EXHIBIT 27

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 AND HER PATIENTS); AND **W.W.** (IN HER INDIVIDUAL CAPACITY)	CIVIL ACTION NO.
Plaintiffs,	JURY TRIAL REQUESTED
v.	
ANTHEM HEALTH PLANS, INC. d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT; AND WELLPOINT, INC.	
Defendants.	APRIL 10, 2013

COMPLAINT

A. INTRODUCTION

Access to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society.

- Patrick Kennedy

(2008, introducing the Mental Health Parity and Addiction Equity Act in Congress)

Although Congress passed the Mental Health Parity and Addiction Equity Act in 2008 to end this discrimination against those with a mental illness, Patrick Kennedy's observation remains true to this day. This Complaint asks the Court to declare that the Defendants' direct and indirect discrimination against mental health patients is illegal and to compel the Defendants' compliance with the mandates of federal and state law which require that they provide mental health benefits to their enrollees in parity with the medical/surgical benefits they provide.

Approximately twenty percent of the United States population suffers from a mental illness and approximately five percent of that population suffers from a seriously debilitating mental illness. On average, insurance companies in Connecticut charge premiums ranging between $400 and $999 per month, yet report spending only $7.88 to $11.56 per enrollee per month on mental health and substance use coverage. This happens because some insurance companies, like the named Defendants herein, manipulate the rates they will pay for medically necessary mental health treatment in a manner designed to drive psychiatrists out of their networks and otherwise limit their ability to provide necessary care to members of our society who require it. Access to mental health benefits for which patients and their employers have paid high premiums or investments is, therefore, blocked or, at a minimum, made more difficult and financially burdensome to obtain. Inevitably, costs for such treatment are shifted to the patients themselves at a time when they are most vulnerable, to their families, and to the taxpayers of the State of Connecticut.

The Plaintiffs in this action recognize the critical point that mental health coverage has reached in our State and seek a declaration from the Court that the practices identified above and in the remainder of this Complaint violate the plain language, spirit and intent of federal and state laws which make it illegal for insurance companies to discriminate against mental health coverage and treatment. The federal and state laws at issue in this case, known generally in the industry as mental health parity laws, mandate equality between mental health benefits and benefits provided to medical/surgical patients - a mandate that the Defendants have chosen to ignore.

B. 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. She brings this Complaint on behalf of herself and on behalf of her patients who are insured by the Defendants. 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. Dr. Savulak's patients are reluctant to individually come forward as plaintiffs in this case because of the unjust stigma associated with mental illness and because acting as a plaintiff in a lawsuit may be stressful and deleterious to their progress in treatment.

5. Plaintiff W.W. (hereinafter, "W.W.") is an individual who is insured by the Defendants' health plans and has elected to pay additional amounts of money to the Defendants 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 services through the Defendants' plans. W.W.'s psychiatrist does not participate in the Defendants' health plans. 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.

6. Defendant Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut (hereinafter, "Anthem") is a Connecticut corporation with a principal place of business at 108 Leigus Road, Wallingford, Connecticut. Anthem operates in Connecticut as Anthem Blue Cross and Blue Shield of Connecticut and offers several health plans in Connecticut. This Complaint applies to all Anthem plans that are sold to employers to cover employees in the State of Connecticut and who employ more than fifty (50) employees. Anthem is a subsidiary of Defendant

Wellpoint, Inc.

7. Defendant Wellpoint, Inc. (hereinafter," Wellpoint") is an Indiana corporation, licensed to do business in the State of Connecticut, with its principal place of business at 120 Monument Circle, Indianapolis, Indiana. Wellpoint is a holding company that directly or indirectly owns 100% of the stock of Anthem and other insurance subsidiaries. Wellpoint is one of the largest health benefits companies in the United States and, in 2012, posted net revenues of over $2.6 billion.

C. JURISDICTION AND VENUE

8. The Plaintiffs allege violations of a federal statute, the Mental Health Parity and Addiction Equity Act of 2008 and its corresponding regulations. As this action arises under the laws of the United States, this Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331. Pursuant to 28 U.S.C. § 1367, this Court has supplemental jurisdiction over claims arising under state law.

9. Venue is appropriate in this District under 28 U.S.C. § 1391(b)(1) and (2) as the Defendants reside in this District, and substantially all of the actions and omissions committed by the Defendants which give rise to this Complaint occurred in this District.

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

caused injury within this District.

11. Plaintiffs APA, CPS, and CCCAP have standing to bring this Complaint on behalf of their members, as the 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 relief requested require the participation of each individual member in the lawsuit.

12. APA, CPS, CCCAP, and Dr. Savulak have standing to bring this case on behalf of their members' patients and their own patients (respectively) because their members, they, and their respective patients have been injured, and the patients have a close doctor-patient relationship involving the patients' reliance on their doctors to diagnose and treat illness, and handle administrative matters and disputes with their insurer. The Defendants' unlawful conduct threatens this unique relationship. Additionally, psychiatric patients are generally deterred from bringing litigation themselves because of the unjustified stigma associated with mental illness and because the stress of litigation can be deleterious to their conditions.

13. 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.

D. BACKGROUND FACTS

Mental Health Facts, Insurance Terms, and CPT Codes

14. Health insurance plans in Connecticut, such as the Defendants, purport to provide coverage for medically necessary treatment for mental health and substance use disorders ("MH/SUDs"). This generally includes treatment for inpatient, in-network services; outpatient in-network services; inpatient out-of-network services; outpatient, out-of-network services; emergency care services; and pharmacy. There are specific federal and Connecticut laws that regulate the terms and conditions of these health insurance plans that provide benefits for MH/SUD conditions.

