

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

THE AMERICAN MEDICAL
ASSOCIATION, THE MEDICAL SOCIETY
OF THE STATE OF NEW YORK,
MATTHEW CREMA, and MICHAEL J.
ATTKISS, M.D., individually and on behalf of
all others similarly situated,

Plaintiffs,

v.

METROPOLITAN LIFE INSURANCE
COMPANY, UNITED HEALTHCARE
CORPORATION, and UNITED
HEALTHCARE SERVICES, INC.,

Defendants.

Index No.

**CLASS ACTION
COMPLAINT**

DEMAND FOR JURY TRIAL

Plaintiffs the American Medical Association, the Medical Society of the State of New York, Matthew Crema, and Michael J. Attkiss, M.D., by and through their undersigned counsel and based, *inter alia*, on their counsel's investigation, for their complaint, allege upon personal knowledge as to themselves and their own acts, and upon information and belief as to all other matters, as follows:

INTRODUCTION

1. Defendants Metropolitan Life Insurance Company ("Met Life") and United Healthcare Corporation and United Healthcare Services, Inc. (collectively, "United Healthcare") operate health care insurance plans in New York and throughout the United States. In many such plans, including what is known as the "Empire Plan" offered to certain New York State or municipal employees, subscribers are given the option to pay higher premiums in order to gain access to the

physician of their choice, rather than only “in-plan” physicians, as is true for health maintenance organization (“HMO”) plans. In return, Defendants agree to pay subscribers 80% of the usual, customary and reasonable charge (“UCR”) for such physicians’ services. However, by January 1997, Defendants had begun to utilize inappropriate data to understate the UCR and then to conceal the data from subscribers and providers. The net effect of Defendants’ use of inappropriate data was to force subscribers to pay more than they should have for treatment rendered by out-of-network providers or to cause the out-of-network providers to suffer the loss.

2. Although Met Life contracted to provide health insurance to the subscribers through the Empire Plan, as well as other similar plans, it has relinquished its role in operating such health insurance to its subscribers. Pursuant to an agreement entered in October 1995, Met Life has provided its *life* insurance benefit program to United Healthcare’s customers, while United Healthcare has provided its *health* insurance benefit program to Met Life’s customers. The end result is that certain of the group health insurance benefit programs of the Subscriber Class have been and continue to be determined and controlled not by Met Life, the company with whom many subscribers have a formal contract, but by United Healthcare. Defendants, meanwhile, have not accurately disclosed United Healthcare’s role to the Met Life subscribers; in many communications, United Healthcare refers to itself as merely the “administrator” of the Empire Plan and other Met Life plans, thereby minimizing its true role, while Met Life has not even disclosed in its subscriber materials the significant role played by United Healthcare at all. In light of the contract between United Healthcare and Met Life, pursuant to which United Healthcare provides health care insurance to Met Life customers, both Defendants are responsible for insuring that the contract with the subscribers is properly enforced. Both have failed in doing so, leading to the filing of this action.

3. To obtain relief from Defendants' misconduct in improperly reducing reimbursements for medical services, two major non-profit organizations representing physicians, the American Medical Association ("AMA") and the Medical Society for the State of New York ("MSSNY"), bring this action on their own behalf and, in a representational capacity, on behalf of their members. They are joined by an individual subscriber, Matthew Crema ("Crema"), and an individual physician, Michael J. Attkiss, M.D. ("Dr. Attkiss"), who bring this class action on behalf of a Subscriber Class and a Provider Class, as defined below, whose members have been injured by Defendants' breach of contract and deceptive practices. The AMA and the MSSNY, along with Dr. Attkiss and other physicians, also state a claim against Defendants for trade libel

SUMMARY AND NATURE OF THE ACTION

4. In its contract known as a "Certificate of Insurance" (the "Certificate"), Met Life – and, through its October 1995 contract, United Healthcare – agreed to pay subscribers or their physicians 80% of the UCR for all out-of-network treatments, defined as the lowest of (1) the provider's actual charge, (2) the provider's usual charge, and (3) the "reasonable and customary charge" for the service.

5. Instead of determining UCR amounts in a fair and evenhanded manner as guaranteed by the Certificate, Defendants purposefully used data that pervasively understate the UCR amounts, and therefore understate the amounts Defendants have to pay. Such practice has the necessary and foreseeable effect of forcing the Subscriber Class to pay hundreds and sometimes thousands of dollars over the understated UCR amount for every treatment they receive from an out-of-network provider, or to forego treatment from out-of-network providers.

6. Dr. Attkiss is a highly regarded and qualified physician who routinely performs

venous surgery, requiring the ligation and division of incompetent veins in the groin area (identified hereafter as "Procedure 1"). He also routinely performs sclerotherapy, a nonsurgical, outpatient procedure to remove incompetent veins of the superficial venous system (identified hereafter as "Procedure 2"). Dr. Attkiss successfully performed both procedures on Crema to alleviate a painful medical condition.

7. Crema and several other members of the Subscriber Class assigned their claims for reimbursement to Dr. Attkiss, who in turn submitted the claims to the Empire Plan. In that the purpose of the contracts between members of the Subscriber Class and the Defendants is to ensure that physicians receive proper compensation from the insurer, Dr. Attkiss and other members of the Provider Class are beneficiaries of such contracts and are entitled to move to enforce them.

8. For both procedures, Defendants had previously paid most if not all of the charges submitted by or on behalf of Dr. Attkiss or his patients, finding that his fees fell well within appropriate UCR guidelines. Beginning in early 1997, however, Defendants reversed their prior policy and materially reduced the designated UCR for the procedures performed by Dr. Attkiss, and thus the reimbursements paid for the procedures, thereby requiring him or his patients to bear the expense for the unpaid portion. Pursuant to this new policy, Defendants denied Dr. Attkiss' claims on behalf of Crema, in whole or in part.

