



**REPORT OF THE  
ATTORNEY GENERAL'S INVESTIGATION  
CONCERNING PSYCH MANAGEMENT, INC. AND  
ANTHEM BLUE CROSS AND BLUE SHIELD OF  
CONNECTICUT**

February 14, 2002

**RICHARD BLUMENTHAL**  
ATTORNEY GENERAL

## **I. EXECUTIVE SUMMARY**

In October 2000 Melissa Fahey, 21 years old, found herself in acute distress, struggling to recover from the effects of post traumatic stress disorder (“PTSD”) caused by severe childhood trauma. Although Ms. Fahey needed intensive hospital inpatient psychiatric care specifically targeted to PTSD, her health insurance companies, Anthem Blue Cross and Blue Shield of Connecticut (“Anthem”) and its subcontractor Psych Management Inc. (“PMI”), for weeks refused to authorize appropriate care. Ms. Fahey languished in misery in the psychiatric wards of general hospitals. Depressed and confused, her condition deteriorated and her self-destructive behavior increased.

Melissa Fahey had no way of knowing that PMI, desperately seeking higher profits, was routinely using arbitrary coverage “caps” and “guidelines” to deny coverage for medically necessary care. Ms. Fahey did not know that PMI’s former medical director, Dr. Peter Benet, the same physician who ordered the use of the unfair coverage rules, held a controlling interest in PMI shares and stood to gain personally every time PMI denied access to care.

This story is about a physician who sacrificed his patients for money and power -- abandoning his sacrosanct obligation to help them, or at least do them no harm. This story also is about a managed care industry operating without the most basic safeguards and protections -- an industry that ignores reprehensible conduct so long as it benefits the bottom line. In fact, Dr. Benet was instrumental in making decisions that denied care to Ms. Fahey and numerous other patients also enrolled in Anthem plans who needed psychiatric treatment for severe problems,

some so serious that they were life-threatening. The principle findings of a year long investigation listed here will be the basis for legal action against Dr. Benet:

1. Anthem Blue Cross and Blue Shield of Connecticut ("Anthem") is an insurance company acting as a managed care organization offering managed care plans to Connecticut residents. A crucial component of the managed care plans offered by Anthem is the "behavioral health" benefit. Behavioral health care includes mental health and substance abuse services. Prior to 1996 Blue Cross and Blue Shield of Connecticut administered the behavioral health portion of its popular "BlueCare" plan "in-house" (Blue Cross and Blue Shield of Connecticut merged with Anthem Health Plans, Inc. on August 1, 1997 and thereafter did business as Anthem Blue Cross and Blue Shield of Connecticut.) In 1996, however, Blue Cross decided to "carve out" the behavioral health management of the BlueCare plan to a subcontractor that specialized in behavioral health. In theory, a carve-out subcontractor would be able to manage behavioral health care more efficiently and economically.

2. In January of 1996, Peter Benet, MD, a psychiatrist practicing in Hartford, Connecticut, established a non-profit corporation named PsychCare Inc. PsychCare was formed for the purpose of bidding for the right to manage behavioral health coverage for enrollees in plans administered by Anthem Blue Cross and Blue Shield of Connecticut. Anthem solicited bids to perform behavioral health management. PsychCare developed an extensive list of psychiatrists and other care providers willing to participate in PsychCare's managed care "network," submitted a proposal to Anthem, and was selected by Anthem as its preferred manager. Contract negotiations ensued. Dr. Benet and his associates, however, devised a plan to bilk PsychCare of

its assets and profit personally. Dr. Benet organized a second, for-profit, stock corporation, named Psych Management, Inc. (“PMI”). PsychCare and PMI entered into a purported “management contract” whereby PsychCare transferred all its existing assets and business responsibilities to PMI. PsychCare never received any consideration from PMI for the transfer of its assets. Through this transaction, Peter Benet and his fellow board members violated their fiduciary duty to PsychCare by transferring PsychCare’s right to negotiate with Anthem to PMI without ensuring that PsychCare received fair consideration.

3. Peter Benet and his then-wife Claire Benet received 2500 shares of PMI -- about 25% of the outstanding stock -- essentially without charge. PMI’s board of directors also gave Dr. Benet 3000 shares of stock as a reward for his “performance,” according him and Claire Benet a controlling interest in the company.

4. Owing \$100,000 to the IRS and seeking to buy a home for a new family, in April 1999 Peter Benet persuaded PMI’s board of directors to issue a dividend that he knew PMI could not afford. The major beneficiary of the dividend was Peter Benet, who was paid \$161,700. Dr. Benet violated the statutory standard of conduct for corporation directors by proposing and voting for a dividend when he had reason to know that after payment of the dividend PMI would not be able to pay its debts as they came due and PMI’s assets would be less than the sum of its liabilities.

5. In 1999, after paying Dr. Benet and other shareholders a dividend PMI could not afford, the PMI board of directors decided to withhold part of the reimbursement that providers of care were owed.

6. In order to lower reimbursement to providers and increase PMI profits, Peter Benet used an aggressive campaign of pressure and harassment to force PMI employees to curtail coverage for medically necessary care.