15. Ample studies show that psychotherapy and, where indicated, psychotherapy accompanied with drug therapy, are effective in treating MH/SUDs. Yet, the Defendants and other insurance companies, despite federal and state laws prohibiting discriminatory treatment of MH/SUD benefits, discriminate against psychiatric patients by making it more difficult, costly, or impossible for them to access the medically necessary treatment provided by psychiatric physicians that their health plans claim to provide.

16. In their lifetime, one in five Americans will suffer a mental illness and five percent of Americans will suffer a severe mental illness. *But less than one third of those who need treatment will have access to the treatment they need to live normal and productive lives.* Some will not seek treatment because of the stigma

associated with mental illness. Others, who are courageous enough to seek treatment despite unfair stigma, are denied the medically necessary treatment (including psychotherapy services) they seek or are discouraged from obtaining such medically necessary treatment from appropriately trained MH/SUD providers by health insurance carriers, like the Defendants, who are intent on making a profit at the expense of the patients who pay their fees and the psychiatrists who care for them. For those fortunate enough to receive adequate treatment, 70 to 90 percent will find relief and a reduction in symptoms, allowing them to be productive members of society.

17. By all accounts, the availability of medically necessary MH/SUD services in Connecticut is inadequate to meet the demand for such services by patients in the State. The mental health work force is insufficient to meet patient needs and, for those with private health insurance, provider networks are inadequate to timely provide needed mental health services. While the purpose of health insurance is to facilitate access to medically necessary health care services, insurance carriers, like the Defendants, exacerbate the access problem by discriminating against providers of MH/SUD services.

18. The State currently experiences a shortage of mental health professionals, particularly psychiatrists. Psychiatrists are medical doctors who further specialize in the identification and treatment of mental disorders and 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 complete at least an additional four-year residency program after medical school that focuses on the diagnosis and treatment of mental disorders. Yet, the Defendants, through their inequitable billing and reimbursement strategies, make it difficult for psychiatrists to provide and/or be reimbursed for medically necessary services to patients at levels commensurate with non-psychiatric physicians.

19. Psychiatrist participation in an insurance plan is highly consequential to patient access to appropriate medical treatment. A psychiatrist who participates in a plan's network is an "in-network" provider and contracts with an insurance company, agreeing to the rates for services set by the insurance company in exchange for being listed as a participating provider in the insurer's network. The patients pay only an agreed-upon co-payment and the insurance company pays an agreed-upon fixed fee for the service. For patients, the cost is generally less to use in-network providers. Psychiatrists who participate in a network tend to participate in the networks of several insurance carriers at the same time.

20. Some psychiatrists in Connecticut do not participate in the Defendants' or any other carrier networks because the fees the Defendants pay are substantially less than the psychiatrists' actual fee and substantially less than the fees the Defendants pay to other physicians who provide comparable services. Additionally, the administrative requirements imposed by the Defendants are so onerous that the

doctors believe they 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. If patients pay additional premiums for an "out-of-network benefit" in their plan, they may be reimbursed by the insurer for the amount that the plan would have paid an in-network doctor, or another rate determined by the company. In the vast majority of circumstances, it is more expensive for patients to see out-of-network psychiatrists. This is because insurance reimbursement rates are low. Moreover, seeing an out-of-network psychiatrist costs disproportionately more than seeking out-of-network care for non-psychiatric issues from a non-psychiatric physician. The Defendants reimburse non-psychiatric physicians more than they pay psychiatrists.

21. Each psychiatric diagnosis is represented by a diagnostic code on the insurance forms and in the patient's medical record. Each treatment or procedure provided for the diagnoses is represented on the insurance form and in the patient's records by a Current Procedural Terminology, or "CPT," code.

22. Typically, a physician provides a primary procedure that is represented by a primary CPT code, along with any secondary procedures appropriately performed during the same visit. The secondary procedures have their own CPT codes as well. In psychiatry, during a patient visit, the psychiatrist may provide primary medical evaluation and management ("E/M") services, which include an 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 disorder. During this same visit, the psychiatrist may also provide other services (e.g., psychotherapy). The psychiatrist records the CPT code for the E/M service and the additional service and bills the patient or the insurance company, as the case may be, for each service (i.e., the E/M service and the psychotherapy).

23. *Current Procedure Terminology, 4th edition* ("CPT") codes describe medical, surgical, and diagnostic services and are designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. Each code describes a very specific service and enables the health care industry to speak in the same terms. It is, therefore, very important that doctors properly code on their invoices and in their patient records. Uniformity in coding is so important that in 2000 the CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other healthcare services and procedures under the Health Insurance Portability and Accountability Act ("HIPAA"). Hence, federal law requires that all health care providers and insurance companies use CPT codes in their billing and payment.

24. While CPT codes describe services, they do not set fees for the services. A separate process exists whereby recommendations are provided to the Centers for Medicare and Medicaid Services ("CMS") by the American Medical

Association RVRBS Update Committee. CMS considers these recommendations and 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. The physician work value for a given CPT code remains the same regardless of the physician's specialty. Values are established relative to existing values across all CPT codes so that services that describe different services but encompass similar work are valued similarly. The physician work values are a major component of Medicare's methodology for establishing physician fees, and it is general health insurance industry practice to utilize the Medicare Physician Fee Schedule as a benchmark, albeit each individual insurance carrier determines the fees it will pay for particular codes.

