHPAEA, an NQTL may not be imposed with respect to MH/SUD benefits unless under the terms of the plan as written and *in operation*, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD benefits are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits.

62. Upon information and belief, the Defendants do not set rates for in network or out of network psychiatric physicians in a manner that is comparable to the manner in which they set rates for non-psychiatric physicians and they apply the factors considered more stringently to psychiatric physicians in violation of MHPAEA.

63. The Defendants have not and cannot provide clinically appropriate standards of care that would permit them to engage in the service access and

payment discrimination against subscribers with a mental illness that is described above and none exist.

64. The practices described herein are more restrictive than the predominant limitations applied to substantially all of the medical and surgical benefits covered by the plans. The Defendants' discrimination against psychiatric patients threatens the availability of in-network psychiatrists (which will force patients to seek care on an out-of-network basis with lower reimbursement to patients than in the past), thereby making affordable psychiatric treatment beyond the reach of many insured patients. Discouraging providers from providing psychotherapy and E/M in the same session increases patient costs and discourages them for seeking care. Congress prohibited fiduciaries from applying financial requirements and treatment limitations to MH/SUD benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical surgical benefits, because it concluded that discrimination in this manner causes injury. It causes stigma, it interferes with the decision to seek care, it interrupts physician/patient relationships, causes patients to face higher costs of health care and more difficulty in accessing mental health care; and psychiatrists are economically disadvantaged, which discourages psychiatrists from participating in the Defendants' networks. If there were sufficient psychiatrists available to patients in Defendants' network, very few, if any, enrollees would need to seek treatment from out-of-network physicians and pay the higher costs involved.

65. When patients must see out-of network physicians, their out-of-pocket fees and administrative burdens increase. Many will have to forego care all together.

I. Provider Contracts

66. Providers in Anthem's network, including Dr. Savulak, sign form "Provider Agreements" whose substantive terms do not vary between providers. These agreements are form contracts, not subject to negotiation, and govern the relationship between the parties.

67. These form agreements, including Dr. Savulak's, contain a provision stating: "Anthem BC&BS shall, as applicable, conduct Utilization/Quality Management and administer Covered Services without discriminating against a Member on the basis of race, color, national origin, religion, sex. Marital status, health status, sexual orientation, age of Vietnam veteran's status."

68. Defendants discriminate in the provision of Covered Services (i.e. Mental Health) by violating MHPAEA's requirement that the methodology for determining reimbursement rates for providers of mental health services be comparable and applied no more stringently than the methodology employed for determining reimbursement rates for medical surgical providers. This discrimination results in loss of network providers, limited access to care, increased cost of care, and interruption of physician patient relationships for mental health patients.

COUNT ONE
ERISA §502(a)(3), 29 USC §1132(a)(3)
Violation of MHPAEA, 29 USC §1185a
(APA, CPS, and CCCAP on behalf of their members patients, against Defendants)

69. Plaintiffs incorporate paragraphs 1 through 68 as if fully set forth herein as paragraphs 69 through 79 of Count One.

70. Defendants are bound by the mandates of MHPAEA because they offer health insurance coverage in connection with group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits.

71. Defendants are fiduciaries under ERISA because they have discretionary authority and/or discretionary responsibility in administering health insurance plans.

72. Defendants have the responsibility to discharge their duties with respect to the health insurance plans they offer solely in the interest of the participants and beneficiaries.

73. The APA, CPS, and CCCAP bring this claim on behalf of their members and their members' patients who have been injured and continue to be injured by Defendants' discriminatory practices.

74. The APA, CPS, and CCCAP's members have third-party standing to assert claims on behalf of their patients because of the inherent closeness of the relationship between psychiatrists and their patients. As a result of the particular nature of psychiatric treatment, this relationship is even more intimate and trusting than the relationship of patients with non-psychiatric medical doctors.

75. The stigma associated with receiving mental health treatment is a considerable deterrent to bringing suit. Mental health patients often seek to keep their treatment private, especially from their employers and workplace colleagues. A mental health condition substantively impairs a patient's ability to litigate himself or herself to enforce legal rights.