9. Upon examining Defendants new UCR limits and his own data involving a large number of procedures, Dr. Attkiss confronted United Healthcare, demonstrating that it was relying on flawed data to compute UCR. After lengthy discussions and exchange of correspondence concerning the UCR issue, United Healthcare finally conceded that the data it used for determining the UCR for Procedure 1 was incorrect, leading to an underpayment to Plaintiff and other members

of the Subscriber Class of *nearly* \$2,000 for each such procedure. This concession of underpayment came only after repeated and insistent prior misrepresentations by United Healthcare that the UCR amount was correct and authorized by its data. Yet, United Healthcare refused to admit that its calculations for Procedure 2, which involved many more subscribers than Procedure 1, were also improper, as they were based on similarly erroneous data. Even as to Procedure 1, for which United Healthcare confessed underpayment due to inappropriate UCR data, United Healthcare refused to allow Plaintiffs to review the underlying data. It is therefore doubtful whether United Healthcare completely corrected the original calculation. Because United Healthcare only made the change at Dr. Attkiss's insistence and has not admitted a generic problem, it is apparent that Defendants have not made the required refund to other subscribers or providers who did not dispute the improper reimbursement.

10. In an apparent response to raising this issue of misrepresented UCR amounts, Met Life and United Healthcare recently retaliated, and stopped paying any reimbursement for Procedure 2 at all. They now claim that this procedure is "not medically necessary," even though both United Healthcare and Met Life (as well as other insurance companies) had previously determined the procedure was "medically necessary" and had consistently paid for physicians to perform it.

11. Defendants have profited from their use of skewed UCR data and improper methods of computing UCR, at the expense of both the Subscriber Class and the Provider Class. The state laws of New York and Minnesota, among others, protect the Subscriber Class and Provider Class from the breach of contract, deceptive practices, trade libel, and other violations of law that Defendants are now, and have in the past been, committing.

12. Plaintiffs bring this litigation on their own behalf and on behalf of the Class or their members to remedy the deceptive practices and other violations of law engaged in by Defendants and to ensure that they receive restitution for insurance benefits to which they are entitled, but have not received, as well as other appropriate relief.

THE PARTIES

Plaintiffs

13. The AMA is a national tax-exempt membership organization which represents the interests of approximately 300,000 physicians and their patients located through out the United States, including New York. Founded in 1847 to promote the science and art of medicine and the betterment of public health, the AMA is the largest medical society in the United States. In furthering its purpose, the AMA undertakes to educate the public regarding pressing issues of public health and medical care and it publishes numerous educational journals, including the prestigious Journal of the American Medical Association (“JAMA”). Indeed, the AMA is the largest healthcare publisher in the world. The AMA also holds the copyright for the “CPT” codes that are used as a numerical description of thousands of medical procedures. The AMA and its members have been, and continue to be, adversely affected by the acts, policies and practices of Defendants as alleged herein. The AMA brings this action as a representative and on behalf of its members who have submitted claims, or who will submit claims, to Defendants for medical treatment they performed as out-of-network providers and who have been, or will be, harmed by Defendants’ actions as alleged herein.

14. The MSSNY is a not-for-profit membership organization which represents the

interests of physicians and their patients in New York State. Specifically, the MSSNY's membership includes approximately 28,000 licensed physicians, medical residents and medical students in New York State. The MSSNY is committed to representing the medical profession in advocating health-related rights, responsibilities and issues. Its purposes include the following: (i) federate into one organization the medical profession of this State; (ii) extend medical knowledge and advance the science and art of medicine; (iii) establish principles of professional conduct; (iv) enhance the delivery of high quality medical care; and (v) enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New York State. As is true for the AMA, the MSSNY and its members have been, and continue to be, adversely affected by the acts, policies and practices of Defendants as alleged herein. The MSSNY also brings this action as a representative and on behalf of its members who have submitted claims, or who will submit claims, to Defendants for medical treatment they performed as out-of-network providers and who have been, or will be, harmed by Defendants' actions as alleged herein.

15. The AMA and the MSSNY appear here as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. The member organizations, in addition to the AMA and the MSSNY, are: the Medical Association of the State of Alabama, Alaska State Medical Association, Arizona Medical Association, Arkansas Medical Society, California Medical Association, Colorado Medical Society, Connecticut State Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Medical Association of Georgia, Hawaii Medical Association, Idaho

Medical Association, Illinois State Medical Society, Indiana State Medical Association, Iowa Medical Society, Kansas Medical Society, Kentucky Medical Association, Louisiana State Medical Society, Maine Medical Association, MedChi, the Maryland State Medical Society, Massachusetts Medical Society, Michigan State Medical Society, Minnesota Medical Association, Mississippi State Medical Association, Missouri State Medical Association, Montana Medical Association, Nebraska Medical Association, Nevada State Medical Association, New Hampshire Medical Society, Medical Society of New Jersey, New Mexico Medical Society, North Carolina Medical Society, North Dakota Medical Association, Ohio State Medical Association, Oklahoma State Medical Association, Pennsylvania Medical Society, Rhode Island Medical Society, South Carolina Medical Association, South Dakota State Medical Association, Tennessee Medical Association, Texas Medical Association, Utah Medical Association, Vermont State Medical Society, Medical Society of Virginia, Washington State Medical Association, West Virginia State Medical Association, State Medical Society of Wisconsin, and Wyoming Medical Society.