25. CPT coding was changed for psychiatric physicians on January 1, 2013. Under the previous CPT codes for psychiatry in the 908xx series, psychiatrists billed for codes that combined an E/M component with psychotherapy. The E/M component for these codes was a fixed amount regardless of the level of E/M work actually performed and the psychotherapy portion varied according to the length of the session. It was determined that these codes were inappropriate because the E/M work performed by a psychiatrist varied with any given patient just as for any other physician. Psychotherapy was understood to be a timed procedure that was deemed

appropriate with the understanding that this time will vary according to the time needed and the appropriate timed psychotherapy code would be added to whatever level of E/M code was appropriate. The prior code structure also included a medication management code-90862- that technically included "minimal" psychotherapy. It was determined that this code was more equivalent to an E/M code alone. Moreover, the old code did not allow for variability in work, especially for unstable or complex patients with comorbid medical issues. Accordingly, code 90862 was eliminated from CPT, and psychiatric physicians were directed to use E/M codes for medication management without psychotherapy and an E/M code with a timed psychotherapy add-on code when they provided psychotherapy with medication management.

26. These coding changes, effective on January 1, 2013, were made to reflect significant changes that occurred in the practice of psychiatry, which rendered the previous coding structure inappropriate, as it did not account for the varying levels of patient evaluation, medical management, and psychotherapy that were being provided by psychiatrists. The new CPT coding structure is designed to enable medically trained mental health care providers, like psychiatric physicians, to code and bill in the same manner as their non-psychiatric physician counterparts recognizing the similarity of work and level of effort they perform, and to use the same codes as their counterparts when providing medical evaluation and management services, while at the same time recognizing the distinct specialty

service procedure (i.e., psychotherapy) that these psychiatric physicians provide. To that end, the new CPT coding structure has been specifically changed so that psychiatrists can bill and be reimbursed for an E/M code (e.g, CPT codes 99212-99215 for established outpatients), along with a psychotherapy add-on code (i.e., CPT codes 90833-90836, and 90838), when they conduct psychotherapy as part of a patient's medically necessary treatment. Non-psychiatric physicians (e.g. primary care physicians, cardiologists, rheumatologists) bill the same E/M codes as psychiatrists and may have add-on or other procedure codes for services they provide beyond basic medical evaluation and management as part of a patient encounter.

27. The CPT Evaluation and Management codes are basic medical service codes, and regardless of the level of the E/M service provided, recognize seven components: history, examination, medical decision making, counseling, coordination of care, nature of the presenting problem, and time. While counseling is a component of an E/M service, it is not psychotherapy. Counseling is defined by CPT as a discussion with the patient and/or family concerning one or more of a number of specified issues (e.g., the importance of compliance with the chosen management options, patient and family education).

28. According to CPT: "Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the

emotional disturbance, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, and 90838) as add-on codes to the evaluation and management service."

29. Instead of acknowledging that the change in the CPT coding structure was meant to accurately recognize the provision of medically necessary E/M and psychotherapy services by psychiatrists, the Defendants have, *de facto*, used the CPT code changes as a platform to redefine and distort services provided by psychiatrists and to reduce the fees paid to psychiatrists, thereby imposing a greater burden and expense upon patients receiving psychiatric treatment than they impose upon patients seeking non-psychiatric medical services and further hindering access to medically necessary care.

30. In early January of 2013, contrary to the intent of the CPT code changes and to federal and state law, Anthem representatives communicated to psychiatrists in its network that if the psychiatrists provided both E/M and psychotherapy services, they should only bill the E/M code and not use the add-on code for psychotherapy. During these conversations, Anthem representatives explained to psychiatrists that

they would not pay for psychotherapy, and therefore, it was not necessary to bill for the psychotherapy services. They instructed psychiatrists providing psychotherapy to use E/M codes (99212-99215 for established outpatients). These are codes used for evaluation and management with *counseling and coordination of care*. This service is distinctly different from evaluation and management with *psychotherapy*, and use of the codes suggested by Anthem would thus have resulted in inaccurate patient medical records.

31. On January 11, 2013, Anthem seemed to somewhat modify its position. In a letter to participating behavioral health providers, Anthem stated that psychiatrists could use an E/M CPT code and make a "note" of a psychotherapy add-on code, but that Anthem would not pay for a psychotherapy add-on separately, as add-on "codes are included as part of the reimbursement for services represented by the applicable primary CPT codes", i.e., the E/M code. Anthem stated that the fee schedule that was provided to network providers was a "representative fee schedule" and it was made retroactive to January 1, 2013. Anthem claimed that its goal was to maintain the reimbursement levels psychiatrists received for services as of December, 2012. The message provided by this letter was the same as the message communicated by telephone: psychiatrists would be paid the same if they provided E/M services alone or E/M services <u>in addition to</u> psychotherapy services. In other words, psychiatrists would not be paid for psychotherapy.

32. Anthem's new position in its January 11, 2013 letter, was further reinforced by Anthem's February 2013 Network Update, which attached a 2013 Outpatient Treatment Report ("OTR"). The OTR is a list of the services by CPT code that a clinician provides, along with a description of the service. This OTR showed that psychiatrists are to report (but not bill) add-on codes when part of a continued treatment plan, but there was no indication of any change in the Anthem payment policy for these codes.

