

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

THE STATE OF CONNECTICUT

Plaintiff,

v.

Anthem Blue Cross and Blue Shield of Connecticut;
Anthem Health Plans, Inc.; CIGNA Healthcare of
Connecticut, Inc.; CIGNA Health Plans, Inc.; Oxford
Health Plans of Connecticut, Inc.; Oxford Health Plans,
Inc.; Physicians Health Services of Connecticut, Inc., and
Foundation Health Systems, Inc.

Defendants.

CIVIL ACTION NO.

September 7, 2000

CLASS ACTION COMPLAINT

I. INTRODUCTION

1. The State of Connecticut, by and through the Honorable Richard Blumenthal, Attorney General of the State of Connecticut, brings this action challenging the dangerous and wrongful undisclosed, systemic practices of eight managed care companies. These dangerous practices deprive enrollees of essential information about their health care coverage, subject enrollees to bureaucratic delay and obstruct enrollees' access to medically necessary care.

2. The defendants are insurance companies acting as managed care organizations offering managed care plans (the "Plans") to residents of Connecticut and other states. The Plans provide for the delivery of health care services to people who enroll in the Plan (the "enrollees"),

in exchange for monthly premiums and applicable co-payments.

3. The State of Connecticut, acting as the assignee of individual enrollees and in its capacity as *parens patriae*, asserts claims for relief pursuant to Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. 1132(a)(3), which permits an enrollee in a health care plan established pursuant to ERISA to bring a civil action “. . . to enjoin any act or practice which violates any provision . . . of the plan . . . or . . . to obtain appropriate equitable relief”

4. ERISA imposes a fiduciary duty upon the defendants to administer their health Plans “solely in the interest” of enrollees. The defendants are also required by ERISA to inform enrollees fully concerning the essential elements of plan coverage and claims procedure. In addition, ERISA requires that the defendants provide the enrollees with adequate notices of appeal and a reasonable opportunity to appeal denials of coverage. The defendants have violated ERISA and injured enrollees by engaging in the following undisclosed internal practices:

a. The defendants have used inappropriate and arbitrary coverage guidelines as the basis of coverage denials.

b. The defendants have used prescription drug “formularies” in a manner which obstructs enrollee access to medically necessary prescription drugs, at the same time that they have failed to give enrollees the denial notices, including notice of the right to appeal, required by ERISA. ¹

c. The defendants have failed to make timely payments to providers, thereby threatening enrollees with the loss of necessary care.

¹ A separate case, *Connecticut v. Physicians Health Services of Connecticut, Inc.*, C.A. No. 399CV2402(SRU), now pending before the United States Court of Appeals for the Second Circuit, addresses the prescription drug formulary system employed by Physicians Health Services of Connecticut, Inc. (“PHS”). The present Complaint does not charge PHS with operating an unlawful formulary process as that issue will be addressed through the prior lawsuit.

d. The defendants have failed to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

e. The defendants have failed to disclose to enrollees essential information about the health care plans upon which the enrollees rely, including the true nature of the coverage provided and the steps necessary to submit claims and appeal denials of coverage.

5. In addition, each of the defendants issue certificates of coverage that represent that the defendants will provide coverage for medically necessary care and will enact certain procedural mechanisms for the benefit of their plan members. In direct contravention of these representations, by implementing the undisclosed practices challenged herein, defendants have materially breached their contractual undertakings, in violation of ERISA.

II. JURISDICTION AND VENUE

6. Jurisdiction is invoked pursuant to 29 U.S.C. 1132(e)(1) which provides that district courts of the United States shall have exclusive jurisdiction of civil actions brought under ERISA § 502(a)(3), 29 U.S.C. 1132(a)(3), and pursuant to 28 U.S.C § 1331(federal question jurisdiction).

7. Venue is based upon the location of the parties and on the location of the events at issue, pursuant to 29 U.S.C. 432 (e)(2).

III. PARTIES

The Plaintiffs

8. The State of Connecticut brings this action in its capacity as assignee of the ERISA rights of individual enrollees, and as *parens patriae*. Four enrollees have assigned their ERISA rights to the State of Connecticut: Torrey D. Brooks (Oxford Health Plans of Connecticut, Inc.); Renée Piontkowski (Anthem Blue Cross and Blue Shield of Connecticut);

Frances E. Errico (Physicians Health Services of Connecticut, Inc.); Kathleen P. Fiala (CIGNA Healthcare of Connecticut, Inc.). Each enrollee-assignor has executed an Assignment of Cause of Action Under ERISA (attached as exhibits 1-4).