16. Crema is a subscriber to the Empire Plan, an indemnity health insurance program which is offered by Met Life through the State of New York and numerous New York State municipalities. The terms and conditions of Crema's health care coverage are governed by the Met Life Certificate. Crema brings this action for himself individually and, pursuant to New York Civil Practice Law and Rules ("CPLR") Article 9, on behalf of all subscribers of healthcare plans, insured or administered by Met Life or United Healthcare, who have submitted claims for medical, surgical or other expenses on or after January 1, 1997, which claims were denied in whole or in part on the basis that the charge was in excess of "reasonable and customary" amounts (the "Subscriber Class").

Many members of the Subscriber Class live in New York.

17. Dr. Attkiss is a physician who is licensed to practice medicine in the State of New York and has an office in Great Neck, New York. He specializes in the treatment of varicose veins. Dr. Attkiss has treated Crema and certain members of the Subscriber Class, among others, for vascular and other medical disorders. He brings this action for himself individually and, pursuant to CPLR Article 9, on behalf of all medical care providers who have furnished health care services to members of the Subscriber Class on whose behalf claims have been submitted to Met Life or United Healthcare for medical, surgical or other expenses on or after January 1, 1997, which claims were denied in whole or in part on the basis that the charge was in excess of “reasonable and customary” amounts (the “Provider Class”). Except where otherwise stated, the Subscriber Class and the Provider Class are referred to herein collectively as the “Class.”

Defendants

18. Defendant Met Life is an insurance company incorporated in New York with its principal corporate offices located at 1 Madison Avenue, New York, New York 10010. Met Life has offices throughout the United States and is one of the largest insurance companies in the world. Met Life, in name at least, insures the Empire Plan.

19. Pursuant to a contract entered into with United Healthcare in October 1995, Met Life has permitted United Healthcare to operate and control Met Life’s group health insurance benefit programs, including the Empire Plan.

20. Defendant United Healthcare Services, Inc. is a wholly-owned subsidiary of Defendant United Healthcare Corporation. Both United Healthcare Defendants are incorporated in

Minnesota, and at all relevant times controlled, and continue to control, the Empire Plan as well as many other health insurance plans, both inside and outside New York State. United Healthcare maintains offices in the State of New York, including one in Kingston, New York that rendered many of the UCR determinations that are in dispute in this action. United Healthcare's wholly-owned subsidiary, Ingenix, purchased the PHCS database from the Health Insurance Association of America (HIAA) in 1998. The database, as fully described below, is used by Defendants as the basis for making UCR determinations.

JURISDICTION AND VENUE

21. This Court has jurisdiction over Defendant Met Life pursuant to CPLR § 301 because Met Life conducts business in New York State out of its principal corporate offices located in New York. All of Met Life's insurance policies, including the Empire Plan, are created, administered and marketed in New York. New York State and municipal employees, among others, are subscribers to the Empire Plan.

22. This Court has jurisdiction over United Healthcare because United Healthcare does substantial business in New York, has sufficient minimum contacts with New York, including maintaining an office in Kingston, New York, and otherwise intentionally avails itself of the economic opportunities here, and is clearly "present" in New York so as to make it fair and just for a New York court to exercise jurisdiction over it. Moreover, in entering into a contract with Met Life whereby United Healthcare operates and controls the Empire Plan and other health insurance programs offered by Met Life, United Healthcare understood that it would be making important determinations affecting New York State and municipal employees, their spouses and their eligible dependents.

23. Venue is appropriate because Defendant Met Life is a resident of New York County

and this is the chosen forum of Plaintiffs.

SUBSTANTIVE ALLEGATIONS

I. THE EMPIRE PLAN

24. Health and medical insurance is considered an essential benefit in New York State and elsewhere and, when made available by an employer, is considered an important employee benefit.

25. Crema and many other members of the Subscriber Class are employees of New York State or municipalities in the state of New York, or are spouses of such employees. As such, they are provided two options for health and medical insurance as part of their employee benefits. One option is a health maintenance organization (“HMO”) plan, pursuant to which employees receive medical and other care from physicians employed by, or under contract with, an HMO. Employees who select the HMO plan do not have the option to be treated by physicians outside the HMO, except in an emergency. Employees choosing the HMO option pay a part of the cost of their premium, with the remainder paid by their employers. The second option is the Empire Plan. The Empire Plan, which is described as “an indemnity plan with some managed care features,” permits subscribers to use out-of-network providers. For the benefit of preserving his ability to choose his own physician, Crema, like other Empire Plan subscribers, agreed to pay significantly more than employees choosing the HMO plan.

26. Dr. Attkiss, as well as the other members of the Provider Class, is considered an out-of-network provider by the Empire Plan and by other Met Life plans. A physician who would normally be considered a participating, or “in-network,” provider can in certain circumstances be

considered an out-of-network provider. For example, a physician who is usually considered an “in-network” provider (and who has thereby agreed to accept discounted contract rates from an insurer) will nevertheless be considered an out-of-network provider in the event a patient comes to such physician without a referral from the patient’s primary care physician.

27. A detailed description of the Empire Plan is contained within the Certificate. The Certificate specifies that “Covered Medical Expenses” under the Basic Medical Program means “the reasonable and customary charges for covered medical services performed or supplies prescribed by a doctor . . . due to your sickness, injury or pregnancy.” Subscribers are instructed to “submit claims to Metropolitan,” with the Empire Plan to reimburse subscribers “80 percent of the reasonable and customary charges for covered services, or the actual billed charges, whichever is less.”