76. Defendants' policies and procedures relating to the administration of mental health benefits, including reimbursement rates paid, prevent the APA, CPS, and CCCAP's members' patients from receiving necessary mental health services and its members from providing those services or being appropriately compensated for providing those services; the APA's, CPS' and CCCAP's interest and that of its members' patients are therefore aligned.

77. APA, CPS, and CCCAP have standing to bring claims on behalf of their members' patients. These associations' members have standing to bring claims on behalf of their patients because the nature of the relationship between a psychiatrist and his or her patient aligns their interests in litigation, and because those patients face substantial obstacles in bringing and litigating a case on their own behalf. The associations in turn have standing to litigate these claims on behalf of their members because those members have standing in their own right, the interests the associations seek to protect are germane to their missions, and neither the claims asserted nor the declaratory and injunctive relief requested require the participation of any individual member of the associations in the lawsuit.

78. On information and belief, Defendants failed to exercise their authority and responsibility in a manner that fulfills their fiduciary obligations to participants and beneficiaries and in a manner that insures compliance with MHPAEA by engaging in conduct including, but not limited to, the following:

a. Applying financial requirements and treatment limitations only to MH/SUD benefits that are not applicable to medical surgical benefits and/or are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical surgical benefits;

b. Discouraging psychiatric physicians from providing psychotherapy and E/M in the same treatment session;

c. Discouraging psychiatric physicians from participating in Defendants' networks;

d. Discouraging patients with mental illness or substance use disorders from accessing medically necessary services by increasing patient costs; and

e. Interfering with and interrupting physician/patient relationships.

79. ERISA §502(a)(1)(B) does not provide an adequate remedy because Plaintiffs are not seeking to recover benefits under the terms of a Plan, to enforce their rights under the terms of a Plan, or to clarify their rights to future benefits under the terms of a Plan. Rather, Plaintiffs seek equitable relief to enjoin Defendants' acts and practices that violate the provisions of MHPAEA, which prevent Plaintiffs from receiving the mental health services patient's need, limit their access to in network providers and treatment, and often times forces them to change mental health providers. No exhaustion of administrative remedies is required, and even if it were, the attempt to exhaust such remedies would be futile.

COUNT TWO
ERISA §502(a)(3), 29 USC §1132(a)(3)
Breach of Fiduciary Duty
(Dr. Savulak, as assignee of BG and SM, against Defendants)

80. Plaintiffs incorporate paragraphs 1 through 79 as if fully set forth herein as paragraphs 80 through 85 of Count Two.

81. BG as a participant and SM as beneficiary under Lumenos Health Savings Accounts ("LHSA"), have assigned all right, title and interest in and to any claim or cause of action in law or in equity, including but not limited to claims for

breach of fiduciary duty and injunctive and declaratory relief, arising out of or relating to any alleged violation of MHPAEA to Dr. Savulak. Like BG and SM, Dr. Savulak has been harmed by Defendants' discriminatory practices and any declaratory relief provided to BG and SM as a result of this lawsuit would benefit Dr. Savulak.

82. Defendant Anthem is a fiduciary under ERISA because it offered the LHSA Plans, insures SM's plan and it has discretion to administer benefits under both BG's and SM's LHSA Plan.

83. WellPoint is a fiduciary under ERISA because it has discretionary authority and/or discretionary authority in connection with management of the LHSA Plan.

84. In their fiduciary capacities, all Defendants have responsibility to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries, such as SM and BG, and in a manner that insures compliance with MHPAEA. On information and belief, Defendants failed to exercise their authority and responsibility in a manner that fulfills their fiduciary obligations to participants and beneficiaries and in a manner that insures compliance with MHPAEA by engaging in conduct including, but not limited to, the following:

a. Applying financial requirements and treatment limitations only to MH/SUD benefits that are not applicable to medical surgical benefits and/or that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical surgical benefits;

b. Discouraging psychiatric physicians providers from providing psychotherapy and E/M in the same treatment session;

c. Discouraging psychiatric physicians from participating in Defendants' networks;

d. Discouraging patients with mental illnesses and/or substance use disorders from accessing medically necessary services by increasing patient costs; and

e. Interfering with and interrupting physician/patient relationships.

