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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

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

Plaintiffs,

-against-

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

Defendants.

Suffolk County Index No. 064276/2014

DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION TO DISMISS COUNTS I, II, and IV OF THE AMENDED COMPLAINT

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<u>INTRODUCTION</u>

Plaintiff, Michael A. Kamins ("Kamins"), asserts that he has been improperly denied certain mental health benefits for his adult son under the Empire Plan, the New York State government-sponsored healthcare plan in which Kamins participates. The Empire Plan is exempt from the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq*., so Kamins cannot pursue his claim for benefits in federal court under ERISA (although, as set forth below, he unsuccessfully tried to do so).

Instead, Kamins has initiated an action in this Court against the Empire Plan, as well as United Healthcare Insurance Company of New York ("UHIC-NY") and United Behavioral Health ("UBH") d/b/a OptumHealth Behavioral Solutions (collectively "United" and, together with the Empire Plan, "Defendants")), to seek compensation for what he perceives as Defendants' wrongful denial of his claim for mental health benefits. Kamins has asserted a breach-of-contract claim against Defendants (Count III) on the ground that the terms and conditions of the Empire Plan were violated to his detriment. Defendants do not challenge the contract claim on this motion, but will be prepared to test that claim on summary judgment and at trial, if necessary.

Defendants do challenge on this motion a series of other claims asserted by Kamins (Counts I, II and IV) that purport to arise under certain New York State insurance and consumer protection statutes, as well as common law fiduciary duty principles. The assertion of these claims is a transparent effort to turn a straightforward breach-of-contract suit between the named parties into a class action. However, as a matter of law, none of these additional claims state a cause of action, and, therefore, they should be dismissed. The parties will then be in a position to address their contract dispute.

This is not the first time that Kamins has sought to litigate his claim that he was denied mental health benefits for his son. The Amended Complaint in this action raises several of the same claims that Kamins previously asserted in federal court as part of a putative class action that he and others initiated in the U.S. District Court for the Southern District of New York. *See N.Y. State Psychiatric Ass'n, et al. v. UnitedHealth Grp., et al.*, 980 F. Supp. 2d 527 (S.D.N.Y. 2013) ("*NYSPA*").[1] In that litigation, United moved to dismiss all of Kamins' claims (as well as the claims of six other plaintiffs not covered by the Empire Plan), noting, in part, that Kamins had failed to assert a claim for breach of contract. In October 2013, the federal court granted United's motion to dismiss in its entirety. *NYSPA*, 980 F. Supp. 2d at 532.[2] Since (a) the Court dismissed all of the federal claims asserted by the other plaintiffs, (b) Kamins' remaining claims did not involve a federal question, and (c) diversity jurisdiction did not exist, the federal court declined to exercise its supplemental jurisdiction to adjudicate Kamins' claims and dismissed them without prejudice for lack of subject matter jurisdiction. *Id*. at 549-51.

In this new action, Kamins has re-asserted claims under the New York Parity Act ("Timothy's Law") and the New York Unfair Trade Practices Act codified in N.Y. General Business Law § 349 ("GBL § 349") (Counts I and II), and added new claims for breach of contract (Count III) and breach of fiduciary duty (Count IV).[3]

The allegations asserted by Kamins in support of Counts I and II are insufficient to state a cause of action pursuant to the statutes that Kamins has sought to invoke. There is no private

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[1] The *NYSPA* federal action was brought by Kamins as well as several others against UHIC-NY and UBH, two of the Defendants in the case currently before this Court.

[2] Several of the plaintiffs other than Kamins have appealed that dismissal to the Second Circuit Court of Appeals and such appeal remains pending. *See N.Y. State Psychiatric Ass'n, et al. v. UnitedHealth Grp., et al.*, Case No. 14-20 (2d Cir.)

[3] The original Complaint in this action also re-asserted a count under the New York Prompt Pay Statute (*see* Compl., ¶¶ 118-20), but that count was omitted from the Amended Complaint.

right of action under Timothy's Law, requiring the dismissal of Count I. Fully disclosed healthcare policies and procedures governing the administration of a government-sponsored healthcare plan cannot possibly be "deceptive," and, therefore, the deceptive acts and practices claim asserted under GBL § 349 in Count II must likewise be dismissed. Finally, Kamins' breach-of-fiduciary-duty claim, as alleged in Count IV, must be dismissed for several independently sufficient reasons, including the fact that Kamins has not identified a legal basis for the existence of a fiduciary duty that was owed to him by Defendants.