The Defendants

9. Defendant Anthem Blue Cross and Blue Shield of Connecticut is a Connecticut corporation with its principal offices located at 370 Bassett Road in North Haven, Connecticut. Anthem Blue Cross and Blue Shield of Connecticut is a wholly owned subsidiary of Anthem Health Plans, Inc.

10. Defendant Anthem Health Plans, Inc. is an Indiana corporation with its principal offices located at 120 Monument Circle in Indianapolis, Indiana. Anthem Health Plans, Inc. together with Anthem Blue Cross and Blue Shield of Connecticut provide health care benefits to approximately 700,000 HMO members throughout the United States including approximately 300,000 HMO enrollees in the State of Connecticut.

11. Defendant CIGNA Healthcare of Connecticut is a Connecticut corporation with its principal offices located at 900 Cottage Grove Road in Bloomfield, Connecticut. CIGNA Healthcare of Connecticut is a wholly owned subsidiary of CIGNA Health Plans, Inc.

12. Defendant CIGNA Health Plans, Inc. is a Connecticut corporation with its principal offices located at 900 Cottage Grove Road in Bloomfield, Connecticut. CIGNA Healthcare of Connecticut is a subsidiary of CIGNA Health Plans, Inc. which through its other subsidiaries, including Connecticut General Life Insurance Company provides health care benefits to approximately 6,700,000 HMO members throughout the United States including approximately 35,000 HMO enrollees in the State of Connecticut.

13. Defendant Oxford Health Plans of Connecticut, Inc. is a Connecticut corporation with its principal offices located at 800 Connecticut Avenue in Norwalk, Connecticut. Oxford is a wholly owned subsidiary of Oxford Health Plans, Inc., a Connecticut corporation located at 800 Connecticut Avenue in Norwalk, Connecticut. Oxford Health Plans of Connecticut, Inc. and Oxford Health Plans, Inc. together provide health care benefits to approximately 1,500,000 members throughout the United States including approximately 60,000 HMO enrollees in the State of Connecticut.

14. Defendant Physicians Health Services of Connecticut, Inc. is a Connecticut corporation with its principal offices located at One Far Mill Crossing in Shelton, Connecticut. PHS is a wholly owned subsidiary of Foundation Health Systems, Inc.

15. Defendant Foundation Health Systems, Inc. is a California corporation with its principal offices located at 3400 Data Drive in Rancho Cordova, California. Physicians Health Services of Connecticut, Inc. and Foundation Health Systems, Inc. together provide health care benefits to approximately 5,500,000 enrollees throughout the United States, including approximately 500,000 enrollees in the State of Connecticut.

16. The defendants have discretionary authority over their health care plans, either directly or through wholly-owned and controlled subsidiaries, including the power to grant or deny health care benefits offered to its subscribers. As such, the defendants and the Health Plans are fiduciaries to plaintiff and the Class members under ERISA.

IV. CLASS ACTION ALLEGATIONS

17. Plaintiff brings this action against defendants on its own behalf and, pursuant to Rules 23(a) and (b) of the Federal Rules of Civil Procedure, as a class action on behalf of all persons in Connecticut who are members in HMO or POS plans operated or administered by any of the defendants (the "Class"). Class members who are participants in or beneficiaries of employee welfare benefit plans governed by ERISA and operated or administered by any of the defendants (sometimes referred to hereafter as the "ERISA Class Members") seek remedies under ERISA. Excluded from the Class are defendants, any entity in which any defendant has a controlling interest or is a parent or subsidiary of, or any entity that is controlled by any of the defendants and any of their officers, directors, employees, affiliates, legal representatives, heirs, predecessors, successors and assigns.

18. There are thousands of members of the Class. Accordingly, the Class is so numerous that joinder of all members is impracticable. The Class is ascertainable as the names and addresses of all Class members can be identified in business records maintained by defendants.

19. Plaintiff will fairly and adequately protect the interests of the Class and have no interests adverse to, or which directly and irrevocably conflict with, the interests of other Class members. Plaintiff is represented by counsel experienced and competent in the prosecution of consumer and class action litigation.

20. There are questions of law and fact common to the Class which predominate over any questions affecting only individual Class Members. Such common questions include, inter alia:

a. Whether defendants breached their obligations under ERISA by failing to disclose, concealing and misrepresenting the nature and extent of the coverage provided by the

Plans, including, inter alia, material facts concerning how defendants determine whether proposed or ongoing care is medically necessary and, hence, covered under those Plans;

b. Whether defendants breached their obligations under ERISA by obstructing and/or denying its members access to medically necessary medications that are not included in its list of "preferred" medications;

c. Whether defendants breached their obligations under ERISA by providing inadequate and inadequately trained staff to handle inquiries (both written and telephonic) from members and/or providers (acting on their behalf), making it difficult to have such claims addressed by defendants in a reasonably timely manner;

d. Whether defendants breached their obligations under ERISA by routinely and unjustifiably failing to make timely payments to providers thereby threatening enrollees with the loss of necessary care;

e. Whether defendants breached their obligations under ERISA by using inappropriate and arbitrary coverage guidelines as the basis of coverage denials;

f. Whether defendants have breached their contractual obligations to plaintiffs, in violation of ERISA.

g. What remedies are appropriate for defendants' violations of ERISA .