7. At Dr. Benet's direction, PMI implemented a practice of arbitrary denial of medically necessary care through the use of coverage "caps" and "guidelines" which were unrelated to the actual care needs of enrollees and instead were related only to PMI's profit margin.

8. PMI's lawless behavior has injured Connecticut citizens like Melissa Fahey, struggling to recover from serious illness.

9. At the same time that he forced dramatic and harmful cutbacks in coverage and care available to patients, Dr. Peter Benet spent extravagantly on luxury office space, furniture, leased automobiles (including a BMW 740 for himself), lavish parties, and redundant and over-priced new executives.

10. With its financial condition degraded by greed and mismanagement, PMI withheld checks to reimburse providers for services rendered -- issuing them but holding them in a metal filing closet.

11. By misrepresenting that payment to providers had been made, PMI was able to obtain reimbursement from Anthem under false pretenses.

12. His misconduct exposed in September 2000, Peter Benet was forced out of PMI but received a "golden handshake" paid by Anthem.

13. Anthem is ultimately responsible for PMI's misdeeds. Anthem either knew or should have known of the problems at PMI. Anthem helped create PMI and, as the prime contractor, Anthem cannot shield itself from the abuses PMI imposed on its customers.

14. PMI's use of arbitrary coverage guidelines continues to the present day.

#### **RECOMMENDATIONS**

1. That the State initiate litigation seeking injunctive relief ensuring that state employees enrolled in managed care plans administered by Anthem and PMI are protected from arbitrary and unfair coverage determinations liable to deny them medically necessary behavioral health services.

2. That the Commissioner of the Connecticut State Department of Public Health initiate proceedings to suspend or revoke the license of Dr. Peter Benet to practice medicine on the grounds of "negligent conduct in the practice of medicine."

3. That the legislature enact a law protecting patients from carveout bias and greed, and ensuring that managed care companies are held accountable for their misdeeds.

## **II. INTRODUCTION**

Richard Blumenthal, Attorney General of the State of Connecticut, issues the accompanying Report of the Attorney General's investigation concerning Psych Management, Inc.

and Anthem Blue Cross and Blue Shield of Connecticut, pursuant to the authority vested in him by Section 4-61dd of the Connecticut General Statutes.

This Report is based upon the sworn testimony of witnesses with first hand knowledge of the circumstances described, as well as documents produced by Psych Management, Inc. and Anthem Blue Cross and Blue Shield of Connecticut pursuant to subpoena (through his attorneys, Dr. Peter Benet asserted his constitutional right against self-incrimination and refused to testify.)

This Report presents a picture of a physician driven -- morally and professionally -- by the promise of wealth. Perhaps more important, however, is the revelation that the dynamics of the managed care industry not only permit but even encourage such failings.

The hard lessons of the situation at Psych Management, Inc. were understood by the PMI care managers who were struggling to ensure that adequate behavioral health care was delivered to enrollees. The Supervisor of Care Management described the conflict of interest existing at PMI in succinct terms:

You have a decision maker who has tens of thousands of dollars wrapped up in a company, whereby, if he makes a decision to extend services, it is basically coming out of his pocket . . . and I just think that that's very dangerous, very, very dangerous. . . . I know, as a consumer, if I knew the Medical Director and President was the chief shareholder in that company, I'd get different insurance . . . it's a slippery slope and it's a dangerous setup.[1]

Another care manager, who eventually resigned from PMI in disgust, expressed a more cynical and pessimistic view of managed care: "It's my personal opinion that it's about the mighty dollar and not about the care or quality of care that patients get." [2]

600,000 Connecticut residents depend upon Anthem Blue Cross and Blue Shield of Connecticut and Psych Management, Inc. for fair determinations of their entitlement to crucial behavioral health services. Anthem and PMI have broken their promises to enrollees and violated the trust of vulnerable people in distress.

### **III. REPORT**

#### **A. PETER BENET AND PSYCH MANAGEMENT INC. MISAPPROPRIATED THE ASSETS OF THE NON-PROFIT PSYCHCARE, INC.**

Anthem Blue Cross and Blue Shield of Connecticut ("Anthem") is an insurance company acting as a managed care organization offering managed care plans to Connecticut residents. A managed care plan provides for the delivery of health care services to people who enroll in the plan ("enrollees") in exchange for monthly premiums paid by enrollees and/or their employers. Managed care organizations arrange for services to be delivered to enrollees by physicians, hospitals and other care "providers."

A crucial component of the managed care plans offered by Anthem is the "behavioral health" benefit. Behavioral health care includes mental health and substance abuse services. Prior to 1996 Blue Cross and Blue Shield of Connecticut administered the behavioral health portion of its popular "BlueCare" plan "in-house" (Blue Cross and Blue Shield of Connecticut merged with Anthem Health Plans, Inc. on August 1, 1997 and thereafter did business as Anthem Blue Cross and Blue Shield of Connecticut.) In 1996 however, Blue Cross decided to "carve out" the behavioral health management of the BlueCare plan to a subcontractor that specialized in

behavioral health. In theory, a carve-out subcontractor would be able to manage behavioral health care more efficiently and economically.