85. ERISA §502(a)(1)(B) does not provide an adequate remedy because Dr. Savulak, as an assignee of the participant/beneficiary, does not seek to recover benefits under the terms of the Plan, to enforce their rights under the terms of a Plan, or to clarify their rights to future benefits under the terms of a Plan. Rather, Dr. Savulak seeks equitable relief to enjoin Defendants' acts and practices that violate the provisions of MHPAEA, which prevent participants and beneficiaries like BG and SM from receiving the mental health services they need, limits their access to in network providers and treatment, and often times forces them to change mental health providers. No exhaustion of administrative remedies is required, and even if it were, the attempt to exhaust such remedies would be futile.

COUNT THREE
ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)
Violation of MHPAEA
(Dr. Zanker, on behalf of his patients, against Defendants)

86. Plaintiffs incorporate paragraphs 1 through 85 as if fully set forth herein as paragraphs 86 through 94 of Count Three.

87. Plaintiff Theodore Zanker, MD is a psychiatrist specializing in the care of child and adolescent patients. As participants and beneficiaries of the Plans offered by Defendants, Dr. Zanker's patients have a cause of action under ERISA § 502(a)(3) to enjoin any act or practice that violates ERISA, including MHPAEA.

88. Dr. Zanker has third-party standing to assert this claim on behalf of his patients because of the inherent closeness of the relationship between a psychiatrist and his patient and because of the substantial obstacles facing patients in pursuing litigation themselves. This is particularly true in the context of child and adolescent patients who have a mental illness or substance use disorder, for whom the stigma associated with treatment is especially severe.

89. Psychiatrists are able to be fully effective proponents of their patients' rights because psychiatrists develop an intimate and trusting relationship with their patients as their doctors. As a result of the nature of psychiatric treatment, this relationship is even more intimate and trusting than the relationship of patients with non-psychiatric medical doctors.

90. Defendants' policies prevent Dr. Zanker's patients from receiving necessary mental health services and prevent him from providing those services. Dr. Zanker's interest and that of his patients are therefore aligned.

91. Mental health patients face substantial obstacles in bringing litigation against Defendants on their own behalf to enforce the provisions of MHPAEA. The stigma associated with receiving mental health treatment is a considerable deterrent to bringing suit. Mental health patients often seek to keep their treatment private, especially from their employers and workplace colleagues. Child and adolescent mental health patients are particularly susceptible to stigma. The nature of mental health patients' condition further impairs their ability to litigate to enforce their rights. Child and adolescent patients and their families rely upon their psychiatrists to provide diagnosis and treatment of illness, to defend their need for treatment when the

Defendants inquire, and to correctly bill and code the treatment provided so that coverage and medical records will be accurate. Dr. Zanker's patients on whose behalf this claim is brought are fully insured by Defendants, or are insured by their employer's self-funded plan which gives Defendants unfettered discretion to determine coverage, medical necessity and reimbursement rates.

92. ERISA §502(a)(1)(B) does not provide an adequate remedy because Plaintiffs are not seeking to recover benefits under the terms of a Plan, to enforce their rights under the terms of a Plan, or to clarify their rights to future benefits under the terms of a Plan. Rather, Plaintiffs seek equitable relief to enjoin Defendants' acts and practices that violate the provisions of MHPAEA, which prevent Plaintiffs from receiving the mental health services patient's need, limit their access to in network providers and treatment, and often times forces them to change mental health providers. No exhaustion of administrative remedies is required, and even if it were, the attempt to exhaust such remedies would be futile.

93. Defendants' practice of: (1) non-payment for psychotherapy services provided by out-of-network psychiatrists and/or reduced payment for psychotherapy if the physician also provides medical services in the same visit; (2) applying financial and quantitative limitation only to mental health benefits; and (3) using and applying methodologies for determination of provider reimbursement for psychiatric physicians that are not comparable to and/or applying them more stringently to psychiatric physicians than the methodologies used to determine non-psychiatric physician rates violates MHPAEA.