28. Met Life’s Certificate contains the following definition of “Reasonable and Customary Charge”:

Reasonable and Customary Charge” means the lowest of:

- (i) the actual charge for a service or supply; or
- (ii) the usual charge by the doctor or other provider for the same or similar service or supply; or
- (iii) the usual charge of other doctors or other providers of similar training or experience in the same or similar geographic area for the same or similar service or supply.

The determination of the reasonable and customary charge for a service or supply is made by Metropolitan.

You are responsible for any amount billed by a non-participating provider which exceeds the reasonable and customary charge, in addition to the annual deductible and coinsurance amounts.

Met Life’s Certificate at 4 (definition L).

29. In many instances, a subscriber will be paid 80% of “the usual charge of other doctors

or other providers of similar training or experience in the same or similar geographic area for the same or similar service of supply” because that charge is purportedly lower than the doctor’s actual or usual charge. Thus, the manner in which United Healthcare determines the “usual charge” of other providers with comparable experience and in similar geographic areas is of significant importance to Crema and other Empire Plan subscribers.

30. No further information regarding the “reasonable and customary” calculation – such as how “reasonable and customary charge” is determined, what data contributes to the determination, what or how many doctors are surveyed, how “similar training or experience” is compared, or what “the same or similar geographic area” means – is provided or is available on request to an Empire Plan subscriber.

31. The use of the term "usual charge" in the contract means, or is reasonably interpreted by subscribers to mean, the amount that a physician normally charges to his or her patients in the free market, *i.e.*, without an agreement with an insurance company to reduce such a charge in exchange for obtaining access to the insurance company's subscribers. As such, the "usual charge" for medical services is clearly distinguishable from a "schedule of allowances," defined in the Certificate as Met Life's "schedule of amounts it will pay to participating providers for covered medical services." Certificate at 62 (Definition F). Moreover, the term "usual charge" as used in the Certificate does not mean merely the usual charge by all physicians for a particular service, but is limited to the usual charge in the "same or similar geographic area" by a doctor of "similar training or experience."

32. Under the Certificate, Met Life (and, through its assumption of the control and operation of the Met Life health insurance plans, United Healthcare) must pay Subscriber Class members enrolled in the Empire Plan 80% of the “reasonable and customary charge” for services they receive from out-of-network providers using data sufficient to identify what charges are usually

billed to patients in the open market by physicians with similar training or experience in the same or similar geographic area.

33. Because Defendants have arbitrarily and improperly reduced UCR amounts for Subscriber Class members based on data that does not satisfy the requirements set forth in the Certificate and other subscriber contracts, as alleged herein, Defendants are in breach of the terms of the Certificate and other contracts Met Life and United Healthcare have with their subscribers, and are unlawfully profiting thereby. In addition, Defendants have engaged in deceptive practices which have harmed, and continue to harm, their subscribers.

II. DEFENDANTS' CALCULATION OF UCR AND OTHER PRACTICES

34. Met Life's Certificate warrants to subscribers that the UCR determination is made by Met Life. It is in fact United Healthcare, not Met Life, which determines the UCR for Empire Plan subscribers, and for many other subscribers of Met Life's health insurance programs.

35. To establish UCR, United Healthcare claims that it uses data from a database known as the Prevailing HealthCare Charges System ("PHCS") produced in 1997 and 1998 by the Health Insurance Association of America (hereafter "HIAA"). In 1998, United Healthcare, through its subsidiary Ingenix, purchased the PHCS database.

36. Significantly, before United Healthcare purchased the PHCS database, HIAA told insurers that its PHCS data were unsuitable for the purpose of setting UCR. Specifically, HIAA released its data with the following disclaimer:

The [PHCS] data are provided to subscribers [e.g., insurance companies such as United Healthcare] for informational purposes only and the HIAA disclaims any endorsement, approval or recommendation of the data. There is neither a stated nor implied "usual and customary" charge.

37. The PHCS database is flawed in a number of ways, each of which cause the UCR

determination based on it to be artificially reduced. Among other things, these flaws include the fact that the PHCS data:

1. systematically under-reports the actual number of procedures performed in a geographic area, and often eliminates the highest charges for each type of medical procedure maintained in the PHCS database;
2. includes the charges for medical procedures from other, and non-comparable, geographic areas, in which the provider charges were lower;
3. fails to segregate procedures performed by providers of the same or similar skill and experience level, but rather, indiscriminately lumps together all provider charges by procedure code without regard to skill or experience level; and
4. includes charges for various procedures which are pre-set with participating “in-network” providers so as to incorporate discounts on the “usual” charges based on an anticipated increase in patient volume, thereby skewing the data below the true “usual and customary” rates.

38. Through their reliance on the PHCS database, Met Life and United Healthcare routinely fail to determine the usual charge of other doctors for a given medical procedure “in the same or similar geographic area” as is promised under the definition of UCR.

39. Similarly, Met Life and United Healthcare routinely fail to determine a provider’s professional stature in the community (*e.g.*, whether the Physician is Board certified, or the provider’s

years of experience). The consequence is that Met Life and United Healthcare fail to comply with their UCR definitions (for example, in the Empire Plan, promising to compare a given charge to the usual charge of other doctors “of similar training or experience”).

40. Met Life and United Healthcare also misuse confidential patient information received from their subscribers. Instead of applying the confidential information in a manner consistent with the expectation of subscribers, Met Life and United Healthcare subvert the information in order to understate the UCR amounts, which they then use to pay subscribers less than the amount the subscribers are entitled to receive under their Certificates.

41. Plaintiffs believe there are other fraudulent practices which affect the calculation of UCR amounts. At this juncture, Defendants exclusively possess this specific knowledge, since they have refused Plaintiffs’ repeated requests to provide information about the manner in which UCR amounts are calculated and to provide the underlying data. Rather they deliberately withhold information concerning their UCR determinations in an effort to prevent subscribers and providers from having sufficient data to contest the arbitrary reductions of reimbursements pursuant to the UCR provisions in the Certificates.