On January 5, 1996, Peter Benet, MD, a psychiatrist practicing in Hartford, Connecticut, established a non-profit corporation named PsychCare, Inc. PsychCare was formed for the purpose of bidding for the right to manage behavioral health coverage for enrollees in plans administered by Blue Cross and Blue Shield of Connecticut. PsychCare eventually had 33 "members," each of whom contributed \$5000 to fund the initial operations of the corporation.[3]

Physicians working with Blue Cross while Blue Cross was managing its own behavioral health benefit had developed an "anchor group" concept whereby particular multi-disciplinary practices would have responsibilities for treating patients on an emergency basis. The anchor groups also had responsibility for caring for patients who were particularly difficult. The anchor group approach was developed to provide higher quality outpatient care to difficult patients in danger of inpatient admission, thereby keeping patients out of the hospital and lowering costs.[4] Several of the physicians associated with PsychCare had earlier worked with Blue Cross as members of behavioral health anchor groups.

PsychCare was intended to address the opportunity presented by Blue Cross's desire to subcontract the behavioral health management of BlueCare's 120,000 enrollees. PsychCare's advantage in the bidding process was its emphasis on the local control of area psychiatrists, its anchor group approach to providing care, its low bid, and its non-profit status.[5]

Dr. Benet organized a group of psychiatrists who would serve as anchor group physicians and participating care providers in the PsychCare provider network. A small group worked with Dr. Benet to prepare a response to the Blue Cross Request for Information ("RFI") which solicited bids to perform behavior health management for Blue Cross. The PsychCare proposal was successful, and PsychCare was selected by Blue Cross as its preferred manager. Contract negotiations ensued.

Although PsychCare had submitted the winning response to the Blue Cross RFI and had organized and contracted with a network of care providers, PsychCare was soon supplanted by a for-profit stock corporation named Psych Management, Inc. ("PMI"). Dr. Benet also organized PMI; it was incorporated on September 6, 1996. The organizational meeting of PMI was held on November 21, 1996. Dr. Benet was appointed Chairman.

On August 20, 1996, Richard T. Keppelman, a personal friend of Peter Benet's[6] and attorney for both PsychCare, Inc. and Psych Management, Inc., wrote to the members of PsychCare and proposed "restructuring alternatives." Mr. Keppelman frankly admitted that PsychCare's not-for-profit structure had been chosen to appeal to insurers like Anthem:

PsychCare was originally organized to be a somewhat loose affiliation of practicing psychiatrists, intended primarily as a vehicle to bid for managed care contracts with HMOs. **It was organized as a non-stock corporation because . . . its non-tax status . . . gave it a professional image which the organizers felt would be attractive to insuring groups and the general public . . . .** [7]

Mr. Keppelman described how the contract won by PsychCare would be taken over by a new corporation (eventually named Psych Management, Inc.):

The new vision would be the creation of a physician practice management company (“PPMC”) or a management services organization (“MSO”), which would have the **potential to generate income beyond the mere rendition of services by its members and to reward its organizers with a level of wealth ordinarily unattainable to by rendition of professional services alone.**[8]

According to Mr. Keppelman, the new organization “would take over the entire management of the PsychCare Blue Cross contract on a fee basis.”[9] The new for-profit corporation (Psych Management, Inc.) would pay as a fee to PsychCare “an amount equal to 20% of all revenues.”[10] Mr. Keppelman’s plan called for rapid growth and large profits:

The ultimate business plan for the new MSO would be to use the PsychCare contract as a base from which to build a strong regional MSO business, creating value for its customers (including PsychCare) and a leveraged income for its entrepreneurial investors, the possible outcome of which could be sale of the new company to a major national company or a public offering of its shares in either case **creating liquid wealth for the shareholders.**[11]

In fact, however, Psych Management, Inc. took over the PsychCare contract with Anthem and the PsychCare provider network (all apparently with Anthem’s approval) and never compensated PsychCare for the transfer of those valuable assets. For some time PMI has kept on its books an amount owing to PsychCare as a liability. In 1999, however, Mr. Keppelman dismissed the importance of this obligation:

There is a line item of \$146,869 shown as “due to PCI” [PsychCare, Inc.] which represents a purported amount owing to PsychCare, Inc. for use of the provider network originally established under PsychCare’s name and at PsychCare’s expense. **There is no legal obligation to pay that amount to PsychCare and there would be no adverse consequences to the Company [PMI] if that amount was never paid.[12]**

According to Steven Ruth, the present CEO of PMI, no management contract or other writings specifying the relationship between PsychCare and PMI can be found.[13] PMI now contracts directly with all physicians, hospitals and other providers in the provider network, having fully supplanted PsychCare in this respect.

PsychCare's Certificate of Incorporation provides that it shall be non-profit and operate under the Connecticut Nonstock Corporation Act. The Nonstock Corporation Act., Conn. Gen. Stat. Sec. 33-1000 *et. seq.*, provides standards of conduct for directors of nonstock corporations. A director is required to discharge his duties "in a manner he reasonably believes to be in the best interests of the corporation." [14] The statute provides that a director who votes or assents to a distribution of the corporate assets made in violation of the corporation's Certificate of Incorporation is personally liable to the corporation for the amount of the improper distribution.[15] Peter Benet and other PsychCare directors who arranged the distribution of PsychCare assets to the for-profit Psych Management, Inc. in violation of PsychCare's Certificate of Incorporation specifying its non-profit nature, would appear to be liable to PsychCare for the amount of all such distributions.