21. The plaintiff's claims are typical of the claims of the Class members because, as a result of the conduct alleged herein, defendants have breached fiduciary obligations to the Class.

22. The plaintiff will fairly and adequately protect the interests of the members of the Class, is committed to the vigorous prosecution of this action, is represented by counsel competent and experienced in class action litigation and has no interests antagonistic to or in conflict with those of the Class. As such, the plaintiff is an adequate Class representative.

23. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications which would establish incompatible standards of conduct for the party opposing the Class.

24. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members of the Class is impracticable. Furthermore, because the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for the Class members individually to redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

V. FACTUAL ALLEGATIONS

A. The Defendants' Improper Use of Arbitrary Coverage Guidelines

25. The defendants have adopted undisclosed and arbitrary coverage guidelines which they use to deny coverage and care. The defendants use guidelines to deprive enrollees of a determination of coverage based solely on the medical necessity of the care involved. Even when the coverage denial required by the guidelines is "reviewed" by a physician employed by one of the defendants, the reviewing physician will routinely rubber-stamp the denial without a good faith examination of the medical necessity at issue. In fact, a fair determination of medical necessity is unlikely in such cases because the defendant's physician will routinely deny the claim without a full review of the patient's entire medical record, without a physical examination of the patient, without discussing the case with the patient's attending physician, and generally without consulting physicians with expertise in the particular area of medicine relevant to the case under consideration.

B. The Defendants' Denial of Coverage for Medically Necessary Prescription Drugs

26. A crucial component of the Plans offered by the defendants is the prescription drug benefit. Although the defendants have a fiduciary duty to act solely in the interest of enrollees, they are violating their obligation to enrollees by using a drug formulary to obstruct enrollees' access to the prescription medications their physicians believe are most safe and effective.² Enrollees who are denied prescription drug coverage by the defendants are routinely forced to go without the medication they need. The result is unnecessary pain and suffering and delayed recovery.

C. Defendants' Failure to Make Timely Payment

27. In order to maximize profits, the defendants unreasonably delay payment to providers. The defendants employ a variety of excuses to avoid prompt payment, insisting, for example, that the claims have been lost or that further documentation is required. The defendants' strategy is to hold payment as long as possible and profit from the interest (the "float") that money earns for the defendants during the delay.

28. The defendants' delay of payment to providers injures patients as well. This conduct threatens the overall financial viability of providers thereby threatening enrollees with the loss of necessary care.

D. The Defendants' Failure to Respond to Enrollee Written and Telephonic Communications

29. The defendants have adopted policies of delay, obfuscation, and obstruction which discourage enrollees from pursuing coverage. Enrollees telephoning the defendants for information are routinely placed on "hold" for excessive periods of time. The defendants' employees, once the enrollee is able to speak with one, are often unable or unwilling to provide effective assistance. Enrollees are often given contradictory information. Documentation

² See Footnote 1 on page 2

submitted by enrollees will routinely be “lost.” The defendants’ response to enrollees’ written inquiries is often slow or even nonexistent.

E. The Defendants’ Misrepresentations and Failure to Disclose

30. The defendants have failed to disclose to enrollees essential information about the health care plans upon which the enrollees rely, including the true nature of the coverage provided and the steps necessary to submit claims and appeal denials of coverage. The defendants do not inform enrollees that the defendants often use arbitrary coverage guidelines as the basis of coverage denials. The defendants do not inform enrollees that services recommended by the attending physician will routinely be denied coverage by a non-physician reviewer, and that if a physician reviewer is involved at all, the physician reviewer will routinely rubber stamp the guideline-based denial without an independent consideration of the medical necessity of the services involved and routinely without consulting physicians with expertise in the particular area of medicine relevant to the case under consideration.

31. The defendants do not inform the enrollees that they may be denied coverage for a prescription drug ordered by their attending physician and yet not receive a denial notice, including instructions on how to appeal as required by ERISA.

32. Defendants do not inform enrollees that the defendants routinely delay payment to providers and that as a result enrollees are threatened with the loss of necessary care.