FACTS

Kamins alleges that he is employed by the State University of New York at Stony Brook. (Am. Compl., ¶ 8.) He receives health insurance benefits for himself and his family through the Empire Plan, a collectively-bargained non-ERISA plan through which the State of New York provides healthcare benefits to its employees. The Empire Plan is statutorily exempt from ERISA, *see* 29 U.S.C. § 1003(b)(1), and is instead governed by New York State law. The State of New York, through its Department of Civil Service, contracted with UHIC-NY to administer the Empire Plan's Mental Health and Substance Abuse Program.[4] (Am. Compl., ¶ 10; Declaration of Faye Ewing ("Ewing Decl."), Ex. A (Agreement No. C000585 between New York State Department of Civil Service and UHIC-NY, as amended ("Empire Plan Agreement")), § 1.26.0.)[5]

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[4] UBH acted as administrator for the Empire Plan's Mental Health and Substance Abuse Program until January 1, 2014. (Am. Compl., ¶ 11.)

[5] Kamins references and quotes from the Ewing Declaration's exhibits but has not attached them to his Amended Complaint. (*See* Am Compl., ¶¶ 59-60, 80-81, 104-05, 111, 113-14.) This Court, however, may properly consider these documents on a motion to dismiss even though Kamins did not attach them to his pleading. *See Alliance Network, LLC v. Sidley Austin LLP*, 987 N.Y.S.2d 794, 798 n.1 (Sup. Ct. New York Co. 2014) ("On a motion to dismiss, the Court may consider documents referenced in a complaint, even if the pleading fails to attach them."). Consideration of such documents does not convert the motion into one for summary judgment. The Ewing Declaration and its exhibits are attached as Exhibit A to the Affirmation of Richard H. Silberberg accompanying this motion.

The Empire Plan Agreement provides that the Empire Plan is "experience rated" such that premiums and other obligations are dependent upon the claims experience of its participants. (*See* Ewing Decl., Ex. A §§ 17.1.0; 13-18.) The Empire Plan Agreement requires that UHIC-NY maintain a claims processing system capable of integrating and enforcing various clinical management and utilization review procedures. (*See id*., §§ 1.74.0, 1.18.0, 1.35.0, 6.15.4.)

Kamins' son, who is also an Empire Plan beneficiary, has suffered from mental illness since 2011. Kamins holds a durable power of attorney for his son and sues here in his own capacity and as his son's attorney-in-fact. (Am. Compl., ¶ 9.) The son began outpatient psychiatric therapy in September 2011 in California, where he then lived, with UCLA Associate Clinical Professor of Psychiatry Dr. Thomas Brod. (Am. Compl., ¶ 18.) Kamins acknowledges that "[f]rom September 2011 through May 2012, United generally pre-certified the requested treatments submitted by Dr. Brod." (Am. Compl., ¶ 35.)

By June 2012, the son's condition had improved to the point that he was intent on leaving California and returning to school at an Ivy League college on the East Coast. (Am. Compl., ¶ 25.) In June, United approved coverage for bi-weekly therapy sessions with Dr. Brod from May 16, 2012 through June 16, 2012, and further approved ongoing coverage with Dr. Brod twice a month going forward, expressly noting that "frequency could be adjusted as needed according to the clinical situation." (Am. Compl., ¶ 39.) In July 2012, on Kamins' administrative appeal from that determination, United adhered to its decision that it would not pre-authorize twice-weekly therapy sessions "with Thomas Brod, MD for dates of service June 16, 2012 through October 31, 2012." (Am. Compl., ¶¶ 47-48.)

The son returned to his East Coast college in September 2012 (Am. Compl., ¶ 30), thereby effectively ending his ongoing therapy sessions with Dr. Brod in California and mooting

his appeal. Kamins nevertheless filed a further appeal on September 4, 2012 from the denial of authorization for twice-weekly therapy sessions with Dr. Brod through October 31, 2012. (Am. Compl., ¶ 51.) That appeal was also denied, with the "panel . . . determin[ing] that coverage is not authorized under your benefit plan for your ongoing treatment with Thomas Brod, MD for the following dates of service: June 16, 2012 through October 31, 2012." (Am. Compl., ¶ 54.)