33. Regardless of the payment and coding scheme advanced by the Defendants, the distortions created discourage psychiatrists from providing an appropriate scope of service where indicated as medically necessary, i.e., psychotherapy in addition to basic E/M. To illustrate: a psychiatrist seeing a stable patient for evaluation and management of their psychopharmacologic regimen without psychotherapy would typically bill a code 99213 for this service. CPT notes that the typical time for this code is 15 minutes. However, a psychiatrist seeing a stable patient for management of their psychopharmacological regime <u>and</u> the provision of psychotherapy would typically bill a code 99213 and psychotherapy add-on 90833. The typical time for this patient would be 45 minutes. Yet, Anthem has instructed that it will pay both psychiatrists the same amount and only for the 99213 code. Paying physicians identically for wholly nonequivalent work severely disincentivizes the provision of psychotherapy when indicated and thereby *de facto* limits the scope of the benefit otherwise covered by the plan. Where psychiatrists

do not provide psychotherapy, the patient is required to either see a second provider for that service or 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.

34. The fee schedule Anthem provided did not include some of the CPT codes commonly used for services provided by psychiatrists, which any reasonable beneficiary would presume their health plan covered for treatment of a psychiatric condition.

35. Dr. Savulak complained to the Insurance Commissioner about these changes on or about January 21, 2013.

36. The Connecticut Insurance Department inquired of Anthem, which responded that the fees were only "representative" and that if a psychiatrist wanted to bill a code not on their fee schedule, the psychiatrist could submit the bill with the code and then call Anthem to ask if it would be reimbursed and, if so, at what rate. This practice effectively requires preauthorization of psychotherapy for any patient seen by a psychiatrist where the patient's plan does not otherwise require such preauthorization or alternatively, asks the psychiatrist to provide the service and then "roll the dice" as to whether Anthem will pay. Either option results in impeding access to psychiatric care.

37. Upon information and belief, non-psychiatric physicians are able to bill for primary E/M and add-on services or related procedures, as provided to the patient and are paid the amount set forth in their contract for both the E/M service and the related service. Further, the Defendants do not require non-psychiatric physicians to bundle payments for codes into one code that does not accurately reflect the type or amount of work done or level of effort required, and the payment for the add-on service reflects the payment for the service performed. Non-psychiatric physicians are not required to haggle with the Defendants for each patient over which codes not on the fee schedule they can bill and how much they will be paid. The scope of medically necessary care as determined by the physician is not compromised for medical/surgical benefits in the manner that it is for psychiatric treatment.

38. On or about February 13, 2013, APA contacted Anthem and was informed by Anthem how it had "cross-walked" the old codes to the new ones. APA informed Anthem that the methodology employed made no sense and resulted in payments for services to psychiatrists that were significantly lower than in 2012, despite Anthem's claim that it intended to keep payments in 2013 equivalent to the payments in 2012. Anthem also informed APA that one of the missing codes had been added back in although the Plaintiffs have not seen any evidence that this is true.

39. That Anthem did not maintain payments at 2012 levels is evident from W.W.'s experience. W.W.'s out-of-network provider sees her for psychotherapy and psychopharmacologic management on a regular basis. The psychiatrist's fees have remained constant in 2012 and 2013. Yet, in 2013, the amount that Anthem reimbursed for the identical services was almost 50% less than in 2012, causing W.W. to incur out-of-pocket costs that she cannot afford to pay, thereby threatening her continued treatment and relationship with her psychiatrist.

40. On March 13, 2013, APA, CPS, and the Connecticut State Medical Society wrote to David Fusco, President of Anthem, explaining that: (a) Anthem's implementation of the CPT codes was in violation of federal and state laws and that its failure to include appropriate psychiatric codes resulted in improper billing for services; (b) that its refusal to pay for psychotherapy for patients of psychiatrists meant that these patients were effectively being told that the plan would not allow them to seek psychotherapy from psychiatrists and that they would have to seek a non-medical provider to provide psychotherapy; (c) that this results in disruption of patient care, requiring psychiatric patients to make two appointments and pay two-co-payments – one for medical services and another for psychotherapy and requiring psychiatric patients to miss more time from work, attend multiple appointments when one should suffice, and pay more for the services they receive – all of which adds to the stress of their daily life; (d) that it increases the cost to the patient of out-of-network services; and (e) that there was no justifiable reason to

pay psychiatric physicians who bill E/M codes less than other physicians billing the same E/M codes, which have equal work values. The letter requested that Anthem provide the information it used to claim that the services under the two codes were "cross-walked" and provided rates equivalent to those paid in 2012.

41. On March 21, 2013, Mr. Fusco "responded" to this letter by ignoring most of the facts and not providing the information requested. Instead, Mr. Fusco claimed that Anthem had loaded one missing code onto its system and that its reimbursement rates and manner of establishing them was otherwise fine. He provided no information that would illustrate that the manner of establishing the rates was comparable to how rates are established for services for medical/surgical conditions, whether on an in- or out-of-network basis. However, Mr. Fusco stated that Anthem would divide the payment for Evaluation and Management that it currently provides into two, so that some of that funding would be attributable to the psychotherapy add-on code. In effect, what this does is simply reduce the reimbursement for Evaluation and Management done by psychiatric physicians even further below their physician counterparts. As an example, if Anthem offered to pay $100 for an E/M code in January and nothing for the psychotherapy add-on code so that a psychiatrist who did not do psychotherapy would have been paid the same as one who did, Anthem is now suggesting that it will pay $50 for the E/M code and $50 for the psychotherapy code for a total of $100, effectively reducing the value of the E/M code for psychiatric physicians only. All non-psychiatric

physicians providing the same E/M service and billing that code would receive at least the $100 and likely more.