94. Dr. Zanker's patients are harmed as a result by facing higher out-of-pocket costs for mental health treatment and in foregoing or reducing necessary medical treatment or in being forced to change doctors after a long and productive doctor-patient relationship.

COUNT FOUR
Tortious Interference with Business Relationship
(Dr. Zanker against Defendants)

95. Plaintiffs incorporate paragraphs 1 through 94 as if fully set forth herein as paragraphs 95 through 101 of Count Four.

96. Plaintiff Theodore Zanker, MD is a medical doctor specializing in the treatment of child and adolescent psychiatric patients. Many of his patients are insured under health plans Anthem administers or issues that provide mental health benefits subject to MHPAEA. The Health Plans give Anthem discretion in setting provider reimbursement rates.

97. Mental health patients and their families rely upon their psychiatrists to provide diagnosis and treatment of illness, to defend their need for treatment when the Defendants inquire, and to correctly bill and code the treatment provided so that coverage and medical records will be accurate. The patients on whose behalf this claim is brought are fully insured by Defendants, or are insured by their employer's self-funded plan which gives Defendants unfettered discretion to determine coverage, medical necessity and reimbursement rates.

98. Psychiatrists and mental health patients have a special relationship that often involves an expectation that treatment with the same psychiatrist will continue

until the patient recovers. As a result, if a denial of or restriction on benefits forces a patient to change psychiatrists or to interrupt treatment, this can impede a patients' recovery, damaging their health and well-being as well as increasing the total cost the patient must bear if the course of treatment is prolonged.

99. Psychiatrists and their patients therefore have an ongoing business relationship. Defendants' practice of: (1) non-payment for psychotherapy services provided by out-of-network psychiatrists and/or reduced payment for psychotherapy if the physician also provides medical services in the same visit; (2) applying financial and quantitative limitation only to mental health benefits; and (3) using and applying methodologies for determination of provider reimbursement for psychiatric physicians that are not comparable to and/or applying them more stringently to psychiatric physicians than the methodologies used to determine non-psychiatric physician rates violates MHPAEA. This is improper conduct that tortiously interferes with the relationship between psychiatrist and patient by forcing patients to forgo treatment with the psychiatrist with whom they had developed a trusting doctor-patient relationship that is a pre-requisite to effective mental health treatment.

100. Defendants further tortiously interfered with the relationship between psychiatrist and patient via its improper conduct in applying a method of determining fee schedules for MH/SUD services that does not set rates for psychiatric physicians in a manner which is comparable to and/or applied no more stringently than for non-psychiatric physicians, as required by MHPAEA.

101. Because of Defendants' improper conduct, Dr. Zanker has lost patients who cannot afford to pay the increased out of pocket costs resulting from Defendants unlawful conduct.

COUNT FIVE
Breach of Contract
(Dr. Savulak against Anthem)

102. Plaintiffs incorporate paragraphs 1 through 101 as if fully set forth herein as paragraphs 102 through 108 of Count Five.

103. On September 1, 2002, Dr. Savulak, d/b/a Associates in Psychotherapy & Psychiatry, signed a Participating Provider Group Agreement ("the Provider Agreement") with Anthem Health Plans, Inc. The Provider Agreement is a standard form contract that Anthem uses with health care providers throughout Connecticut.

104. The Provider Agreement governs the relationship between the providers and Anthem for the provision of and reimbursement for covered services.

105. Section II(A) "Obligations of the Parties", paragraph 4 of the Provider Agreement states that Anthem "shall, as applicable, conduct Utilization/Quality Management and administer Covered Services without discriminating against a Member on the basis of race, color, national origin, religion, sex, marital status, health status, sexual orientation, age or Vietnam veteran's status."