The Amended Complaint is clear that Kamins' allegations of harm are based upon difficulties that his son encountered at some unspecified time in the Fall of 2012 while he was at school on the East Coast (Am. Compl., ¶ 57), and the son's resulting hospitalization in February 2013 (*id.*), but it is striking that there are *no* allegations in the Amended Complaint relating to any claims for treatment rendered by any of the son's East Coast mental health care providers in the Fall of 2012 or in any way relating to his clinical situation while he was attending school on the East Coast. That is hardly surprising because all claims submitted by the son's East Coast mental health care providers for treatment in the Fall of 2012 were *paid*,[6] including those for therapy.

Although United had previously advised that "frequency [of coverage] could be adjusted as needed according to the clinical situation" (Am. Compl., ¶ 39), there is *no* allegation in the Amended Complaint that any of the son's East Coast providers (or anyone else for that matter) ever requested additional treatment for the son in the Fall of 2012 or thereafter, based upon his clinical situation at his Ivy League college, for which coverage was denied. Indeed, after noting that, on a per provider basis, the first 10 visits are "pass through" visits, for which authorization based on submission of provider reports is not required (Am. Compl., ¶¶ 64-65), the Amended Complaint contains no allegation that the son utilized these 10 visits, per provider (he didn't),

[6] It is undisputed that all claims for treatment by the son's East Coast providers were paid and that his hospitalization in 2013 was covered. (Am. Compl., ¶ 58.)

while being treated on the East Coast, let alone requested additional visits with his East Coast providers.[7] Instead, this lawsuit is about UHIC-NY's failure to authorize more frequent therapy sessions with Dr. Brod in California after mid-June 2012, despite the fact that the son had already decided by then to return to school on the East Coast.

Citing state laws mandating parity between medical and mental health ("behavioral") benefits, Kamins challenges plan terms, and medical management and utilization review procedures, which he alleges resulted in denials of pre-authorization for ongoing treatment with Dr. Brod in California. (*See* Am. Compl., ¶¶ 59-70, 74-85.) Such medical management and utilization review procedures are commonly required by employers, and indeed have been recognized by the U.S. Supreme Court and other authorities as being necessary to reduce healthcare costs by identifying patterns of fraud, abuse and overuse. Here, Kamins alleges that the following medical management and utilization review procedures resulted in a denial of pre-authorization for more frequent therapy sessions with Dr. Brod:

1) the methods through which United communicated with medical providers during the course of treatment to assess participants' eligibility for benefits, including through the use of Outpatient Treatment Reports (OTRs) that the Empire Plan required after ten (10) sessions for certain outpatient visits (*See* Am. Compl., ¶¶ 63-65); and

[7] The vague suggestion in Paragraph 30 of the Amended Complaint that at some unspecified date, United somehow limited the amount of treatment that Kamins' son received from his East Coast therapist in the Fall of 2012, is false, and inconsistent both with the Kamins' own allegations in Paragraph 64 regarding the "OTR" process and the undisputed facts relating to the treatment provided by the East Coast therapist. Kamins billed United in late January 2013, after his son had returned home to California, for seven sessions that his son had in the Fall of 2012 with his East Coast therapist (Dr. H), which United paid in late March 2013. *See* Exhibit B to the Affirmation of Richard H. Silberberg accompanying this motion. When United paid for those sessions, it also informed Kamins that the first 10 visits with Dr. H had been approved, which is consistent with the process specified in the Empire Plan for 10 visits, per provider, to be covered without the need for submission of an "Outpatient Treatment Report (OTR)." *See* Am. Compl., ¶ 64 and Exhibit C to the Affirmation of Richard H. Silberberg accompanying this motion. The son neither used all of his first 10 visits with Dr. H, nor is there any claim that Kamins or his providers ever requested approval of additional visits with Dr. H.

2) United's use of allegedly discriminatory definitions of, or standards for, determinations of medical necessity (*See* Am. Compl., ¶¶ 78-81.)

Kamins does not allege that these practices are necessarily improper in and of themselves, but instead argues that they are unlawful because they were applied more "stringently" to behavioral benefits than to "analogous" medical benefits that his employer offered under the Empire Plan, thereby allegedly violating Timothy's Law. (Am. Compl., ¶¶ 107-09.)