42. The Defendants' discrimination against psychiatric physicians results in discrimination against psychiatric patients and this threatens the availability of in-network psychiatrists (forcing many 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 patients in Connecticut – a state where obtaining care is already difficult. Refusing to allow subscribers to receive psychotherapy and E/M in the same session increases patient costs and discourages them for seeking care.

43. Of course, this result is not distasteful to the Defendants since the Defendants' customers will not access care and the Defendants will not have to pay for it. Indeed, appropriate payment for services, to the extent it increased, is an expense the Defendants would have to deduct from their $2.6-plus billion in net revenue.

44. Not all insurers have manipulated CPT codes to deny mental health patients the care for which they and their employers have paid, and not all have placed their profit above access to care for their subscribers. However, upon information and belief, all *Wellpoint* subsidiaries, including, *inter alia,* those in Ohio, California, Georgia, New York and New Jersey have all implemented the CPT code changes in a similar manner demonstrating a coordinated and system-wide violation

of state and federal law orchestrated by Wellpoint. Upon information and belief, Wellpoint coordinates these strategies between its subsidiaries.

45. Upon information and belief, Anthem pays psychiatrists considerably less on average than other physicians billing the same E/M codes.

46. Upon information and belief, Anthem does not crosswalk the CPT codes for substantially all of the medical/surgical codes in a manner that combines non-E/M services or procedures with the E/M code for purposes of payment.

47. The Plaintiffs are injured by the Defendants' conduct because physician/patient relationships are interrupted; patients face higher costs of health care and more difficulty in accessing mental health care; and psychiatrists are economically disadvantaged, which discourages psychiatrists from practicing in Connecticut and/or from participating in Anthem's network.

The Mental Health Parity and Addiction Equity Act (2008)

48. In 1996, Congress enacted the Mental Health Parity Act of 1996 (the "1996 Act"), which prohibited plans from imposing disparate annual and lifetime limits for mental health benefits compared to medical/surgical benefits. However, it contained many loopholes that insurance plans exploited to continue discriminating against mental health patients. For example, plans covered lower percentages of mental health costs than medical/surgical costs; imposed higher coinsurance rates on mental health benefits; and restricted the number of outpatient visits and inpatient hospital days for mental health patients but not for medical/surgical patients. 87% of

plans reported imposing some restrictions on mental health coverage that were not imposed on medical/surgical benefits. As a result, mental health patients either had to pay higher health care costs or forgo treatment altogether.

49. To close the loopholes in the 1996 Act, in 2008, Congress, with broad bipartisan support in the House and Senate, enacted comprehensive mental health parity legislation – the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA"). Congress' primary objectives in passing MHPAEA were to eliminate discrimination in benefits and improve access to MH/SUD services. Members of Congress expressed these objectives. Representative James Ramstad said, "It is time to end discrimination against people who need treatment for mental illness and addiction. It's time to prohibit health insurers from placing discriminatory barriers to treatment." Moreover, Representative Bill Pascrell called this "a civil rights issue" and stated, "Parity removes the discrimination against a population that has been discriminated against and stigmatized. This is a humanitarian issue; without parity, we allow those with illnesses to continue to suffer." This statutory purpose was specifically acknowledged in *Coalition for Parity, Inc. v. Sebelius*, 709 F. Supp, 2d. 10, 13 (D.D.C. 2010).

50. According to the preamble of MHPAEA's Interim Final Rules ("IFR"), it was anticipated that MHPAEA would result in many benefits to patients suffering

from MH/SUD conditions. These benefits included improved access to the services and procedures afforded by a patient's MH/SUD benefits under their health plan.

51. MHPAEA prohibits group health plans and health insurance issuers that cover more than 50 employees and offer 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.

52. The IFR establishes specific tests to meet this general parity requirement, which ensures that plans and issuers are not applying any financial requirement or treatment limitation to MH/SUD benefits that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits.

53. The IFR defines key concepts important to compliance with the law: financial requirements and treatment limitations. Financial requirements are defined as aspects of plan design that outline cost sharing between the plan and the enrollee, including copays, coinsurance, deductibles, and out-of-pocket limits. Treatment limitations are limits on benefits that are based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or any other

similar limits on the scope of duration of treatment. The IFR provides that treatment limitations can be either quantitative or non-quantitative. Quantitative treatment limitations ("QTLs") are those 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, or as here, forcing mental health patients to pay two co-pays). 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" (such as the illustrations set forth below).

54. The IFR provides specific illustrations of NQTLs, which include, without limitation, medical management standards; standards for provider admission to participate in a provider network, including reimbursement rates; and plan methods for determining usual and customary rates ("UCR").

55. The Defendants' practice of non-payment for psychotherapy services provided by psychiatrists otherwise limits the scope of the health plan's benefit for psychiatric treatment. This limiting of the scope of the benefit squares the Defendants' practice within the IFR's definition of an NQTL.

56. A health plan cannot impose financial requirements, QTLs, or NQTLs that only apply to MH/SUD benefits. 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.