We conclude that Peter Benet and his associates devised a plan to bilk PsychCare of its assets and profit personally. Any “contract” between PsychCare and PMI was a sham. Dr. Benet

himself was eventually able to take away hundreds of thousands of dollars in profit by exploiting assets properly belonging to a non-profit corporation. In the process, Peter Benet and his fellow Board members violated their statutory duty to PsychCare by transferring PsychCare's right to negotiate with Anthem, and PsychCare's provider network, to PMI without ensuring that PsychCare received fair consideration in return.

**B. THROUGH STOCK MANIPULATION, PETER BENET CAME TO OWN A DISPROPORTIONATE SHARE OF PSYCH MANAGEMENT, INC.**

As a condition of entering into a contract with PMI, Blue Cross required that PMI establish a \$1 million "letter of credit" that Blue Cross could draw upon in the event PMI failed to comply with its obligations under any contract eventually entered into between the parties.[16] PMI (and PsychCare) attorney Richard Keppelman devised a plan whereby the letter of credit would be backed by the assets of PMI shareholders. PMI would agree to reimburse shareholders for any loss they might suffer as a result of a call upon the letter of credit. PMI shareholders pledging assets to secure the letter of credit would receive one share of stock for every \$200 worth of letter of credit guaranteed.[17]

Claire Benet, then the wife of Peter Benet, contributed \$500,000 towards the \$1 million letter of credit and received 2,500 shares of PMI stock in return.[18] Mrs. Benet's 2,500 shares amounted to 21% of the total of PMI shares then outstanding.

PsychCare commenced operations in space lent to it by Blue Cross at Blue Cross headquarters in North Haven, Connecticut on October 15, 1996. The contract between PMI and Anthem was not signed until November 21, 1997, however, even though the effective date of the

contract was January 1, 1997, nearly 11 months earlier.[20] The contract provides that Psych Management shall maintain a letter of credit through December 31, 1997 but that thereafter the letter of credit may be replaced by “financial reserves.”[21] On December 19, 1997, Carl J. Maleri, Senior Vice President of Anthem, wrote to PMI officer Paul F. Mulkerrin informing him that Anthem had decided to accept PMI’s proposal “that Psych Management replace the Letter of Credit, commencing January 1, 1998, with a restricted bank account in the amount of \$1 million in cash or cash equivalent.”[22] On December 31, 1997, Peter Benet wrote to PMI shareholders announcing that “. . . we have been able to make satisfactory alternate arrangements with Blue Cross, so that the collateral for the \$1 Million Letter of Credit will be released this week, as planned.”[23]

Thus shareholders who had advanced funds towards the letter of credit were permitted to, and did, retrieve their money, plus interest, in January 1998.[24] The Benets were able to obtain 2,500 shares in PMI by placing \$500,000 at “risk” for approximately six weeks between the signing of the contract with Anthem on November 21, 1997 and the expiration of the letter of credit requirement on January 1, 1998. The manipulation of the share ownership rules and the renegotiation of the letter of credit arrangement by Peter Benet and Richard Keppleman removed any real risk to the Benets; Peter and Claire Benet were able to obtain a large proportion of the shares of PMI essentially for free.

Moreover, with the help of Richard Keppleman, Dr. Benet was able to persuade the PMI Board of Directors to grant him large blocks of PMI shares in recognition of his "performance." The Board granted Dr. Benet 1800 shares on April 15, 1999 (this gift amounted to 13.5% of all

PMI shares then outstanding). The Board gave Dr. Benet an additional 1200 PMI shares on January 27, 2000 (representing 8.5% of PMI shares then existing). Dr. Benet eventually came to own 6000 shares of PMI representing 42% of all PMI shares issued. With the help of the PMI Board of Directors Peter Benet had come to own a controlling interest in the company.

**C. IN NEED OF MONEY, PETER BENET PERSUADED PMI TO ISSUE A DIVIDEND IT COULD NOT AFFORD.**

Psych Management, Inc. is a for-profit corporation owned by shareholders; such corporations are empowered to distribute profits to shareholders in the form of dividends. During the first quarter of 1999, Peter Benet approached Mark Cesaro, PMI's chief financial officer, and suggested that PMI pay its shareholders a dividend.[25] Mr. Cesaro told Dr. Benet that he thought a dividend was a bad idea.[26] Of crucial importance was the fact that PMI's "incurred but not reported" ("IBNR") indebtedness had not yet been determined for calendar year 1998. The IBNR was the amount PMI would eventually owe to providers of services but which had not yet been billed. The audited financial statement for 1998 had not yet been finalized because the estimate of the IBNR was not complete.[27]

Paul Mulkerrin, then a financial advisor to PMI, recommended against paying the dividend,[28] but Dr. Benet was adamant, even though preliminary financial reports for the first quarter of 1999 showed a loss.[29]