In addition, Kamins alleges that procedural errors were made during the review of the claims for behavioral benefits that he submitted on behalf of his son. Specifically, Kamins asserts that a medical reviewer who had been involved in the denial of his initial request for more frequent therapy sessions with Dr. Brod improperly considered his appeal from that denial. (Am. Compl., ¶¶ 104-06.)

ARGUMENT

I. Standard of Review

Under § 3211(a)(7) of the N.Y. Civil Practice Law and Rules ("CPLR"), a motion to dismiss must be granted where a plaintiff fails to allege facts stating a cause of action.[8] "[A]lthough on a motion to dismiss plaintiff's allegations are presumed to be true and are accorded every favorable inference, conclusory allegations – claims consisting of bare legal conclusions with no factual specificity – are insufficient to survive a motion to dismiss." *Godfrey v. Spano*, 13 N.Y.3d 358, 373 (2009); *see also Goel v. Ramachandran*, 111 A.D.3d 783,

[8] Because Defendants have moved to dismiss three of Kamins' four remaining causes of action under CPLR § 3211(a), Defendants' time to answer the remaining breach of contract cause of action in Count III is extended "until ten days after service of notice of entry of the order" on the motion to dismiss. *See* CPLR § 3211(f) (addressing extension of time to plead); *United Equity Servs., Inc. v. First Am. Title Ins. Co. of N.Y.*, 347 N.Y.S.2d 377, 379 (Sup. Ct. Nassau Co. 1973) (holding that motion to dismiss second cause of action extended party's time to answer complaint's remaining causes of action).

791 (2d Dep't 2013) ("[B]are legal conclusions are not presumed to be true" when ruling on motion to dismiss).

Claims that purport to be based upon misrepresentation and fraud are subject to a heightened standard of particularized pleading, under which "the circumstances constituting the wrong shall be stated in detail." CPLR § 3016(b); *see Mandarin Trading Ltd. v. Wildenstein*, 16 N.Y.3d 173, 178 (2011) (observing that actions based upon fraud must be pleaded with specificity); *Mariono v. Fiorvante*, 118 A.D.3d 961, 962 (2d Dep't 2014) (affirming dismissal of fraud claim where "neither the complaint nor the factual submissions made in opposition to the subject motion alleged any false representation of fact by any of the defendants"). This requirement of specificity applies equally to causes of action for breach of fiduciary duty. *U.S. Fire Ins. Co. v. Raia*, 94 A.D.3d 749, 751 (2d Dep't 2012).

II. Kamins' Claim Under Timothy's Law Must Be Dismissed.

A. Kamins' Claim Fails Because Timothy's Law Provides No Private Cause of Action Against Defendants.

Kamins asserted a claim under Timothy's Law in the *NYSPA* federal action. Despite his awareness of United's arguments in that case, and the absence of any authority for the proposition that a private right of action exists under the statute, Kamins has incomprehensibly continued his quixotic pursuit of that claim before this Court.

Timothy's Law is codified in N.Y. Insurance Law § 3221(l)(5), *et seq*. An examination of the statutory provisions reveals that Timothy's Law does not include a civil enforcement mechanism and does not otherwise provide for a private right of action. Rather, as with other provisions of the N.Y. Insurance Law regulating group insurance, enforcement of Timothy's Law is explicitly delegated to the N.Y. Superintendent of Insurance. *See, e.g.*, L. 2006, c. 748 § 6; N.Y. Insurance Law § 3201; N.Y. Public Health Law § 4401(5); § 4406.

Due to this same explicit grant of authority to the Superintendent of Insurance, New York State courts have refused to imply a private right of action under related provisions of the N.Y. Insurance Law. *See, e.g., Hudes v. Vytra Health Plans Long Island*, 295 A.D.2d 788, 789 (3d Dep't 2002) (rejecting private right of action for violation of N.Y. Insurance Law § 3221 even though patients were "part of the class for whose particular benefit the statute was enacted"). This is fully consistent with the general rule in New York State that a private cause of action should not be implied "where a regulatory agency has either been selected or, in fact, serves to administratively enforce the duties created by a statute." *Id.* at 789; *see Mark G. v. Sabol*, 93 N.Y.2d 710, 720 (1999); *Carrier v. Salvation Army*, 88 N.Y.2d 298, 302 (1996); *Di Blasi v. Traffax Traffic Network*, 256 A.D.2d 684, 686 (3d Dep't 1998) (refusing to imply private right of action in face of clear rule that no such action exists under New York law); *see also Harrison v. Metro. Life Ins. Co.*, 417 F. Supp. 2d 424, 432 (S.D.N.Y. 2006) (rejecting claim under N.Y. Ins. Law § 3023(b)(1)(B) because it does not explicitly create private right of action); *cf.*, *Hammer v. Am. Kennel Club*, 1 N.Y.3d 294, 300 (2003) (refusing to recognize private right of action under N.Y. Agriculture and Markets Law § 353 where such action would be "incompatible with the mechanisms chosen by the Legislature"). Accordingly, Count I for violation of Timothy's Law must be dismissed.