57. With respect to NQTLs that are not separate treatment limitations, the IFR specifically prohibits a health plan from imposing NQTLs on MH/SUD benefits, unless the health plan or health insurance issuer can demonstrate that certain requirements or tests are met.

58. Specifically, if a health plan imposes an NQTL on MH/SUD benefits, the plan must be able to 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 test above.

59. Using the NQTL Rule to analyze "standards for provider admission to participate in a provider network," the contractual requirements for network providers to participate in a network providing medical/surgical services must be comparable to the contractual requirements for network providers to participate in a network providing MH/SUD services, and the contractual requirements must be applied in a no more stringent manner to network providers providing MH/SUD services than the contractual requirements are applied to network providers providing medical/surgical services.

60. These contractual requirements specifically include the reimbursement rates provided to network providers, which are set forth in provider contracts and

fee schedules. The purpose of including reimbursement rates as an NQTL is to avoid exactly the situation presented here; *i.e.*, the beneficiary is forced to incur higher co-pays, more time away from work, more inconvenience, and possibly treatment by a lesser trained professional than is required on the medical/surgical side because the Defendants are refusing to pay for some or most of the services the mental health physician is licensed to provide and the patient and his or her employer have paid the Defendants to provide. Furthermore, a reimbursement rate that is less than the reimbursement rate paid to other network physicians, causes psychiatric physicians to decline participation in the network. This reduces the number of qualified providers in the network and reduces the choices for patients suffering from MH/SUD conditions with a consequent reduction in access to care.

61. Therefore, the provider admission standards, including the reduced reimbursement rates offered to MH/SUD providers and the codes, which are allowed to be billed, are NQTLs or separate treatment limitations applied to MH/SUD benefits and must comply with MHPAEA and the IFR. The reduced reimbursement rates and codes allowed to be billed must also comply with MHPAEA and the IFR when provided on an out-of-network basis.

62. Likewise, the methods health plans use to determine usual and customary rates ("UCR") for MH/SUD services must be comparable to the methods used to determine the UCR for medical/surgical services and the methods must not

be applied in a more stringent manner when determining MH/SUD rates than when determining medical/surgical rates. UCR methodologies are typically, but not exclusively, used by health plans to establish what they will reimburse for out-of-network services. Like provider admission standards, the plan methods for determining UCR must comply with MHPAEA and the IFR.

63. It is inconceivable that a recognized clinically appropriate standard of care would permit a difference in a financial parameter (i.e., how provider rates are established or a UCR methodology is utilized) and therefore no exception to this rule applies.

64. The Defendants' policy of non-payment or inappropriate payment for psychotherapy add-on services, which limits the scope of the MH/SUD benefit to a patient from a psychiatrist, is a separate treatment limitation and a per se violation of MHPAEA, unless it can be shown that this process complies with the NQTL Rule. If the NQTL Rule applies, the Defendants must demonstrate their policy of non-payment or inappropriate payment of psychotherapy add-on services is comparable to what is done for medical/surgical services with similar application.

65. Upon information and belief, the Defendants do not set rates or utilize a UCR methodology for psychiatric physicians in a manner which is comparable to and/or applied no more stringently than for non-psychiatric physicians.

66. Upon information and belief, the Defendants have not had a comparable refusal to pay for services, elimination of codes within licensure, or

forced false billing requirement on the medical/surgical side of Anthem's business. Nor is there any legitimate basis to pay psychiatrists significantly less (on average) than other medical doctors who use the same and identically valued codes to provide E/M services.

67. The Defendants can provide no 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 because none exists.

Connecticut's Mental Health Parity Law

68. Connecticut's state Mental Health Parity Act requires that all plans offer mental health benefits and that the plans not establish terms or conditions on benefits that place a greater burden on an individual seeking mental health benefits than on an individual seeking medical/surgical benefits.

The Defendants' Provider Contracts

69. The Defendants' contracts with health care providers preclude the Defendants from discriminating against a member in the provision of covered services on the basis of the member's health status. Those contracts also require 30 days' written notice of any amendment to the contract before the amendment takes effect.

COUNT ONE
DECLARATORY JUDGMENT THAT DEFENDANTS VIOLATE MHPAEA
(By All Plaintiffs)

1- 69. The Plaintiffs hereby incorporate Paragraphs 1 through 69 of the

Complaint as if fully stated herein as Paragraphs 1 through 69 of the First Count.

70. The Defendants' implementation of the CPT codes for psychiatry through their "representative fee schedule," failure to recognize CPT codes, imposition of double co-payments on psychiatric patients, reduction in rates, disparity in rates between mental health and medical/surgical services, failure to pay for psychotherapy for psychiatric physicians, and other conduct described above imposes quantitative and non-quantitative treatment limitations on mental health benefits that are not imposed upon any or substantially all non-mental health benefits or that are imposed in a manner that is not comparable and/or more stringent than those imposed upon non-mental health benefits in violation of MHPAEA.

71. There is no clinically recognized standard that would allow this disparity in treatment between mental health and non-mental health benefits.

72. Wherefore, the Plaintiffs seek a declaration from the Court that:

a. By engaging in the conduct set forth above, the Defendants have violated, and continue to violate, MHPAEA;

b. The rate scheme proposed by the Defendants on January 13, 2013 and effective January 1, 2013 is illegal and invalid under MHPAEA; and

c. Under MHPAEA, the Defendants may not pay mental health physicians less than they pay non-mental health physicians for the same level of service under an E/M code; and

d. The Defendants are enjoined from continuing violations of MHPAEA in

the manner described herein.