Payment of a dividend was considered at the PMI Board meeting on April 15, 1999. After a short presentation Mark Cesaro and PMI administrator Janet Izzo were told that they could leave the Board meeting. This was a new practice; Mr. Cesaro and Ms. Izzo had never been

asked to leave Board meetings before.[30] After Mr. Cesaro and Ms. Izzo left, Peter Benet described PMI as having \$1 million dollars in profit available for the payment of a dividend.[31] PMI attorney Richard Keppelman told the Board that PMI could afford the dividend.[32] Paul Mulkerrin also supported the dividend.[33] The Board voted a dividend of \$33 per share, a total of more than \$440,000.[34]

Also at the April 15, 1999 Board of Directors meeting PMI attorney Richard Keppelman urged the Board to compensate Dr. Benet for his success in obtaining new business from Anthem Blue Cross. The Board resolved to grant Dr. Benet 1,800 shares of stock. It was noted in the minutes that Dr. Benet would be entitled to receive the cash dividend with the respect to the 1,800 shares. At \$33 per share, this amounted to an additional dividend to Dr. Benet totaling \$59,400. Dr. Benet's total dividend share was \$161,700.

The day after the Board meeting, Peter Benet approached Mark Cesaro and requested a check reflecting Dr. Benet's dividend. Mr. Cesaro resisted, saying that he wanted to see the official paperwork indicating the decision of the Board of Directors before issuing checks. Eventually, Dr. Benet received his dividend in 2 installments: \$79,200 (reflecting 2400 shares at \$33 per share) on April 22, 1999, and \$82,500 (reflecting 2500 shares at \$33 per share) on May 14, 1999. (At that time Dr. Benet owned a total of 4900 PMI shares). Dividend checks were sent to the other shareholders on May 26, 1999.

Peter Benet's insistence that a dividend be paid appears to have been influenced by his personal financial circumstances. Dr. Benet was divorced from Claire Benet on August 10, 1998. In the financial statement Dr. Benet filed on that date, he listed a debt of \$100,000 due to the U.

S. Internal Revenue Service. As part of the divorce agreement, Peter Benet took ownership of Claire Benet's 2500 shares in PMI. In return, Dr. Benet promised to pay Claire Benet \$260,000. Dr. Benet remarried in November, 1998. On or about June 21, 1999, Dr. Benet purchased a home in West Hartford, Connecticut, for \$437,500. He currently resides there with his present wife and children.

On April 16, 2001, after PMI's condition had worsened still further and Peter Benet had been forced to resign his positions as a PMI Medical Director and CEO, PMI executive Steven Ruth and Board Chairman Richard Berkley, MD, wrote to Dr. Benet discussing

serious . . . claims which PMI may have against you [Peter Benet] in connection with the \$33/share dividend approved by PMI's Board of Directors on April 15, 1999, the payment of which contributed in great measure to the dire financial condition in which PMI now finds itself. . . .

It appears that you may have arranged payment to yourself of the dividend well before May 25, 1999, the date on which other shareholders received the dividend. We have received information which indicates this was done due to your need for funds in connection with a purchase of a personal residence. . . .

Based on the information available to us, we believe there is a substantial basis to conclude that **you intentionally withheld material information from the Board; that you were motivated to withhold such information by your personal financial concerns, and that the failure to disclose such information is a direct and proximate cause of the financial distress which PMI is presently suffering.**[35]

**D. PMI IMPROPERLY WITHHELD PART OF THE REIMBURSEMENT DUE PROVIDERS IN 1998.**

An important element in PMI's decision to pay a dividend in April of 1999 was its supposed ability to repay the "provider withhold" for 1998. In the May 26, 1999 cover letter sent with dividend checks to PMI shareholders, Peter Benet assured the shareholders that "in

coming weeks we will be producing . . . another 100% withhold return for 1998." [36] In fact, however, Dr. Benet's insistence upon a dividend in 1999 destroyed any chance that PMI would, voluntarily, return to care providers the 1998 "withhold" compensation to which they were entitled.

A "withhold" amount is a percentage of the contracted rate due to providers of services that is initially withheld by the managed care organization. [37] A withhold is a mechanism for sharing risk with providers. [38] The withhold provision of PMI's Provider Agreement provides that the withhold may be permanently retained by PMI if "payments and expected payments for services exceeds the actuarially determined budget for cost and use of contracted covered services." [39] In other words, if the actual cost of care exceeds the amount budgeted by PMI, PMI may retain the withhold (20% of the compensation due providers) to make up the difference. In reality, however, PMI never made a determination whether the budget for services had been exceeded; [40] it decided not to pay the withhold because after the payment of the shareholder dividend it did not have enough money to fulfill its obligation to caregivers.

In 1997, PMI withheld 20% of the reimbursement ordinarily due to non-institutional providers for care rendered to enrollees. The 20% withhold was kept in the bank and was eventually repaid to providers because the contractual conditions necessary to repay the withhold to providers were satisfied in 1997.

During 1998, a 20% withhold amount was again retained by PMI. On the draft of the unaudited financial statement for 1998, the withhold appears as a liability totaling \$709,055. [41] Before the 1998 withhold could be returned to providers, however, the PMI Board, at Dr.