III. <u>Kamins' Claim Under New York General Business Law § 349 Must Be Dismissed.</u>

A. <u>N.Y. General Business Law § 349 Does Not Create a Private Right of Action for Alleged Violations of Timothy's Law.</u>

Because Kamins has no private right of action under Timothy's Law, he seeks to use his parity-based allegations as a basis for a claim under GBL § 349. (*See* Am. Compl., ¶ 111.) But the New York State courts have consistently and explicitly rejected efforts by plaintiffs to overcome the absence of a private right of action under a statute by stating the claim as one

arising under GBL § 349. *See Broder v. Cablevision Sys. Corp.*, 418 F.3d 187, 199 (2d Cir. 2005) (affirming dismissal of GBL § 349 claim, noting that "a plaintiff cannot circumvent the lack of a private right of action for violation of a New York state law by pleading his claim under GBL § 349"); *Conboy v. AT&T Corp.*, 241 F.3d 242, 258 (2d Cir. 2001); *Mascoll v. Strumpf*, 2006 WL 2795175, at *9 (E.D.N.Y. Sept. 26, 2006).

B. The Amended Complaint Does Not State a Cause of Action Under GBL § 349.

GBL § 349(a) declares that "[d]eceptive acts or practices in the conduct of any business, trade or commerce, or in the furnishing of any service in [the] state" are unlawful. To state a claim for relief under GBL § 349, Kamins must allege the following elements: (1) "that the challenged act or practice was consumer-oriented"; (2) "that it was misleading in a material way"; and (3) "that the [person] suffered injury as a result of the deceptive act." *Stutman v. Chem. Bank*, 95 N.Y.2d 24, 29 (2000). The Amended Complaint does not and cannot satisfy these pleading requirements.

Kamins tries to convert his breach-of-contract claim for failure to provide an appellate process with a different clinical reviewer (Am. Compl., ¶¶ 114, 128, 133) into deception sufficient to state a claim under GBL § 349. But Kamins' own allegations flatly contradict any claimed deception. The Amended Complaint clearly acknowledges that Kamins was fully aware of the reviewer's identity and involvement in all aspects of the claims review process. (*See* Am. Compl., ¶¶ 39, 53-54.) There is no claim, for example, that United told Kamins that Drs. X, Y and Z decided the appeal, when, in reality, Dr. A, who initially denied the claim, also decided the appeal. That would be deception. Here, by contrast, there is only the allegation that, with full disclosure, United failed to live up to its alleged statutory and contractual obligations by having a separate appeal reviewer. That allegation may allow Kamins to go forward, at the pleading stage, on a claim for breach of contract, but it is insufficient to state a claim under GBL § 349.

Kamins also fails to allege in concrete, factual terms how an alleged error in the appeal process was "consumer oriented" as required under GBL § 349. It is well established that one-to-one disputes between private parties do not impact the public at large and are insufficient to establish a GBL § 349 claim. *See N.Y. Univ. v. Continental Ins. Co.*, 662 N.E.2d 763, 771 (N.Y. 1995) (dismissing GBL § 349 claim because "[i]t is essentially a 'private' contract dispute over policy coverage and the process of a claim which is unique to these parties, not conduct which affects the consuming public at large"); *Shou Fong Tam v. Met. Life Ins. Co.*, 79 A.D.3d 484, 486 (1st Dep't 2010) (dismissing GBL § 349 claim because it was not consumer-oriented); *see also Poller v. BioScrip, Inc.*, 974 F. Supp. 2d 204, 238 (S.D.N.Y. 2013) ("[W]here an alleged harm is associated with a private contractual dispute, it will fail to fall within the ambit of [GBL] § 349").