42. As a consequence of Defendants’ practices, subscribers have been reimbursed in amounts less than what they should have been paid had the definition of “Reasonable and Customary Charge” in the Certificates been properly applied. Defendants never informed subscribers that they were paying UCR amounts lower than the amounts that should properly have been paid under their insurance contracts with subscribers, and misrepresented that the UCR amounts were calculated correctly.

III. CREMA’S AND DR. ATTKISS’ EXPERIENCE WITH UCR

43. Beginning in or about January 1997, when Defendants claim they first started using

the PHCS data to determine UCR amounts, they drastically reduced their UCR allocation for Procedure 1 and Procedure 2, which had been performed on a regular basis by Dr. Attkiss, thereby reducing the amount of charges for such procedures that they would reimburse to subscribers or providers.

44. The effect on Subscriber Class members, and their providers, has been dramatic. For example, whereas a subscriber prior to January 1, 1997 would have received full reimbursement for a provider charge of \$725 for Procedure 2, Defendants suddenly reduced their reimbursement for that procedure to only \$435 in 1997. Similarly, whereas a subscriber would have received full reimbursement for a provider charge of between \$5,400 and \$5,800 for Procedure 1 prior to 1997, Defendants dramatically dropped their reimbursement for it to only \$3,833 in 1997. In slashing reimbursement far below the amount that should have been paid, Defendants left Subscriber Class members in the position of not being able to use an out-of-network provider, or being liable for the unpaid balance to their chosen provider. In either event, Subscriber Class members were deprived of the full value of the insurance benefit for which they paid.

45. Upon being informed of the material reduction in UCR amounts for Procedure 1 and 2, Dr. Attkiss has repeatedly informed Defendants orally and through written correspondence that they had no basis for reducing the reimbursements to subscribers and providers, in that the original charges by Dr. Attkiss fell within appropriate UCR limits. Since at least September 1, 1998, Defendants have been on clear notice through such correspondence that the data upon which it relied in setting UCR amounts were seriously flawed. Nevertheless, Defendants have refused to take systemic action to correct the problem.

46. Crema suffered from a painful varicose vein condition in his legs, which made it difficult for him to stand or walk. He therefore sought treatment from Dr. Attkiss, whom

Defendants consider to be an out-of-network provider. Dr. Attkiss determined that Crema required vein surgery, referred to in this Complaint as Procedure 1, which was performed on January 15, 1998.

47. Although Crema experienced partial relief following Procedure 1, Dr. Attkiss determined that further medical treatment was required. Dr. Attkiss therefore performed injection sclerotherapy (Procedure 2) on Crema on two occasions: April 1, 1998 and April 7, 1998. Crema experienced virtually complete relief following a brief recovery period from the Procedure 2 treatments by Dr. Attkiss.

48. On Crema's behalf, Dr. Attkiss thereafter submitted claims to Defendants for the Procedure 1 surgery he had performed on January 15, 1998 and for the two Procedure 2 treatments he had performed in April of 1998. Defendants, however, failed to pay appropriate UCR amounts for these procedures, despite having been repeatedly advised in writing regarding their insufficient payment and their violation of Crema's Certificate with Met Life. With respect to Procedure 1, Defendants ultimately conceded that they had improperly reduced reimbursements based on faulty UCR data, although only doing so after extensive communications with Plaintiffs and a clear demonstration of Defendants' error and without agreeing to change its reliance on the flawed PHCS database

49. Significantly, at no time did Defendants comply with Plaintiffs' request for access to the underlying data which purportedly supported the new UCR limits, thereby preventing them from having the necessary information to question Defendants' unilateral UCR determinations. By refusing to provide such data to Plaintiffs, Defendants acted contrary to a July 31, 1996 Advisory Opinion of the Department of Labor which specified that "the schedule of 'usual and customary' fees," including "studies, schedules or similar documents that contain information and data, such as

information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements," must be disclosed to participants and beneficiaries of health care plans under sections 104(b)(2) and 104(b)(4) of the Employee Retirement Income Security Act of 1974 ("ERISA").

50. Despite a further persuasive showing by Plaintiffs that Defendants had established an inordinately low UCR amount for Procedure 2, Defendants continued to insist that the dramatically lower UCR amount for procedures performed in 1997 and thereafter was the correct UCR for Procedure 2, and on such basis refused to make any additional payments for Crema or for any of the other members of the Subscriber Class.

51. While United Healthcare claimed that its UCR amount for Procedure 2 in 1998 in the provider's area was "in adherence to the provisions of Empire Plan coverage," it continued to refuse to comply with Plaintiffs' requests for additional information or for the data allegedly showing that its lowered UCR amount complied with the Met Life Certificate.

52. Since Dr. Attkiss began to question the inadequate payments, Met Life and United Healthcare, which considered Procedure 2 "medically necessary" for many years and paid for it as such, suddenly stopped reimbursing subscribers for Procedure 2 altogether, arbitrarily alleging it was not "medically necessary." Such a conclusion is contrary to accepted medical standards and inconsistent with decisions of numerous other insurance companies which continue to reimburse Dr. Attkiss and his patients for such procedures.

53. It is thus clear that, absent court intervention, Defendants have no intention of fairly reimbursing subscribers and providers or providing data substantiating that the amount it established as the UCR for Procedure 2 beginning in 1997 or thereabouts was appropriate or in compliance with subscribers' Certificates. It is also clear that, absent court intervention, Defendants have no intention

of paying for Procedure 2 at all, currently or in the future.