106. Section II(B) "Compensation", paragraph 1 of the Provider Agreement states that Anthem "shall secure the agreements of Payors to compensate the Group for Covered Services as described in Schedule B hereto, subject to the Member's payment obligations under the Applicable Plan or Program." Schedule B references the fee schedules for the requisite programs and plans. Anthem's practice of: (1) non-

payment for psychotherapy services provided by psychiatrists and/or reduced payment for psychotherapy if the physician also provides medical services in the same visit; (2) applying financial and quantitative limitation only to mental health benefits; and (3) using and applying methodologies for determination of provider reimbursement for psychiatric physicians that are not comparable to and/or applying them more stringently to psychiatric physicians than the methodologies used to determine non-psychiatric physician rates violates MHPAEA and breaches the Provider Agreement because Anthem is discriminating on the basis of health status of its Member in its administration of Covered Services.

107. Anthem breached the Provider Agreement because its method of determining fee schedules for MH/SUD services does not set rates for psychiatric physicians in a manner which is comparable to and/or applied no more stringently than for non-psychiatric physicians, as required by MHPAEA.

108. Dr. Savulak has been damaged as a result by receiving lower compensation for in-network patients than she would have received had Defendants complied with MHPAEA.

COUNT SIX
Breach of Contract
(APA, CPA, and CCCAP on Behalf of Its Members against Anthem)

109. Plaintiffs incorporate paragraphs 1 through 108 as if fully set forth herein as paragraphs 109 through 117 of Count Six.

110. Members of the APA, CPA, and CCCAP participate in Anthem's network of providers.

111. As participants in Anthem's network, these members sign a Provider Agreement that governs the relationship between the providers and Anthem for the provision of and reimbursement for covered services.

112. The Provider Agreement is a standard form contract, drafted by Anthem and over which Anthem will not negotiate.

113. The APA, CPA, and CCCAP have standing to pursue the claim detailed below on behalf of their members because each member would have standing to pursue the claim as parties to the Provider Agreement, the interest in determining the members' rights under the Provider Agreement is germane to the purpose of the organizations, and neither the claim nor the declaratory relief requested would require the participation of individual members because the Provider Agreement is a standard form contract.

114. Section II(A) "Obligations of the Parties", paragraph 4 of the Provider Agreement states that Anthem "shall, as applicable, conduct Utilization/Quality Management and administer Covered Services without discriminating against a Member on the basis of race, color, national origin, religion, sex, marital status, health status, sexual orientation, age or Vietnam veteran's status."

115. Section II(B) "Compensation", paragraph 1 of the Provider Agreement states that Anthem "shall secure the agreements of Payors to compensate the Group for Covered Services as described in Schedule B hereto, subject to the Member's payment obligations under the Applicable Plan or Program." Schedule B references the fee schedules for the requisite programs and plans. Anthem's practice of: (1) non-payment for psychotherapy services provided by psychiatrists and/or reduced

payment for psychotherapy if the physician also provides medical services in the same visit; (2) applying financial and quantitative limitation only to mental health benefits; and (3) using and applying methodologies for determination of provider reimbursement for psychiatric physicians that are not comparable to and/or applying them more stringently to psychiatric physicians than the methodologies used to determine non-psychiatric physician rates violates MHPAEA and breaches the Provider Agreements because Anthem is discriminating on the basis of health status of its Members in its administration of Covered Services.

116. Anthem breached the Provider Agreement because its method of determining fee schedules for MH/SUD services does not set rates for psychiatric physicians in a manner which is comparable to and/or applied no more stringently than for non-psychiatric physicians, as required by MHPAEA.

117. The members of the APA, CPA, and CCCAP have been damaged as a result.

COUNT SEVEN
Tortious Interference With Contract
(W.W. against Anthem)

118. Plaintiffs incorporate paragraphs 1 through 117 as if fully set forth herein as paragraphs 118 through 125 of Count Seven.

119. W.W. is a participant in a State of Connecticut Health Plan that is not subject to ERISA. The State nonetheless elected to comply with MHPAEA, and therefore is contractually bound to comply with its terms. W.W. pays a higher premium for an option in the plan that allows her access to mental health care on an out of network basis.