33. The defendants do not disclose to enrollees that the defendants typically fail to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

VI. FIRST CLAIM FOR RELIEF

BREACH OF FIDUCIARY DUTY UNDER ERISA

34. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges:

35. The defendants are "fiduciaries" as that term is defined in ERISA § 3(21) (A), 29 U.S.C. § 1003 (21) (A). The defendants exercise discretionary authority, control, and responsibility over the management and administration of the ERISA-governed managed care plans in which the members of the Class have enrolled. ERISA § 404 (a)(1), 29 U.S.C. § 1104 (a)(1), requires fiduciaries to discharge their duties "solely in the interest of participants [employees] and beneficiaries [their dependents]." The defendants have breached their fiduciary duty to the plaintiffs by using arbitrary coverage guidelines as the bases of coverage denials; by using prescription drug formularies in a way which obstructs enrollee access to medically necessary prescription drugs; by failing to make timely payment to providers, thereby threatening enrollees with the loss of necessary care, and by failing to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

36. In addition, by implementing the practices challenged herein, defendants have breached their contractual obligations owed to plaintiffs and have violated the terms of their ERISA-governed managed care plans.

VII. SECOND CLAIM FOR RELIEF

BREACH OF ERISA DISCLOSURE OBLIGATIONS

37. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges:

38. ERISA requires that each plan participant and beneficiary shall be given a summary plan description written in a manner calculated to be understood by the average plan participant, sufficiently accurate and comprehensive to reasonably apprise participants of their rights and obligations under the plan and containing, among other things, information regarding the plan's requirements respecting eligibility for participation and benefits and the circumstances which may result in disqualification, ineligibility or denial or loss of benefits. ERISA § 102, 29 U.S.C. § 1022. In addition, ERISA § 104(b), 29 U.S.C. § 1024(b), requires that a summary description of any reductions in covered services must be provided to participants and beneficiaries within 60 days after the changes are adopted.

39. The defendants are “administrators” as that term is defined at ERISA § 3 (16)A(i), 29 U.S.C. 1002 (16)(A)(i). The defendants have failed to disclose to enrollees the information required by the statutory provisions described above. For example, the defendants have failed to disclose to Class members essential information about the health care plans upon which the enrollees rely, including the true nature of the coverage provided and the steps necessary to submit claims and appeal denials of coverage. The defendants do not inform enrollees that the defendants routinely use arbitrary coverage guidelines as the basis of coverage denials. The defendants do not inform enrollees that services recommended by the attending physician will sometimes be denied coverage by a non-physician reviewer, and that if a physician reviewer is involved at all, the physician reviewer may rubber stamp the guideline-based denial

without a fully independent consideration of the medical necessity of the services involved and generally without consulting physicians with expertise in the particular area of medicine relevant to the case under consideration.

40. The defendants do not inform the enrollees that they may be denied coverage for a prescription drug ordered by their attending physician and yet not receive a denial notice, including instructions on how to appeal as required by ERISA.

41. Defendants do not inform enrollees that they routinely delay payment to providers and that enrollees are thereby threatened with the loss of necessary care.

42. The defendants do not disclose to enrollees that the defendants typically fail to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

VIII. THIRD CLAIM FOR RELIEF

BREACH OF ERISA NOTICE OBLIGATIONS

43. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges:

44. Under the employee benefit plans at issue in this case, the defendants are charged with administering the processing of claims and appeals.

45. Section 503(1) of ERISA, 29 U.S.C. § 1133(1), provides that every employee benefit plan must "provide adequate notice in writing to any participant or beneficiary whose claim for benefits has been denied, setting forth the specific reasons for such denial"

The applicable regulations provide that the written denial notice must include:

- a. The specific reason or reasons for the denial;

b. Specific reference to pertinent plan provisions on which the denial is based;

c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
and

d. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

46. Although Class members' claims for coverage of prescription drugs are regularly and routinely denied by the defendants, the defendants fail to provide Class members with the detailed written notices required by law.

IX. RELIEF REQUESTED

47. WHEREFORE, plaintiff, on its own behalf and on behalf of the Class, asks for the following relief:

a. An Order certifying that this action be maintained as a class action;

b. Preliminary and permanent injunctions enjoining the defendants from pursuing the policies, acts, and practices complained of herein; and

c. Such other and further relief as the Court may deem necessary and proper.

PLAINTIFF STATE OF CONNECTICUT

BY: _____
RICHARD BLUMENTHAL
ATTORNEY GENERAL

Charles C. Hulin
Federal Bar No. ct06790

Arnold I. Menchel
Federal Bar No. ct07348
Assistant Attorneys General
P.O. Box 120
Hartford, CT 06141-0120
Tel: (860) 808-5355

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

THE STATE OF CONNECTICUT

Plaintiff,

v.