In an attempt to avoid dismissal of his GBL claim because the reviewer-identity issue is particular to Kamins' individual situation, Kamins has included in his Amended Complaint wildly speculative allegations of systemic problems involving the administration of the Empire Plan.[9] He first hypothesizes, based on the allegation that UHIC told the N.Y. Department of Civil Service that it will have "two Medical Directors" as part of its Empire Program leadership team (Am. Compl., ¶ 103), that United has only two Medical Directors who review Empire Plan mental health claims. (Am. Compl., ¶ 105.) No concrete facts are alleged to support this (untrue) speculation. He then speculates further that "any second level appeal must necessarily make use of either Medical Director who previously denied the claim" (Am. Compl., ¶ 105), despite clear language in the contract between the N.Y. Department of Civil Service and UHIC-

[9] Defendants challenged the GBL § 349 claim in moving to dismiss four of the five causes of action in the original Complaint. Fully cognizant of the argument that his GBL § 349 claim is subject to dismissal because it does not implicate the public at large, Kamins has tried to plead around that obstacle by claiming, albeit without any factual support, that what he allegedly experienced was a systemic issue affecting other beneficiaries of the Empire Plan. (*See, e.g.,* Am. Compl. ¶ 105.)

NY stating that level two appeals will be decided by a panel whose "members have not been involved in the previous determinations of the case . . ." (Am. Compl., ¶ 104.)

It is not surprising that, after years of litigation in state and federal court, Kamins has failed to offer any facts to corroborate his speculation that there is a systemic problem, let alone identify other Empire Plan participants who allegedly were adversely affected by such a problem. For present purposes, what matters is that speculation should not be credited in resolving a motion to dismiss. *See, e.g., Ferrandino & Son, Inc. v. Wheaton Builders, Inc.,* 82 A.D.3d 1035, 1036 (2d Dep't 2011) (citations omitted).

Equally unavailing is Kamins' allegation, again without factual support, that "United has engaged in various misrepresentations and omissions in the sale and/or circulation of plan documents." (Am. Compl., ¶ 115.) Kamins focuses first upon the Empire Plan's Medical Necessity Definitions and OTR requirements. (Am. Compl., ¶¶ 63-65, 78-81, 111.) But these provisions were incorporated and *fully disclosed* in the government-sponsored healthcare plan as administered by UHIC-NY pursuant to its contract with the N.Y. Department of Civil Service. (*See* Declaration of Faye Ewing, Ex. B (Empire UHIC-NY Mental Health and Substance Abuse Program Certificate of Insurance), 5, 10; Ex. A (Empire Contract), 1.35.0, 1.74.0, 6.1.0, 6.1.5.1, 6.15.1, 6.18.0.).[10]

Kamins fails to allege how he (or any other reasonable consumer) possibly could be deceived by provisions of the Empire Plan advising participants of its terms. Stated differently, Kamins has not alleged how he or anyone else conceivably could have been deceived by terms of his healthcare plan that were *fully disclosed*. *See*, *e.g.*, *Goldman v. Met. Life*, 5 N.Y.3d 561, 572 (2005) (dismissing GBL § 349 claim because plaintiff failed to "properly allege[] any deceptive practices"); *Gomez-Jimenez v. N.Y. Law Sch.*, 103 A.D.3d 13, 17 (1st Dep't 2012) ("[A] party

[10] *See* n.5, *supra*.

does not violate [GBL § 349] by simply publishing truthful information and allowing consumers to make their own assumptions about the nature of the information"); *Citipostal, Inc. v. Unistar Leasing*, 283 A.D.2d 916, 918 (4th Dep't 2001) ("[B]ecause the conduct complained of is specifically provided for by the parties' agreement and thus was fully disclosed, such conduct is not a deceptive practice within the meaning of section 349"); *Andre Strishak & Assocs., PC v. Hewlett Packard Co.*, 300 A.D.2d 608, 609-10 (2d Dep't 2002) (concluding that defendant's representation that printer cartridges were included with printer purchase but not disclosing that cartridges were economy-size was not deceptive and dismissing GBL § 349 claim); *see also Derbaremdiker v. Applebee's Int'l, Inc.*, 2012 WL 4482057, at *4 (E.D.N.Y. Sept. 26, 2012) (New York courts have dismissed GBL § 349 claims "where a defendant fully disclosed the terms and conditions of an alleged deceptive transaction that caused harm to the plaintiff"), *aff'd* 519 Fed. App'x 77 (2d Cir. 2013); *Shovak v. Long Island Comm. Bank*, 50 A.D.3d 1118, 1120 (2d Dep't 2008) ("[T]here was no materially misleading statement, as the record indicated that the yield spread premium, which is not *per se* illegal, was fully disclosed to the plaintiff").