120. Anthem administers and exercises discretion with respect to the administration of the Plan.

121. Anthem exercises discretion in setting the amount of reimbursement to be paid to the Plan participant when the participant seeks access to mental health care from an out of network physician.

122. Anthem is aware that the State's Plan must comply with MHPAEA.

123. Anthem's conduct in (a) applying financial requirements and treatment limitations to MH/SUD benefits that are not applicable to medical/surgical benefits and or are more restrictive then the predominant financial requirements and treatment limitations applied to substantially all medical surgical benefits; and (b) discouraging patients from having E/M and psychotherapy in one visit because of unreasonable reimbursement rates are not in compliance with MHPAEA.

124. Anthem's conduct thereby intentionally and improperly interferes with the State of Connecticut's performance of its contractual obligations to W.W. under the Plan by causing the State to breach its agreement to provide insurance in compliance with MHPAEA.

125. As a result W.W. has been injured by paying higher costs and foregoing necessary treatment.

COUNT EIGHT
Tortious Interference with a Contract
(Dr. Savulak, and the APA, CPS, and CCCAP on behalf of their members against WellPoint)

126. Plaintiffs incorporate paragraphs 1 through 125 as if fully set forth herein as paragraphs 126 through 139 of Count Eight.

127. On September 1, 2002, Dr. Savulak, d/b/a Associates in Psychotherapy & Psychiatry, signed a Participating Provider Group Agreement ("the Provider Agreement") with Anthem Health Plans, Inc. The Provider Agreement is a standard form contract that Anthem uses with health care providers throughout Connecticut, including the members of the APA, CPS, and CCCAP.

128. Members of the APA, CPA, and CCCAP participate in Anthem's network of providers.

129. As participants in Anthem's network, these members sign a Provider Agreement that governs the relationship between the providers and Anthem for the provision of and reimbursement for covered services.

130. The Provider Agreement is a standard form contract, drafted by Anthem and over which Anthem will not negotiate.

131. The APA, CPA, and CCCAP have standing to pursue the claim detailed below on behalf of their members because each member would have standing to pursue the claim as parties to the Provider Agreement, the interest in determining the members' rights under the Provider Agreement is germane to the purpose of the organizations, and neither the claim nor the relief requested would require the participation of individual members because the Provider Agreement is a standard form contract.

132. The Provider Agreement governs the relationship between the providers and Anthem for the provision of and reimbursement for covered services.

133. Section II(A) "Obligations of the Parties", paragraph 4 of the Provider Agreement states that Anthem "shall, as applicable, conduct Utilization/Quality

Management and administer Covered Services without discriminating against a Member on the basis of race, color, national origin, religion, sex, marital status, health status, sexual orientation, age or Vietnam veteran's status."

134. Section II(B) "Compensation", paragraph 1 of the Provider Agreement states that Anthem "shall secure the agreements of Payors to compensate the Group for Covered Services as described in Schedule B hereto, subject to the Member's payment obligations under the Applicable Plan or Program." Schedule B references the fee schedules for the requisite programs and plans.

135. On information and belief, WellPoint was aware of the Provider Agreement and its terms and provisions.

136. WellPoint intentionally and tortiously interfered with Anthem's contractual obligations under the Provider Agreement by setting the unlawful medical policies that governed Anthem's practice of: (1) non-payment for psychotherapy services provided by psychiatrists and/or for reduced payment for psychotherapy if the physician also provides medical services in the same visit, and (2) determining provider reimbursement rates in violation of MHPAEA as described in this complaint breaches the Provider Agreement because Anthem is discriminating on the basis of health status of its Member in its administration of Covered Services.

137. On information and belief, WellPoint set its medical policies in knowing and deliberate violation of its legal obligations under MHPAEA.

138. As a result of the unlawful medical policies set by WellPoint, Anthem breached the Provider Agreement because its method of determining fee schedules for MH/SUD services does not set rates for psychiatric physicians in a manner which

is comparable to and/or applied no more stringently than for non-psychiatric physicians, as required by MHPAEA and therefore in violation of the Provider Agreement's non-discrimination provision.