Anthem Blue Cross and Blue Shield of Connecticut;
Anthem Health Plans, Inc.; CIGNA Healthcare of
Connecticut, Inc.; CIGNA Health Plans, Inc.; Oxford
Health Plans of Connecticut, Inc.; Oxford Health Plans,
Inc.; Physicians Health Services of Connecticut, Inc., and
Foundation Health Systems, Inc.

Defendants.

CIVIL ACTION NO.

September 7, 2000

CLASS ACTION COMPLAINT

I. INTRODUCTION

1. The State of Connecticut, by and through the Honorable Richard Blumenthal, Attorney General of the State of Connecticut, brings this action challenging the dangerous and wrongful undisclosed, systemic practices of eight managed care companies. These dangerous practices deprive enrollees of essential information about their health care coverage, subject enrollees to bureaucratic delay and obstruct enrollees' access to medically necessary care.

2. The defendants are insurance companies acting as managed care organizations offering managed care plans (the "Plans") to residents of Connecticut and other states. The Plans provide for the delivery of health care services to people who enroll in the Plan (the "enrollees"),

in exchange for monthly premiums and applicable co-payments.

3. The State of Connecticut, acting as the assignee of individual enrollees and in its capacity as *parens patriae*, asserts claims for relief pursuant to Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. 1132(a)(3), which permits an enrollee in a health care plan established pursuant to ERISA to bring a civil action “. . . to enjoin any act or practice which violates any provision . . . of the plan . . . or . . . to obtain appropriate equitable relief”

4. ERISA imposes a fiduciary duty upon the defendants to administer their health Plans “solely in the interest” of enrollees. The defendants are also required by ERISA to inform enrollees fully concerning the essential elements of plan coverage and claims procedure. In addition, ERISA requires that the defendants provide the enrollees with adequate notices of appeal and a reasonable opportunity to appeal denials of coverage. The defendants have violated ERISA and injured enrollees by engaging in the following undisclosed internal practices:

a. The defendants have used inappropriate and arbitrary coverage guidelines as the basis of coverage denials.

b. The defendants have used prescription drug “formularies” in a manner which obstructs enrollee access to medically necessary prescription drugs, at the same time that they have failed to give enrollees the denial notices, including notice of the right to appeal, required by ERISA.¹

c. The defendants have failed to make timely payments to providers, thereby threatening enrollees with the loss of necessary care.

¹ A separate case, *Connecticut v. Physicians Health Services of Connecticut, Inc.*, C.A. No. 399CV2402(SRU), now pending before the United States Court of Appeals for the Second Circuit, addresses the prescription drug formulary system employed by Physicians Health Services of Connecticut, Inc. (“PHS”). The present Complaint does not charge PHS with operating an unlawful formulary process as that issue will be addressed through the prior lawsuit.

d. The defendants have failed to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

e. The defendants have failed to disclose to enrollees essential information about the health care plans upon which the enrollees rely, including the true nature of the coverage provided and the steps necessary to submit claims and appeal denials of coverage.

5. In addition, each of the defendants issue certificates of coverage that represent that the defendants will provide coverage for medically necessary care and will enact certain procedural mechanisms for the benefit of their plan members. In direct contravention of these representations, by implementing the undisclosed practices challenged herein, defendants have materially breached their contractual undertakings, in violation of ERISA.

II. JURISDICTION AND VENUE

6. Jurisdiction is invoked pursuant to 29 U.S.C. 1132(e)(1) which provides that district courts of the United States shall have exclusive jurisdiction of civil actions brought under ERISA § 502(a)(3), 29 U.S.C. 1132(a)(3), and pursuant to 28 U.S.C § 1331(federal question jurisdiction).

7. Venue is based upon the location of the parties and on the location of the events at issue, pursuant to 29 U.S.C. 432 (e)(2).

III. PARTIES

The Plaintiffs

8. The State of Connecticut brings this action in its capacity as assignee of the ERISA rights of individual enrollees, and as *parens patriae*. Four enrollees have assigned their ERISA rights to the State of Connecticut: Torrey D. Brooks (Oxford Health Plans of Connecticut, Inc.); Renée Piontkowski (Anthem Blue Cross and Blue Shield of Connecticut);

Frances E. Errico (Physicians Health Services of Connecticut, Inc.); Kathleen P. Fiala (CIGNA Healthcare of Connecticut, Inc.). Each enrollee-assignor has executed an Assignment of Cause of Action Under ERISA (attached as exhibits 1-4).

The Defendants

9. Defendant Anthem Blue Cross and Blue Shield of Connecticut is a Connecticut corporation with its principal offices located at 370 Bassett Road in North Haven, Connecticut. Anthem Blue Cross and Blue Shield of Connecticut is a wholly owned subsidiary of Anthem Health Plans, Inc.