Benet's urging, voted a dividend to shareholders. On the final 1998 statement audited by PMI's accountants the withhold does not appear as a liability. Instead, the statement contains a note stating that the withhold would not be paid because "the PMI Board of Directors has determined that provider costs for 1998 exceeded budget by more than [the amount of the withhold] and had determined that no portion of the 1998 provider withhold will be returned to providers." [42]

Providers were told nothing concerning the decision by PMI not to repay the 1998 withhold. In fact, on October 28, 1999 the PMI Board considered whether to inform providers about the decision not to return the withhold and decided that "no action or communication would be appropriate at this time." [43] Providers and PMI shareholders, however, eventually learned of the decision not to return the withhold and many complained. [44] Diana Harbison, MD, formerly a PMI Medical Director and also a PMI shareholder, was bitterly opposed to PMI's decision to retain the withhold. On October 4, 1999, she wrote to Richard Keppleman and denounced the PMI Board's decision:

. . . I would like to convey my sense of moral outrage that the officially stated commitment to return 100% of the 1998 practitioner earned risk withhold has been renegeged upon . . . .

Do the subsequent actions of the members of the Board of Directors represent a breach of their fiduciary responsibility to the corporation, its shareholders, and its practitioner network?

Once the formal announcement is made to the practitioner network that the risk portion of their professional fees will not be returned, would it not be fraudulent to use an explanation that consists of some version of "the corporation had not been able to break even or incurred some unexpected expenses," when indeed it had the funds to pay a dividend to its shareholders in the very same fiscal year. . . .

Personally, I do wonder whether the ex-Mrs. Benet's substantial line of credit which translated into a huge number of shares for Dr. Benet, actually has provided the current Mrs. Benet with a new home, all at the expense of professional fees earned by practitioners in the Psych Management, Inc. network.[45]

Eventually, Anthem learned that PMI had not returned the 1998 withhold. Katherine Giordano, an Anthem Vice President, telephoned Peter Benet and ordered him to return the withhold to providers.[46] At the January 27, 2000 meeting of the PMI Board of Directors it was resolved “. . . that an amount equal to 1998 provider withhold should be returned to the providers as soon as cash becomes available.” The withhold, approximately \$750,000, was eventually returned to providers on September 7, 2000.[47]

Also at the January 27, 2000 meeting, the Board gave Dr. Benet an additional 1,200 shares of stock on the grounds that “Dr. Benet’s performance had warranted recognition . . . .” Dr. Benet also requested and received from the Corporation a \$45,000 advance on salary to help him in resolving a “real estate situation.”

**E. PETER BENET PRESSURED PMI EMPLOYEES TO CUT BACK ON COVERAGE FOR MEDICALLY NECESSARY CARE.**

As Anthem’s carve-out subcontractor, PMI was given the power to decide whether coverage should be available to pay for mental health and substance abuse care. In essence, PMI was charged with deciding who received care and who did not. Effective January 1, 2000, Anthem subcontracted PMI the power to manage behavioral health care for the Century Preferred and State Employee plans, as well as the original BlueCare managed care plan -- a total of 600,000 enrollees who now depend on Anthem and PMI to make sure that they receive the behavioral health services they need. Typically, a provider -- a psychiatrist practicing in the community, or a psychiatric hospital, for example -- would contact PMI and request coverage for behavioral health services that were, in the provider’s opinion, medically necessary for an enrollee. Requests for coverage of outpatient care were submitted in writing on an outpatient treatment report (“OTR”). Requests for coverage of inpatient care were communicated by telephone call from a worker employed by the provider to a “care manager” at PMI.

During 1999 and 2000, the PMI care managers came under increasing pressure from Dr. Peter Benet to deny coverage and reduce utilization. As Medical Director of PMI, it was Dr. Benet's function to train and support the PMI care managers. Over time, however, Dr. Benet expressed an increasing interest in suppressing coverage and care and became less concerned with the medical details of the cases under review.

Dr. Benet's efforts to persuade care managers to curtail coverage eventually became intense. He began meeting with care managers every day to review cases, particularly the status of enrollees who were psychiatric inpatients.[48] Dr. Benet would harass some care managers two or three times a day in an effort to force them to restrict coverage.[49] Dr. Benet was interested only in the number of days the patient had been in the hospital. He would not listen to the clinical details concerning why a patient needed to remain as an inpatient.[50] He let his concern about the costs of individual cases become explicit, exclaiming, for example, that "we spent a lot of money on this member." [51] Referring to enrollees in psychiatric hospitals, Dr. Benet would say "we really need to get them out. They've been there long enough." [52]

During 1999 and 2000 PMI, under Peter Benet's leadership, attempted to secure additional contracts to perform behavioral health management for HMO's.

When PMI was preparing a bid to win the contract to perform behavioral health management for Physicians Health Services, Dr. Benet attempted to force even more drastic cutbacks in coverage. As one care manager described it, ". . . he was really redoubling his efforts, tripling his efforts, in curtailing utilization." [53] Care managers felt badgered and

harassed. They felt that Dr. Benet was sacrificing the interests of patients in his efforts to save money:

I think the main thing, the disturbing elements of working at PMI over time has been the progression of Dr. Benet in trying to curtail utilization by a number of different means, primarily badgering the care managers, trying to get us to do things that weren't ethical, but over time really creating roadblocks and obstacles to people accessing their benefits that are necessary, treatments that clearly are medically necessary . . . really trying to minimize people's mental status and psychiatric presentation and degree of impairment.[54]

Many care managers were deeply offended by Dr. Benet's tactics. Arguments between Benet and the care managers were often heated and "sometimes downright nasty." [55] Care managers "felt very threatened." [56]

When intimidation did not work, Dr. Benet tried cash incentives; Dr. Benet offered the PMI supervisor of Care Management a bonus if she was able to reduce lengths of stay below a certain level.[57] The supervisor declined the offer.