Recognizing that disclosure defeats his GBL § 349 claim, Kamins has inserted allegations in his Amended Complaint about allegedly "secret and undisclosed" "internal standards" that OptumHealth Behavioral Solutions adopted pursuant to the express terms of the Certificate of Insurance authorizing their use for the determination of medical necessity. (Am. Compl., ¶¶ 79, 111.) But doing what one is authorized to do by express and fully disclosed contract terms ("professional and technical standards adopted by OptumHealth" – Am. Compl., ¶ 78) is hardly the stuff of deception sufficient to support a GBL § 349 claim. Setting aside the

adjectives that fill the Amended Complaint, there are simply no concrete factual allegations, as required, of deception with regard to the use of contractually-authorized internal standards.[11]

C. Kamins' GBL § 349 Claim Also Fails Because It Constitutes An Improper Attempt to Duplicate or Supplant His Breach-of-Contract Claim.

Kamins' GBL § 349 claim also fails for the additional reason that Kamins has manipulated his allegations in an improper effort to convert a straightforward claim for breach of contract into a tort claim. Thus, in attempting to state a claim under GBL § 349, Kamins alleges that "utilization review practices are contrary to [United's] Master Agreement" with the State of New York governing its administration of the Empire Plan, that the "restrictions on coverage for mental health care" are "contrary to . . . [the] contractual obligations," and that the appeals process allegedly violated the Master Agreement's provisions. (Am. Compl., ¶¶ 111-14).

All of these allegations purport to arise from claimed breaches of the Empire Plan Agreement (*see id.*) and are more appropriately dealt with on Kamins' claim in Count III for breach of contract. Indeed, in pursuing a GBL § 349 claim, Kamins is attempting to duplicate or supplant his breach-of-contract claim with a tort claim, a tactic which has been consistently rejected by the New York State and Federal courts. *See Teller v. Bill Hayes, Ltd.*, 213 A.D.2d 141, 148 (2d Dep't 1995) ("[Section 349] was not intended to supplant an action to recover damages for breach of contract between parties to an arm's length contract."); *The Stanley Agency, Inc. v. Behind the Bench, Inc.*, 2009 WL 975790, at *14 (N.Y. Sup. Ct. Apr. 13, 2009) (noting that GBL § 349 claim must also be dismissed because it was "duplicative of plaintiff's fraud and breach of contract claims"); *Spagnola v. Chubb Corp.*, 574 F.3d 64, 74 (2d Cir. 2009)

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[11] There might be a contract dispute about the definition of "Medically Necessary" and the use of internal standards applying that definition, but even that is highly doubtful. Curiously, the Amended Complaint now labels Defendants' alleged interpretation of this contract language as "dubious," while the original Complaint acknowledged that the internal standard language in the definition of "Medically Necessary" "could be read" in the manner to which the Amended Complaint now objects. (*Compare* Compl. ¶ 63 *with* Am. Compl. ¶¶ 79-80.)

("Although a monetary loss is a sufficient injury to satisfy the requirement under [GBL] § 349, that loss must be independent of the loss caused by the alleged breach of contract."); *Fleisher v. Phoenix Life Ins. Co.*, 858 F. Supp. 2d 290 (S.D.N.Y. 2012) (dismissing GBL § 349 claim because any alleged loss related to GBL claim was not unique "but rather [stemmed] from the alleged" breach-of-contract claim).

For all of these independently sufficient reasons, Count II for violation of N.Y. Gen. Bus. Law § 349 must be dismissed.

IV. Kamins' Claim for Breach of Fiduciary Duty Must Be Dismissed.

Claims for breach of fiduciary duty are reviewed "[i]n light of the particularity required in pleading such causes of action" under CPLR § 3016(b). *Ozelkan v. Tyree Bros. Envtl. Servs., Inc.*, 29 A.D.3d 877, 879 (2d Dep't 2006) (citing *Colello v. Colello*, 9 A.D.3d 855, 859 (4th Dep't 2004)). Kamins' claim for breach of fiduciary duty fails as a matter of law because it is duplicative of his claim for breach of contract, and is impermissibly based on the policyholder/insured-insurer relationship.