COUNT TWO
DECLARATORY JUDGMENT THAT DEFENDANTS VIOLATE CONNECTICUT PARITY LAWS
(By All Plaintiffs)

1-69. The Plaintiffs hereby incorporate Paragraphs 1 through 69 of the Complaint as if fully stated herein as Paragraphs 1 through 69 of the Second Count.

70. The Connecticut Mental Health Parity Act requires the provision of mental health benefits and precludes the Defendants from imposing terms, conditions, or benefits that place a greater financial burden on a patient seeking mental health benefits than on a patient seeking non-mental health benefits.

71. The Defendants' actions described herein impose terms and conditions or benefits that place a greater financial burden on patients seeking mental health services than those seeking non-mental health service by, *inter alia*, increasing co-payments, time required for treatment, and payment obligations for out-of-network services.

72. Wherefore, the Plaintiffs seek a declaration from the Court that:

a. By engaging in the conduct set forth above, the Defendants have violated, and continue to violate, Connecticut Mental Health Parity law;

b. The rate scheme proposed by the Defendants on January 13, 2013, effective January 1, 2013 is illegal and invalid; and

c. The Defendants are enjoined from continuing violations of the Connecticut Mental Health Parity Act in the manner described herein.

COUNT THREE
ANTHEM'S BREACH OF CONTRACT
(APA, CPS, and CCCAP on behalf of their members and their patients; and Dr. Savulak on her own behalf and on behalf of her patients)

1- 69. The Plaintiffs hereby incorporate Paragraphs 1 through 69 of the Complaint as if fully stated herein as Paragraphs 1 through 69 of the Third Count.

70. Anthem's provider contracts impose upon Anthem obligations to conduct utilization/quality management and to administer covered services without discriminating against a member on the basis of health status. This provision is for the benefit of the physicians and for the patients who are intended third party beneficiaries.

71. Dr. Savulak and other APA, CPS, and CCCAP members are parties to contracts with Anthem that contain this or an equivalent provision.

72. Anthem breached this provision of the contract by discriminating against mental health patients on the basis of health status (i.e. their status as mental health patients) in the manner described herein.

73. As a direct and proximate result of Anthem's actions, the Plaintiffs have been injured.

COUNT FOUR
ANTHEM'S BREACH OF CONTRACT
(By Dr. Savulak)

1-72. Dr. Savulak incorporates Paragraphs 1 through 72 of the Third Count as if fully stated herein as Paragraphs 1 through 72 of the Fourth Count.

73. Dr. Savulak is a party to a contract with Anthem that requires Anthem to

provide prior written notice of any amendment to the agreement and to provide 30 days for the Plaintiff to object.

74. By attempting to amend the agreement's rate schedule by providing a "representative fee schedule" on January 13, 2013, without any notice, and by putting that fee schedule into effect retroactive to January 1, 2013, Anthem breached its contract with Dr. Savulak.

75. Anthem has improperly compensated – and continues to improperly compensate – Dr. Savulak according to the "representative fee schedule" since January 2013, as if the contract had properly been amended.

76. As a result of Anthem's conduct as aforesaid, Dr. Savulak has suffered damages.

COUNT FIVE
DEFENDANTS' VIOLATION OF THE CONNECTICUT UNFAIR TRADE PRACTICES ACT
(By All Plaintiffs)

1- 69. The Plaintiffs hereby incorporate Paragraphs 1 through 69 of the Complaint as if fully stated herein as Paragraphs 1 through 69 of the Fifth Count.

70. At all relevant times, the Defendants were persons as defined by Conn. Gen. Stat. § 42-110a(3).

71. At all relevant times, the members of APA, CPS, and CCAP, as well as Dr. Savulak, were "providers," as that term is defined in Conn. Gen. Stat. § 38a-479(2). At all relevant times, the Defendants were "contracting health organization[s]," as that term is defined in Conn. Gen. Stat. § 38a-479(1).

72. Section 38a-479b of the Connecticut General Statutes (hereinafter, the "Notice Statute") mandates that contracting health organizations not make material changes to a provider's fee schedule, unless certain conditions are met. In any such event, the contracting health organization is statutorily required to provide advance written notice of the change.

73. At all times relevant hereto, the Defendants engaged in the conduct of trade or commerce with the APA, CPS, CCCAP and their members and patients, as well as with Dr. Savulak and her patients, and W.W., including the handling, processing, and payment of health insurance claims.

74. MHPAEA prohibits health insurers from creating quantitative or non-quantitative barriers to coverage for mental health treatment which do not exist for certain medical/surgical benefits or which are not comparable to or applied more stringently than barriers to coverage for medical/surgical benefits. The Connecticut Mental Health Parity Act requires that plans offer mental health benefits and that the plans not establish terms or conditions on benefits that place a greater burden on an individual seeking mental health benefits than on an individual seeking medical/surgical benefits.

75. By failing to properly adopt the CPT codes as effective in January of 2013, and by refusing to compensate the Plaintiffs fairly for the "add-on" codes for psychotherapy (and thus, effectively, refusing to provide coverage for psychotherapy performed by psychiatrists), the Defendants have violated both MHPAEA and the

Connecticut Mental Health Parity Act.