At the same time that Dr. Benet was attempting to cut coverage and care generally, he directed that special consideration be given to physicians who were shareholders in PMI.[58] Dr. Benet was granting different amounts of coverage for what seemed to be identical coverage requests based on the identity of the care providers involved.[59] In particular, shareholders in PMI were likely to receive more coverage for outpatient care than physicians or therapists who were not shareholders. Where a former colleague or Board member was involved, Benet would relinquish the control over the coverage determination process to that physician.[60] Patients who happened to be treated by a physician who was given special treatment by Dr. Benet were likely to receive more services than other patients.[61] Care managers were also directed by Dr.

Benet to divert patients to hospitals where they could be cared for by particular physicians whom Dr. Benet wished to favor.[62]

**F. AT PETER BENET'S DIRECTION, PMI IMPLEMENTED A PRACTICE OF ARBITRARY DENIAL OF MEDICALLY NECESSARY CARE THROUGH THE USE OF COVERAGE "CAPS" AND "GUIDELINES" UNRELATED TO THE ACTUAL CARE NEEDS OF ENROLLEES.**

In addition to pressuring care managers to restrict coverage and care, PMI, under Dr. Benet's direction, promulgated arbitrary guidelines designed to reduce utilization. These guidelines changed and became stricter over time: ". . . different parameters were being created on a weekly basis, and it was my feeling that the parameters were getting tighter and tighter and stricter and stricter." [63]

For example, Dr. Benet would terminate coverage in cases he called "chronic," even when the enrollee involved was a child. At least one care manager protested: ". . . I remember sitting there with him and saying, how can you call a child or an adolescent a chronic patient? Developmentally they're not even mature. How can they be chronic?" [64] Of course, even chronically ill patients have a legitimate need for behavioral health care.

Dr. Benet established, in writing, an arbitrary "cap" of nine covered intensive outpatient visits in 30 days for patients in need of substance abuse treatment.[65] In practice, this policy meant that PMI would cover only nine intensive outpatient visits.[66] This rule "had nothing to do with clinical criteria." [67] Coverage was also formally capped at one residential or intensive outpatient episode per calendar year.[68] In the opinion of care managers these caps had no

relation to the actual needs of enrollees: “That's saying nobody is entitled to more, and inherent in the substance abuse population is multiple treatments and relapse . . . .”[69]

PMI also employed a policy of “tapering” whereby care managers were required to taper down the amount of coverage being granted in particular cases. If coverage was granted for 12 outpatient therapy visits in a 3 month period, for example, PMI care managers were required to grant coverage for fewer visits in subsequent periods even though the patient involved might be more sick than she had been.[70] Dr. Benet eventually instituted a coverage policy mandating that where physicians had requested coverage for 12 weekly therapy sessions they would routinely, and arbitrarily, be granted coverage for only 6 sessions.[71]

In most cases Anthem paid PMI a set monthly fee for each covered enrollee. If the payments received from Anthem were less than the cost of caring for the patients involved, PMI would be forced to pay the difference. With this risk in mind, Dr. Benet imposed an arbitrary limitation on coverage for inpatient care which paralleled the amount of compensation PMI was receiving from Anthem. Thus if Anthem was paying PMI an amount sufficient to pay for seven or eight inpatients at one time, Dr. Benet would become very concerned if the PMI inpatient census exceeded that number. He would pressure care managers to limit coverage: "He would want them out." [72]

The primacy of financial over medical considerations in the PMI coverage determination process is starkly illustrated by the different treatment accorded “at risk” and “administrative services only” (“ASO”) patients. Anthem contracted with employers to provide either of two types of health care coverage. Where Anthem “insured” the coverage, it paid all claims for

medically necessary care. If claims exceeded the premiums collected, Anthem would suffer a loss; it was “at risk.” When Anthem contracted with PMI to handle behavioral health claims, the risk was passed along to PMI. If PMI paid out less than the “per member per month” (“PMPM”) fee it received from Anthem, PMI would make a profit. If PMI paid out more than it received in PMPM income, it would suffer a loss.[73]

In contrast, where employers contracted with Anthem for “administrative services only” the employer retained the risk and paid claims out of its own pocket. When Anthem subcontracted ASO claims to PMI, PMI received a relatively low fee for administering the claims and bore no risk because the claims themselves would be paid by the employer, not PMI.[74]

Although PMI was contractually bound to provide the same degree of scrutiny to “at risk” and ASO claims, in practice under the direction of Dr. Benet PMI gave a very aggressive level of attention to at risk claims and approved ASO claims for payment without serious review.[75] If the case was ASO only, Dr. Benet was likely to say “well, it’s not our nickel,” meaning that Dr. Benet had no interest in restricting coverage for that particular case because PMI was not liable for the cost of the care involved.[76] Not surprisingly, at risk cases were authorized for dramatically fewer days or visits of coverage and care than ASO cases.[77] At PMI case management meetings, documents were circulated indicating which cases were ASO and which were at risk. Dr. Benet was interested in seeing an early termination of coverage in the at risk cases; the ASO cases did not interest him. He persisted in his approach despite the protests of care managers and PMI executives.[78]