Like his GBL § 349 claim, Kamins' claim for breach of fiduciary duty is an attempt to convert a contract dispute between the named parties into a tort-based class action. However, where, as here, the tort claim is based on contractual obligations and alleged breaches duplicative of his contract claim, the fiduciary duty claim cannot survive. *Clarendon Nat'l Ins. Co. v. Health Plan Administrators*, 2009 WL 3053736, at *3 (S.D.N.Y. Sept. 24, 2009); *Clark-Fitzpatrick, Inc. v. Long Island Railroad Co.*, 70 N.Y.2d 382, 389 (1987) ("A simple breach of contract is not considered a tort unless a legal duty independent of the contract itself has been violated."); *Brooks v. Key Trust Co. Nat'l Assoc.*, 26 A.D.3d 628, 630 (3d Dep't 2006) (dismissing fiduciary duty claim because its allegations were, in part, "expressly raised in plaintiff's breach of contract claim"); *William Kaufman Org., Ltd. v. Graham & James, LLP*, 269

A.D.2d 171, 173 (1st Dep't 2000) ("A cause of action which is merely duplicative of a breach of contract claim cannot stand.").

Here, Kamins' fiduciary duty claim reiterates and overlaps his contract claim alleging that the terms of the Empire Plan were violated. In pleading his contract claim, he alleges that Defendants "breached the terms of the Empire Plan by applying level of care standards more restrictive than those mandated by the Plan terms[,] . . . violated the terms of the Empire Plan by failing to comply with applicable laws, including the New York Parity Law, incorporated therein[,] . . . [and] failed to provide Plaintiff with the appellate process required by the terms of the Empire Plan for benefit denials." (Am. Compl., ¶¶ 131-33.) In asserting his fiduciary duty claim, Kamins first alleges that he "entrusted Defendants" to act "in compliance with Empire Plan terms and applicable laws [incorporated therein]" (Am. Compl., ¶ 137) with respect to the same exact subjects that allegedly support his contract claim, and then alleges that Defendants breached the Empire Plan and the New York laws he alleges were incorporated in the Empire Plan. (Am. Compl., ¶¶ 132, 138.) Thus, Kamins' breach-of-fiduciary-duty claim is duplicative of his breach-of-contract claim and, accordingly, Count IV must be dismissed. *See Superior Officers Council Health & Welfare Fund v. Empire Healthchoice Assurance, Inc.*, 85 A.D.3d 680, 682 (1st Dep't 2011) (dismissing claim "[b]ecause it [was] not based upon the breach of any fiduciary duty independent of the parties' agreement itself"), *aff'd*, 17 N.Y.3d 930 (2011).

Beyond this blatant attempt to duplicate his claims, Kamins has failed to establish a basic and important element of Count IV: the existence of a fiduciary duty. *See Ozelkan*, 29 A.D.3d at 879 (citation omitted). New York State courts have consistently rejected the notion that a relationship between a policyholder/insured and an insurer, standing alone, is one from which fiduciary duties automatically arise. *See Batas v. Prudential Ins. Co. of Am.*, 281 A.D.2d 260,

264-65 (1st Dep't 2001) (dismissing breach-of-fiduciary-duty claim because plaintiff failed to allege existence of fiduciary relationship); *Gaidon v. Guardian Life Ins. Co.*, 255 A.D.2d 101, 101-02 (1st Dep't 1998) (same), *mod on other grounds*, 94 N.Y.2d 330 (1999), *mod upon remittitur*, 272 A.D.2d 60 (1st Dep't 2000). Here, Kamins has asserted that relationship as the sole basis for the alleged existence of a fiduciary duty. Thus, Kamins has failed to show the existence of a fiduciary duty, as required under CPLR § 3016(b). It is simply not enough to allege that a plaintiff entrusted a defendant to meet its contractual obligations. Therefore, Count IV for breach of fiduciary duty must be dismissed.

CONCLUSION

This is a straightforward breach-of-contract dispute—embodied in Count III of the Amended Complaint—involving the alleged denial of behavioral benefits. As demonstrated above, throughout his Amended Complaint Kamins has attempted to use his breach-of-contract allegations as a predicate for fabricating other statutory and common law causes of action that are legally baseless. These groundless and superfluous claims—Counts I, II, and IV—should be dismissed pursuant to CPLR § 3211(a)(7) for failure to state a cause of action against Defendants.

Dated: New York, New York
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