54. Class members have been damaged by Defendants' computation of reasonable and customary charges in violation of the stated UCR definition in their Certificate or policy and by their failure to ensure correct payments to subscribers and their medical providers. Defendants have consistently reduced the payments made to subscribers by asserting that charges incurred were in excess of "reasonable and customary," when they knew under the particular Certificate or policy definition of UCR that the charges incurred were not in fact in excess of properly computed UCR amounts.

55. Certain Class members have also been damaged by Defendants' recent outright denials of payment for Procedure 2, allegedly on the basis that it is "not medically necessary." Defendants' refusal to pay anything at all for Procedure 2 -- after paying for it for the last decade -- is in improper retaliation for Class members' criticism about Defendants' use of HIAA data and insistence on compliance with the subscribers' contracts.

CLASS ACTION ALLEGATIONS

56. Crema and Dr. Attkiss bring this action on their own behalf and, pursuant to CPLR Article 9, as a class action on behalf of, respectively, the Subscriber Class and the Provider Class, as defined above.

57. Class members are so numerous that joinder of all members is impracticable. United Healthcare is estimated to be the second largest health care insurer in the United States and, collectively, Met Life and United Healthcare insure more than 10 million subscribers nationwide. In addition, Plaintiffs believe that there are thousands of New York subscribers in the Empire Plan. Thus, the numerosity requirement is easily satisfied.

58. Common questions of law and fact exist as to all Class Members and predominate

over any questions affecting solely individual members of the Class. Among the questions of law and fact common to the Class are the following:

1. Whether Met Life and United Healthcare computed UCR through the PHCS database, and whether such use was deceptive, in breach of subscribers' contracts, or otherwise improper;
2. Whether Met Life and United Healthcare used PHCS data, which systematically miscounted (or misreported) the actual number of procedures performed in a geographic area, to eliminate the highest charges for each type of procedure maintained in the PHCS database;
3. Whether Met Life and United Healthcare used PHCS data which included procedures from other, and non-comparable, geographic areas, where the provider charges are lower;
4. Whether Met Life and United Healthcare used PHCS data which failed to segregate procedures according to the skill or experience level of the provider, but, instead, indiscriminately lumped together all provider charges by procedure code;
5. Whether Met Life and United Healthcare used PHCS data which included charges for various procedures which are pre-set with participating "in-network providers," and which are discounted based on an anticipated increase in patient volume even though the use of such discounted rates is improper and serves to skew the data;
6. Whether, while purporting to rely on PHCS data, Met Life and United Healthcare arbitrarily established UCR amounts based on non-PHCS

data, when Defendants did not want to pay the amount that the PHCS data would otherwise dictate;

7. Whether the data upon which Met Life and United Healthcare based their pre- and post- January 1997 calculations of UCR were deceptively represented as accurately reflecting the UCR amounts;
8. Whether Met Life and United Healthcare used Ingenix and HIAA as shields to conceal the PHCS data by claiming such data was available, and then derailing scrutiny by having Ingenix and HIAA assert that the data was proprietary and confidential;
9. Whether Met Life and United Healthcare breached their contractual obligations owed to their subscribers by permitting UCR to be calculated and paid pursuant to a method which systematically understated the amounts paid to or on behalf of Subscriber Class members and not in conformity with the Subscriber Class members' Certificates;
10. Whether Met Life and United Healthcare misused confidential patient information received from subscribers in order to understate UCR amounts, which Defendants then used as the basis to pay Class members less than the amount that they were entitled to receive under their Certificates;
11. Whether Met Life and United Healthcare knew that the data they were using to establish UCR had the effect of understating UCR and thereby reducing the amount Defendants had to pay to Class members

or on their behalf; and

12. The amount of damages Defendants should pay, and the injunctive relief that is appropriate, based on their above-described conduct.

a Crema's claims are typical of the claims of the Subscriber Class members because, as a result of the identical pattern of conduct alleged herein, Defendants breached their contractual obligations to Crema and the Subscriber Class and engaged in deceptive acts and practices with respect to their determination of reasonable and customary charges. Common factual and legal questions predominate. In addition, Crema's interests are substantially aligned with those of the Subscriber Class members.

59. Dr. Attkiss's claims are typical of the claims of the Provider Class members because, as a result of the identical pattern of conduct alleged herein, Defendants breached their obligations to Dr. Attkiss and other members of the Provider Class, as beneficiaries of the contracts Defendants had with members of the Subscriber Class. Defendants engaged in identical deceptive practices as to all members of the Provider Class with respect to Defendants' determination of reasonable and customary charges, and related issues. In addition, Defendants engaged in an identical pattern of trade libel with regard to all of the members of the Provider Class. Common factual and legal questions predominate. Dr. Attkiss's interests are substantially aligned with those of the Provider Class members.

60. Crema and Dr. Attkiss will fairly and adequately protect the interests of the members of the Subscriber and Provider Classes, are committed to the vigorous prosecution of this action, have retained counsel competent and experienced in complex commercial and class litigation, and have no interests antagonistic to or in conflict with those of the Classes. As such, Crema and Dr. Attkiss are adequate representatives of the Classes under CPLR Article 9.

61. Prosecution of these actions individually creates the risk of inconsistent adjudications and, because the damages suffered by individual class members may be relatively small, the expense and burden of individual litigation make it extremely difficult for the Class members to redress the wrongs done to them on an individual basis.

62. There will be little or no difficulty in the management of this action as a class action.

63. For all of the foregoing reasons, Article 9's requirements for class certification are satisfied here and certification of both a Subscriber Class and Provider Class as defined above is appropriate.