10. Defendant Anthem Health Plans, Inc. is an Indiana corporation with its principal offices located at 120 Monument Circle in Indianapolis, Indiana. Anthem Health Plans, Inc. together with Anthem Blue Cross and Blue Shield of Connecticut provide health care benefits to approximately 700,000 HMO members throughout the United States including approximately 300,000 HMO enrollees in the State of Connecticut.

11. Defendant CIGNA Healthcare of Connecticut is a Connecticut corporation with its principal offices located at 900 Cottage Grove Road in Bloomfield, Connecticut. CIGNA Healthcare of Connecticut is a wholly owned subsidiary of CIGNA Health Plans, Inc.

12. Defendant CIGNA Health Plans, Inc. is a Connecticut corporation with its principal offices located at 900 Cottage Grove Road in Bloomfield, Connecticut. CIGNA Healthcare of Connecticut is a subsidiary of CIGNA Health Plans, Inc. which through its other subsidiaries, including Connecticut General Life Insurance Company provides health care benefits to approximately 6,700,000 HMO members throughout the United States including approximately 35,000 HMO enrollees in the State of Connecticut.

13. Defendant Oxford Health Plans of Connecticut, Inc. is a Connecticut corporation with its principal offices located at 800 Connecticut Avenue in Norwalk, Connecticut. Oxford is a wholly owned subsidiary of Oxford Health Plans, Inc., a Connecticut corporation located at 800 Connecticut Avenue in Norwalk, Connecticut. Oxford Health Plans of Connecticut, Inc. and Oxford Health Plans, Inc. together provide health care benefits to approximately 1,500,000 members throughout the United States including approximately 60,000 HMO enrollees in the State of Connecticut.

14. Defendant Physicians Health Services of Connecticut, Inc. is a Connecticut corporation with its principal offices located at One Far Mill Crossing in Shelton, Connecticut. PHS is a wholly owned subsidiary of Foundation Health Systems, Inc.

15. Defendant Foundation Health Systems, Inc. is a California corporation with its principal offices located at 3400 Data Drive in Rancho Cordova, California. Physicians Health Services of Connecticut, Inc. and Foundation Health Systems, Inc. together provide health care benefits to approximately 5,500,000 enrollees throughout the United States, including approximately 500,000 enrollees in the State of Connecticut.

16. The defendants have discretionary authority over their health care plans, either directly or through wholly-owned and controlled subsidiaries, including the power to grant or deny health care benefits offered to its subscribers. As such, the defendants and the Health Plans are fiduciaries to plaintiff and the Class members under ERISA.

IV. CLASS ACTION ALLEGATIONS

17. Plaintiff brings this action against defendants on its own behalf and, pursuant to Rules 23(a) and (b) of the Federal Rules of Civil Procedure, as a class action on behalf of all persons in Connecticut who are members in HMO or POS plans operated or administered by any of the defendants (the "Class"). Class members who are participants in or beneficiaries of employee welfare benefit plans governed by ERISA and operated or administered by any of the defendants (sometimes referred to hereafter as the "ERISA Class Members") seek remedies under ERISA. Excluded from the Class are defendants, any entity in which any defendant has a controlling interest or is a parent or subsidiary of, or any entity that is controlled by any of the defendants and any of their officers, directors, employees, affiliates, legal representatives, heirs, predecessors, successors and assigns.

18. There are thousands of members of the Class. Accordingly, the Class is so numerous that joinder of all members is impracticable. The Class is ascertainable as the names and addresses of all Class members can be identified in business records maintained by defendants.

19. Plaintiff will fairly and adequately protect the interests of the Class and have no interests adverse to, or which directly and irrevocably conflict with, the interests of other Class members. Plaintiff is represented by counsel experienced and competent in the prosecution of consumer and class action litigation.

20. There are questions of law and fact common to the Class which predominate over any questions affecting only individual Class Members. Such common questions include, inter alia:

a. Whether defendants breached their obligations under ERISA by failing to disclose, concealing and misrepresenting the nature and extent of the coverage provided by the

Plans, including, inter alia, material facts concerning how defendants determine whether proposed or ongoing care is medically necessary and, hence, covered under those Plans;

b. Whether defendants breached their obligations under ERISA by obstructing and/or denying its members access to medically necessary medications that are not included in its list of "preferred" medications;

c. Whether defendants breached their obligations under ERISA by providing inadequate and inadequately trained staff to handle inquiries (both written and telephonic) from members and/or providers (acting on their behalf), making it difficult to have such claims addressed by defendants in a reasonably timely manner;

d. Whether defendants breached their obligations under ERISA by routinely and unjustifiably failing to make timely payments to providers thereby threatening enrollees with the loss of necessary care;

e. Whether defendants breached their obligations under ERISA by using inappropriate and arbitrary coverage guidelines as the basis of coverage denials;

f. Whether defendants have breached their contractual obligations to plaintiffs, in violation of ERISA.

g. What remedies are appropriate for defendants' violations of ERISA .