139. Dr. Savulak and the members of the APA, CPS, and CCCAP, have been damaged as a result by receiving lower compensation for in-network patients than she would have received had Defendants complied with MHPAEA and the Provider Agreement.

PRAYER FOR RELIEF

WHEREFORE, in accordance with the foregoing, the Plaintiffs pray that the Court award relief as follows:

I. Count One ERISA §502(a)(3)- Violation of MHPAEA

The APA, CPS, CCCAP seek:

a. Injunctive and declaratory relief that:

i. Declares that Defendants' practices violate MHPAEA;

ii. Enjoins Defendants from continuing to violate MHPAEA; and

iii. Provides other appropriate equitable relief to redress these violations and/or enforce MHPAEA.

b. Their attorneys' fees in this action under 29 U.S.C. §1132(g).

II. Count Two ERISA §502(a)(3)-Breach of Fiduciary Duty

Dr. Savulak seeks, on behalf of her assignees:

a. Injunctive and declaratory relief that:

i. Declares that Defendants' practices breach their fiduciary duties to participants and beneficiaries of the LHSA Plan;

ii. Enjoins Defendants from continuing to breach their fiduciary duties; and

iii. Provides other appropriate equitable relief to redress these breaches of fiduciary duties.

b. Her attorneys' fees in this action under 29 U.S.C. §1132(g).

III. Count Three ERISA §502(a)(3)- Violation of MHPAEA

Dr. Zanker seeks, on behalf of his patients:

a. Injunctive and declaratory relief that:

i. Declares that Anthem's practices with respect to out-of-network psychiatrists violate MHPAEA;

ii. Enjoins Anthem from continuing to violate MHPAEA; and

iii. Provides other appropriate equitable relief to redress these violations and/or enforce MHPAEA.

b. His attorneys' fees in this action under 29 U.S.C. 1132(g).

IV. Count Four- Tortious Interference with Business Relationships

Dr. Zanker seeks:

a. Damages in an amount to be determined at trial; and

b. Attorneys' fees.

V. Count Five - Breach of Contract

Dr. Savulak seeks:

a. Damages in an amount to be determined at trial; and

b. Attorneys' fees.

VI. Count Six- Breach of Contract

APA, CPS, and CCCAP seek:

a. An order declaring that Anthem's practices discriminate on the basis of health status of its Members in violation of the Provider Agreement.

VII. Count Seven- Tortious Interference With Contract

W.W. seeks:

a. Damages to be determined at trial;

b. Attorneys' fees; and

c. Declaratory and Injunctive relief that Anthem's conduct violates MHPAEA and thereby tortuously interferes with the State of Connecticut's performance of its contractual obligations to W.W. under the Plan.

VIII. Count Eight- Tortious Interference With Contract

Dr. Savulak, and the APA, CPS, and CCCAP seek:

a. Damages to be determined at trial; and

b. Attorneys' fees.

AMERICAN PSYCHIATRIC ASSOCIATION (ON BEHALF OF ITS MEMBERS AND THEIR PATIENTS); CONNECTICUT PSYCHIATRIC SOCIETY, INC. (ON BEHALF OF ITS MEMBERS AND THEIR PATIENTS); CONNECTICUT COUNCIL OF CHILD AND ADOLESCENT PSYCHIATRY, INC. (ON BEHALF OF MEMBERS AND THEIR PATIENTS); SUSAN SAVULAK, M.D. D/B/A ASSOCIATES IN PSYCHOTHERAPY & PSYCHIATRY, LLC (ON BEHALF OF HERSELF, HER PATIENTS AND AS ASSIGNEE OF BG AND SM); THEODORE ZANKER, M.D. (ON BEHALF OF HIMSELF AND HIS PATIENTS); AND W.W. (IN HER INDIVIDUAL CAPACITY)

By /s/ Maria Pepe VanDerLaan
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CERTIFICATE OF SERVICE

I hereby certify that on November 21, 2013, a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

/s/ Maria Pepe VanDerLaan
Maria Pepe VanDerLaan- ct10778