FIRST CAUSE OF ACTION
(Breach of Contract and the Implied Covenant of Good Faith and Fair Dealing)

64. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

65. Met Life has entered into valid and enforceable contracts with Crema and other members of the Subscriber Class pursuant to which it has agreed to reimburse 80 percent of the "reasonable and customary charges" for medically necessary treatments received by Subscriber Class members from out-of-network providers.

66. United Healthcare has obligated itself, by virtue of its October 1995 agreement with Met Life, to honor and fulfill the substance of contracts Subscriber Class members had entered into with Met Life. By assuming the contracts with Class members, United Healthcare must strictly comply with the terms of such contracts.

67. Dr. Attkiss and other members of the Provider Class, including physicians whose interests are represented by the AMA and the MSSNY, have furnished medical services to members of the Subscriber Class and have submitted or had submitted on their behalf claims to Defendants for

reimbursement of their charges as out-of-plan providers under the terms of the contracts with the members of the Subscriber Class. As such, Dr. Attkiss and other members of the Provider Class are beneficiaries of these contracts and are entitled to enforce their provisions.

68. Met Life has itself breached its contractual obligations to the Class by permitting United Healthcare to assume control and the operation of the group health benefit programs for Met Life's customers, and failing to ensure that United Healthcare honored the contractual obligations Met Life had entered into with Subscriber Class members. Met Life has itself made payments or has permitted United Healthcare to make payments that are well below the amounts that should have been paid pursuant to subscribers' contracts or has failed to prevent United Healthcare from doing so, in breach of its contracts with the Subscriber Class.

69. Defendants have breached contractual obligations to Class members by failing to compute UCR in conformity with the stated definition of UCR with the result that the payments made by them are below the amounts that should have been paid pursuant to Subscriber Class members' contracts. Defendants' conduct has deprived Subscriber Class members of the full value of the insurance benefit that they paid for.

70. Met Life and United Healthcare have intentionally violated their duty to investigate the true reasonable and customary charges for medical services, have impaired the rights of Subscriber Class members to receive the benefits to which they are entitled, and have acted in a manner inconsistent with the justified expectations of Subscriber Class members. In so acting, Defendants have also breached the covenant of good faith and fair dealing.

71. Met Life and United Healthcare have misused confidential patient information received from subscribers. Instead of applying the confidential information in a manner consistent with the expectation of subscribers and with their contractual and other obligations, Defendants

subverted the information in order to understate and underpay UCR amounts.

72. Met Life and United Healthcare have further breached subscribers' contracts by refusing to pay anything at all for sclerotherapy – "Procedure 2" - allegedly on the ground that Procedure 2 is not "medically necessary." Defendants have long regarded Procedure 2 as "medically necessary" and have paid for such procedure previously. Defendants' arbitrary and capricious determination that Procedure 2 is no longer "medically necessary" is a further breach of contract by Defendants.

73. Met Life and United Healthcare's conduct reflects a conscious disregard of the rights of Class members for which relief is appropriate.

74. As a result of Met Life and United Healthcare's conduct as detailed above, Class members have suffered damages in an amount to be determined at trial. By virtue of the conscious course of conduct, Class members are also entitled to recover punitive damages for the wrongs alleged herein. The Class seeks appropriate compensatory, exemplary and equitable relief. The AMA and the MSSNY request appropriate declaratory and injunctive relief to remedy Defendants' violation of their contractual and other duties.

SECOND CAUSE OF ACTION
(Deceptive Acts and Practices Under New York General Business Law § 349)

75. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

76. As alleged herein, Defendants have violated Section 349 of the New York General Business Law.

77. New York GBL Section 349 specifically prohibits deceptive acts or practices in the conduct of any business, trade or commerce. The statute confers a private right of action on

aggrieved persons thereunder.

78. The contracts that Met Life executed on behalf of Plaintiffs constitute conduct of a business within New York State and subject it to the requirements and prohibitions of New York law, including New York's law prohibiting deceptive trade practices. Similarly, United Healthcare's operation and control of the Empire Plan with New York subscribers, constitutes conduct of a business within New York State and subjects it to the requirements and prohibitions of New York law, including GBL Section 349.

79. Defendants engaged in misrepresentations and omissions which were directed toward consumers, including potential subscribers, in order to induce the viewers of such materials to elect, or to continue, Plan membership in health plans purportedly offered by Met Life.

80. Met Life provided a definition of "reasonable and customary charge" to its subscribers to which it and United Healthcare failed to adhere.

81. Met Life's definition of "reasonable and customary charge," if properly followed, would have led to higher reimbursement amounts than what Defendants actually paid.

82. Met Life also alleged that it would be making the determination of "reasonable and customary charges" for its subscribers. This representation was false and misleading, as Met Life delegated responsibility for making UCR determinations to United Healthcare, an entirely separate corporation, or otherwise acquiesced in United Healthcare's decisions.

83. United Healthcare also engaged in deceptive practices. United Healthcare did not advise Crema or other members of the Subscriber Class that United Healthcare was relying on data from a trade association, HIAA, that regarded its own data as unsuitable for the purpose of establishing UCR. United Healthcare relied on data which had the effect of substantially reducing UCR amounts, upon which payment to subscribers and/or physicians is based.

84. Finally, Defendants engaged in a deceptive practice when they determined that Procedure 2 was not “medically necessary,” as such a determination was arbitrary and capricious and was designed to punish Crema and Dr. Attkiss for contesting Defendants’ UCR determinations.

85. In furtherance of their deceptive practices, Defendants deliberately withheld information and data from subscribers regarding the calculation of UCR amounts. Defendants obstructed efforts by subscribers to learn the basis for UCR amounts or to see the data which Defendants used to calculate UCR amounts.