21. The plaintiff's claims are typical of the claims of the Class members because, as a result of the conduct alleged herein, defendants have breached fiduciary obligations to the Class.

22. The plaintiff will fairly and adequately protect the interests of the members of the Class, is committed to the vigorous prosecution of this action, is represented by counsel competent and experienced in class action litigation and has no interests antagonistic to or in conflict with those of the Class. As such, the plaintiff is an adequate Class representative.

23. The prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications which would establish incompatible standards of conduct for the party opposing the Class.

24. A class action is superior to other available methods for the fair and efficient adjudication of this controversy since joinder of all members of the Class is impracticable. Furthermore, because the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it impossible for the Class members individually to redress the wrongs done to them. There will be no difficulty in the management of this action as a class action.

V. FACTUAL ALLEGATIONS

A. The Defendants' Improper Use of Arbitrary Coverage Guidelines

25. The defendants have adopted undisclosed and arbitrary coverage guidelines which they use to deny coverage and care. The defendants use guidelines to deprive enrollees of a determination of coverage based solely on the medical necessity of the care involved. Even when the coverage denial required by the guidelines is "reviewed" by a physician employed by one of the defendants, the reviewing physician will routinely rubber-stamp the denial without a good faith examination of the medical necessity at issue. In fact, a fair determination of medical necessity is unlikely in such cases because the defendant's physician will routinely deny the claim without a full review of the patient's entire medical record, without a physical examination of the patient, without discussing the case with the patient's attending physician, and generally without consulting physicians with expertise in the particular area of medicine relevant to the case under consideration.

B. The Defendants' Denial of Coverage for Medically Necessary Prescription Drugs

26. A crucial component of the Plans offered by the defendants is the prescription drug benefit. Although the defendants have a fiduciary duty to act solely in the interest of enrollees, they are violating their obligation to enrollees by using a drug formulary to obstruct enrollees' access to the prescription medications their physicians believe are most safe and effective.² Enrollees who are denied prescription drug coverage by the defendants are routinely forced to go without the medication they need. The result is unnecessary pain and suffering and delayed recovery.

C. Defendants' Failure to Make Timely Payment

27. In order to maximize profits, the defendants unreasonably delay payment to providers. The defendants employ a variety of excuses to avoid prompt payment, insisting, for example, that the claims have been lost or that further documentation is required. The defendants' strategy is to hold payment as long as possible and profit from the interest (the "float") that money earns for the defendants during the delay.

28. The defendants' delay of payment to providers injures patients as well. This conduct threatens the overall financial viability of providers thereby threatening enrollees with the loss of necessary care.

D. The Defendants' Failure to Respond to Enrollee Written and Telephonic Communications

29. The defendants have adopted policies of delay, obfuscation, and obstruction which discourage enrollees from pursuing coverage. Enrollees telephoning the defendants for information are routinely placed on "hold" for excessive periods of time. The defendants' employees, once the enrollee is able to speak with one, are often unable or unwilling to provide effective assistance. Enrollees are often given contradictory information. Documentation

² See Footnote 1 on page 2

submitted by enrollees will routinely be “lost.” The defendants’ response to enrollees’ written inquiries is often slow or even nonexistent.

E. The Defendants’ Misrepresentations and Failure to Disclose

30. The defendants have failed to disclose to enrollees essential information about the health care plans upon which the enrollees rely, including the true nature of the coverage provided and the steps necessary to submit claims and appeal denials of coverage. The defendants do not inform enrollees that the defendants often use arbitrary coverage guidelines as the basis of coverage denials. The defendants do not inform enrollees that services recommended by the attending physician will routinely be denied coverage by a non-physician reviewer, and that if a physician reviewer is involved at all, the physician reviewer will routinely rubber stamp the guideline-based denial without an independent consideration of the medical necessity of the services involved and routinely without consulting physicians with expertise in the particular area of medicine relevant to the case under consideration.

31. The defendants do not inform the enrollees that they may be denied coverage for a prescription drug ordered by their attending physician and yet not receive a denial notice, including instructions on how to appeal as required by ERISA.

32. Defendants do not inform enrollees that the defendants routinely delay payment to providers and that as a result enrollees are threatened with the loss of necessary care.