76. By uniformly implementing the "representative fee schedule," with no advance written notice to the members of APA, CPS, or CCCAP, or to Dr. Savulak, the Defendants violated the Notice Statute.

77. The Defendants engaged – and continue to engage – in unfair or deceptive acts and practices in the conduct of trade or commerce by (a) unilaterally, materially, and deceptively altering its fee schedules with APA, CPS, and CCCAP member physicians, in violation of, *inter alia*, the Notice Statute; (b) refusing to offer or provide coverage for psychotherapy to their members or to compensate psychiatrists for the provision of those services; (c) effectively requiring preauthorization for these services; (d) encouraging improper coding of medical services by physicians, which would have the effect of producing inaccurate patient medical records; (e) erecting unjust and disparate barriers to coverage of mental health treatment, which barriers do not exist for coverage of medical/surgical benefits, and which practice materially impacts both patients and their treating providers; (f) refusing to compensate psychiatrists in manners commensurate with reimbursement for other medical doctors performing E/M services, and refusing to pay psychiatrists for services within the scope of their license; and (g) in doing all of the above and other actions described in this Complaint, violating MHPAEA, the Connecticut Mental Health Parity Act, and their provider contracts with psychiatrists.

78. The Defendants' actions, omissions, and statutory violations as set forth

above constitute offenses to the public policy of the State of Connecticut, which includes encouraging access to mental health treatment, ensuring parity regarding the provision of benefits between mental health and other forms of medical/surgical benefits, prohibiting discrimination by insurance carriers against mental health patients and the professionals who treat them, and protecting health care providers from the deceptive practice of unilateral changes to fee schedules.

79. The Defendants' conduct as aforesaid constitutes unfair and/or deceptive acts or practices in the conduct of trade or commerce in violation of Section 42-110b of the Connecticut General Statutes.

80. As a result of the Defendants' conduct as aforesaid, the Plaintiffs have experienced ascertainable losses of money or property in that they have not been compensated by the Defendants, as required, or inadequately compensated, for the provision of mental health services to the Defendants' members, and have not been provided with mental health benefits commensurate with those provided for medical/surgical diagnoses.

COUNT SIX
DEFENDANTS' VIOLATION OF THE CONNECTICUT UNFAIR INSURANCE PRACTICES ACT, THROUGH THE CONNECTICUT UNFAIR TRADE PRACTICES ACT
(By All Plaintiffs)

1-69. The Plaintiffs hereby incorporate Paragraphs 1 through 69 of the Complaint as if fully stated herein as Paragraphs 1 through 69 of the Sixth Count.

70. At all times relevant hereto, the Defendants were persons as defined by

Conn. Gen. Stat. § 42-110a(3) and Conn. Gen. Stat. § 38a-815.

71. At all times relevant hereto, the Defendants were prohibited by Conn. Gen. Stat. § 38a-815 and 42-110b from engaging in unfair or deceptive acts or practices in the conduct of trade or commerce.

72. The Defendants engaged in unfair or deceptive acts or practices in the conduct of trade or commerce in violation of Conn. Gen. Stat. § 38a-816(6), Conn. Gen. Stat. § 42-110b, and the public policy of the State of Connecticut by engaging in the following:

a. Failing to adopt and/or implement reasonable standards for the prompt investigation of claims arising under the Plaintiffs' contracts in violation of Conn. Gen. Stat. § 38a-816(6)(c) in that they never established a legally compliant reimbursement structure for the provision of psychotherapy services, and instead encouraged informal, inaccurate billing practices (to the point of encouraging falsification of bills and patient medical records); and

b. Failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability was reasonably clear in violation of Conn. Gen. Stat. § 38a-816(6)(f) in that they refused to, as mandated by federal and state law, provide coverage and compensate providers for the provision of mental health services at levels commensurate with coverage provided for medical and surgical benefits and have refused to implement any curative changes retroactively.

73. The Defendants' conduct as aforesaid constitutes unfair and/or

deceptive acts and practices in the business of insurance, as set forth in the Connecticut Unfair Insurance Practices Act, Conn. Gen. Stat. §§ 38a-815, et seq.

74. As a result of the Defendants' conduct as aforesaid, the Plaintiffs have experienced ascertainable losses of money or property in that they have not been compensated by the Defendants, as required, or inadequately compensated, for the provision of mental health services to the Defendants' members, and have not been provided with mental health benefits commensurate with those provided for medical/surgical diagnoses.

PRAYER FOR RELIEF

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

With Respect to Counts One, Two, Three, Five and Six

1. A declaration that:

a. By engaging in the conduct set forth above, the Defendants have violated, and continue to violate, MHPAEA, the Connecticut Mental Health Parity law, the Connecticut Unfair Trade Practices Act, and their provider contracts;

b. The rate scheme proposed by the Defendants on January 11, 2013 and made retroactive to January 1, 2013 for services provided on or after that date is illegal and invalid; and

c. The Defendants are enjoined from continuing violations of MHPAEA, the Connecticut Mental Health Parity Act, the Connecticut Unfair Trade Practices Act, and

their provider contracts in the manner described herein.

2. Any other relief that the Court deems just and proper.

With Respect to Count Four

1. Damages

2. Interest and Costs; and

3. Any other relief that the Court deems just and proper.

PLAINTIFFS – 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 AND HER PATIENTS); AND W.W. (IN HER INDIVIDUAL CAPACITY)

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