86. Any reasonable person standing in the shoes of Crema and Dr. Attkiss and other members of the Class would have been deceived by Defendants. Defendants’ misrepresentations and failure to disclose were material, and had the effect of harming Plaintiffs and Class members. Had the members of the Subscriber Class been correctly advised by Defendants, they could have elected the other health plan option offered by their employer, or taken other steps to ensure that they received the full value of their insurance benefit.

87. Defendants’ violations of the New York General Business Law Section 349 were purposeful, entitling Class members to monetary relief and payment of the Class’s counsel fees. In addition, Plaintiffs the AMA and the MSSNY are entitled to declaratory and injunctive relief to ensure that Defendants do not continue to violate New York law.

THIRD CAUSE OF ACTION
(Deceptive Practices Under Minnesota Law)

88. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

89. United Healthcare is incorporated in Minnesota, and as such, is expected to adhere to Minnesota law in the conduct of its business. Minnesota’s Consumer Fraud Act prohibits fraud,

misrepresentations and deceptive practices in the sale of insurance. Minnesota Statutes Annotated Section 325F.68, *et seq.*

90. Minnesota's Uniform Deceptive Trade Practices Act provides it is a deceptive practice to represent that an insurance plan has a characteristic, use or benefit that it does not in fact have. Minnesota Statutes Annotated Section 325D.43, *et seq.*

91. Both Minnesota laws provide a private right of action to persons aggrieved thereunder.

92. United Healthcare violated such law by engaging in the practices alleged herein, including but not limited to, by failing to adhere to the definition of "reasonable and customary charge" in subscriber materials, misrepresenting who would be making UCR determinations, failing to provide underlying data to subscribers, failing to disclose material information to subscribers, and arbitrarily and capriciously determining that Procedure 2 was not "medically necessary."

93. Plaintiffs were harmed by United Healthcare's deceptive practices. Had the members of the Subscriber Class been correctly advised by United Healthcare, they could have elected the other health plan option offered by their employers, or taken other steps to ensure they received the full value of their insurance benefit.

94. United Healthcare's violations of Minnesota Statutes Sections 325F.68, *et seq.*, and 325D.43, *et seq.*, were purposeful, entitling Class members to monetary relief and payment of the Class's counsel fees. In addition, Plaintiffs the AMA and the MSSNY are entitled to declaratory and injunctive relief to ensure that Defendants do not continue to violate Minnesota law.

FOURTH CAUSE OF ACTION
(Trade Libel)

95. The allegations contained above are realleged and incorporated by reference as if fully set forth herein.

96. Defendants purposefully used data that understated the “reasonable and customary charge.” Defendants knew or should have known that subscribers would then be paid less than the amount that an accurate “reasonable and customary charge” computation would have yielded. In addition, Defendants knew or should have known that subscribers were being misinformed, in essence, that the amount being charged by their doctor was excessive and substantially above the charges of similarly trained or experienced doctors in the same or similar geographic area. Plaintiffs had no reason to know that Defendants were not comparing charges from the same or similar geographic area, or that Defendants failed to account for a doctor’s particular training or experience, and were otherwise misusing the data to understate the UCR.

97. Defendants’ use of flawed data, and the consequent lowering of the “reasonable and customary charge,” had the predictable -- and intended -- result of casting the amount a subscriber’s physician was charging as inflated. Defendants knew or should have known that the clear message their falsely lowered UCR sent to subscribers was that the subscribers’ physician was charging in excess of what similar doctors in the same area charge. Defendants thereby disparaged the value of the medical services rendered by Dr. Attkiss and by other members of the Provider Class.

98. Defendants’ conduct caused harm to members of the Provider Class, as well as to members of the AMA and the MSSNY who have been adversely affected by Defendants’ improper use of the PHCS data to reduce UCR amounts. Thus, the Provider Class, the AMA and the MSSNY are entitled to appropriate injunctive and declaratory relief to remedy such harm.

WHEREFORE, Plaintiffs demand judgment against Defendants for themselves and the members of the Class as follows:

1. Determining that the action is a proper class action and certifying appropriate Plaintiff classes.

2. Awarding Plaintiffs and Class members compensatory and exemplary damages and other relief for Defendants' breach of contract and the implied covenant of good faith and fair dealing, and further awarding the AMA and the MSSNY appropriate declaratory and injunctive relief;

3. Awarding Plaintiffs and Class members compensatory and other relief for Defendants' deceptive trade practices under New York law, including treble damages and other relief authorized by law;

4. Awarding Plaintiffs and Class members compensatory and other relief for Defendant United Healthcare's deceptive trade practices under Minnesota law, including treble damages and other relief authorized by law;

5. Awarding the AMA and the MSSNY declaratory and injunctive relief to remedy Defendants' deceptive trade practices under New York law;

6. Awarding the AMA and the MSSNY declaratory and injunctive relief to remedy United Healthcare's deceptive trade practices under Minnesota law;

7. Awarding the AMA, the MSSNY and the Provider Class injunctive and declaratory relief for Defendants' trade libel concerning the value of their or their members' medical services;

8. Awarding Plaintiffs and Class members declaratory and injunctive relief to remedy Defendants' arbitrary and capricious refusal to reimburse subscribers for Procedure 2 on the basis that it is "not medically necessary;"

9. Awarding Plaintiffs the costs and disbursements of this action, including attorneys' fees and expenses in amounts to be determined by the Court;

10. Awarding prejudgment interest; and

11. Granting such other and further relief as the Court may deem to be just and proper.

Dated: March 15, 2000

Respectfully submitted,

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