33. The defendants do not disclose to enrollees that the defendants typically fail to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

VI. FIRST CLAIM FOR RELIEF

BREACH OF FIDUCIARY DUTY UNDER ERISA

34. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges:

35. The defendants are "fiduciaries" as that term is defined in ERISA § 3(21) (A), 29 U.S.C. § 1003 (21) (A). The defendants exercise discretionary authority, control, and responsibility over the management and administration of the ERISA-governed managed care plans in which the members of the Class have enrolled. ERISA § 404 (a)(1), 29 U.S.C. § 1104 (a)(1), requires fiduciaries to discharge their duties "solely in the interest of participants [employees] and beneficiaries [their dependents]." The defendants have breached their fiduciary duty to the plaintiffs by using arbitrary coverage guidelines as the bases of coverage denials; by using prescription drug formularies in a way which obstructs enrollee access to medically necessary prescription drugs; by failing to make timely payment to providers, thereby threatening enrollees with the loss of necessary care, and by failing to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

36. In addition, by implementing the practices challenged herein, defendants have breached their contractual obligations owed to plaintiffs and have violated the terms of their ERISA-governed managed care plans.

VII. SECOND CLAIM FOR RELIEF

BREACH OF ERISA DISCLOSURE OBLIGATIONS

37. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges:

38. ERISA requires that each plan participant and beneficiary shall be given a summary plan description written in a manner calculated to be understood by the average plan participant, sufficiently accurate and comprehensive to reasonably apprise participants of their rights and obligations under the plan and containing, among other things, information regarding the plan's requirements respecting eligibility for participation and benefits and the circumstances which may result in disqualification, ineligibility or denial or loss of benefits. ERISA § 102, 29 U.S.C. § 1022. In addition, ERISA § 104(b), 29 U.S.C. § 1024(b), requires that a summary description of any reductions in covered services must be provided to participants and beneficiaries within 60 days after the changes are adopted.

39. The defendants are “administrators” as that term is defined at ERISA § 3 (16)A(i), 29 U.S.C. 1002 (16)(A)(i). The defendants have failed to disclose to enrollees the information required by the statutory provisions described above. For example, the defendants have failed to disclose to Class members essential information about the health care plans upon which the enrollees rely, including the true nature of the coverage provided and the steps necessary to submit claims and appeal denials of coverage. The defendants do not inform enrollees that the defendants routinely use arbitrary coverage guidelines as the basis of coverage denials. The defendants do not inform enrollees that services recommended by the attending physician will sometimes be denied coverage by a non-physician reviewer, and that if a physician reviewer is involved at all, the physician reviewer may rubber stamp the guideline-based denial

without a fully independent consideration of the medical necessity of the services involved and generally without consulting physicians with expertise in the particular area of medicine relevant to the case under consideration.

40. The defendants do not inform the enrollees that they may be denied coverage for a prescription drug ordered by their attending physician and yet not receive a denial notice, including instructions on how to appeal as required by ERISA.

41. Defendants do not inform enrollees that they routinely delay payment to providers and that enrollees are thereby threatened with the loss of necessary care.

42. The defendants do not disclose to enrollees that the defendants typically fail to respond to enrollee written and telephonic communications in a manner which is speedy, coherent, and fair.

VIII. THIRD CLAIM FOR RELIEF

BREACH OF ERISA NOTICE OBLIGATIONS

43. Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges:

44. Under the employee benefit plans at issue in this case, the defendants are charged with administering the processing of claims and appeals.

45. Section 503(1) of ERISA, 29 U.S.C. § 1133(1), provides that every employee benefit plan must "provide adequate notice in writing to any participant or beneficiary whose claim for benefits has been denied, setting forth the specific reasons for such denial"

The applicable regulations provide that the written denial notice must include:

- a. The specific reason or reasons for the denial;

b. Specific reference to pertinent plan provisions on which the denial is based;

c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
and

d. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

46. Although Class members' claims for coverage of prescription drugs are regularly and routinely denied by the defendants, the defendants fail to provide Class members with the detailed written notices required by law.

IX. RELIEF REQUESTED

47. WHEREFORE, plaintiff, on its own behalf and on behalf of the Class, asks for the following relief:

a. An Order certifying that this action be maintained as a class action;

b. Preliminary and permanent injunctions enjoining the defendants from pursuing the policies, acts, and practices complained of herein; and

c. Such other and further relief as the Court may deem necessary and proper.

PLAINTIFF STATE OF CONNECTICUT

BY: _____
RICHARD BLUMENTHAL
ATTORNEY GENERAL

Charles C. Hulin
Federal Bar No. ct06790

Arnold I. Menchel
Federal Bar No. ct07348
Assistant Attorneys General
P.O. Box 120
Hartford, CT 06141-0120
Tel: (860) 808-5355