PMI care managers concerned about the possibility that enrollees might be forced to go without necessary care did their best to resist Dr. Benet's insistence that they reduce utilization. For example, care managers found a method to "hide" cases from Dr. Benet by placing them in a "pool." Cases in the pool did not appear on the PMI computer-generated case list and therefore escaped Dr. Benet's attention.[79] One care manager disregarded specific instructions from Dr. Benet and granted more coverage than Dr. Benet had ordered because she thought the patients involved required more care than Dr. Benet was permitting them. She thought Dr. Benet's instructions were unethical. She was disobeying instructions in order to prevent harm to patients.[80]

**G. PMI'S TACTICS HAVE INJURED CONNECTICUT CITIZENS STRUGGLING TO RECOVER FROM SERIOUS ILLNESS.**

PMI manages the behavioral health care of some 600,000 enrollees in Anthem managed care plans.[81] In calendar year 2000 PMI administered the care received by 2,500 hospital inpatients and determined the coverage status of tens of thousands of care visits for patients needing partial hospitalization, intensive outpatient, or regular outpatient behavioral health care.[82] The number of patients involved, as well as their vulnerability, means that even a minor bias by PMI towards restricting care would have the potential to do serious harm.

Dr. Benet's harassment of PMI care managers and his imposition of arbitrary caps and guidelines meant that some patients did not receive the medically necessary care they required.[83] The PMI supervisor of care management saw patients "cycle in and out of treatment." Patients were returning to the hospital because they had not been treated long enough at the hospital during their first stay.[84]

Children in particular suffered under Dr. Benet's tenure.[85] When it established its provider network, PMI negotiated with individual hospitals to set a daily "rate" -- the amount PMI would reimburse the hospital for each day of inpatient care delivered to an Anthem/PMI enrollee. Peter Benet then manipulated the care of enrollees to increase the days of care delivered by less expensive facilities. In effect, Dr. Benet was looking to admit patients into hospitals with the lowest reimbursement rates so that PMI would save money on those patients' care. These least expensive hospitals were also likely to discharge patients faster because the hospitals' payment margin on such patients was lower than on other patients they could accommodate.[86] Thus the interests of patients in receiving prompt hospital care within reasonable visiting distance were sacrificed so that PMI could save money. Children were often left languishing in emergency rooms for 24 or even 48 hours in hospitals that had beds for the children because Dr. Benet was trying to locate a bed at a less expensive hospital even though that hospital might be hours away from the child's family[87].

Although people who have received behavioral health care are understandably reluctant to come forward publicly to describe their difficulties in obtaining appropriate health insurance coverage, the Office of the Attorney General has been able to document that particular patients have indeed been denied necessary care. We describe two such cases here. (The facts of both cases are verified by affidavit).[88]

1. Matthew L. was Injured by PMI's Refusal to Pay for Medically Necessary Intensive Outpatient Treatment.

Matthew L. is 21 years old, and lives in Eastern Connecticut. He has health insurance coverage with Anthem Blue Cross and Blue Shield of Connecticut through his father's employment as an educator in a Connecticut town school system. Mr. L. Sr. paid premiums to Anthem (and its predecessor Blue Cross and Blue Shield of Connecticut) for many years, but when the L. family turned to Anthem for help with Matthew's illness, the company refused to authorize the treatment Matthew needed.

Matthew was a high honor student every quarter of high school and a National Honor Society member. He received many awards in high school and was selected as 1 of 20 incoming students for the honors program at his college. At college, Matthew was awarded the Deans List distinction in his first semester. In the second semester, however -- early March, 2000 -- Matthew suffered a breakdown.

Matthew had experienced some sleep difficulties in high school and had received some medication for that problem. In college, however, his sleep problems worsened, and he developed what was diagnosed as a "schizo-affective disorder." He became unable to read except for very

brief periods, unable to concentrate for any length of time, and had difficulty with his short term memory. He was anxious, restless and paranoid.

Matthew's mother, Mary L., immediately sought medical help for Matthew. His psychiatrist prescribed medication. Mrs. L. was able to locate an excellent outpatient program at the Institute of Living in Hartford. Matthew was accepted into the Institute of Living program on the condition that his health insurance, administered for Anthem Blue Cross by Psych Management Inc., would provide coverage. Psych Management Inc. ("PMI"), however, completely denied coverage for any outpatient care at the Institute of Living.

Matthew was forced to go for more than one month without receiving the intensive outpatient treatment he needed. This delay in care may have permanently damaged Matthew.

Mrs. L. understood the seriousness of Matthew's condition and the necessity for early and intense treatment. She embarked on a campaign to pressure Anthem Blue Cross and PMI in any way she could to authorize the care that Matthew needed so badly. After strenuous lobbying efforts PMI eventually agreed to provide coverage for 2 weeks of therapy (3 visits per week, for a total of 6 visits), even though it was obvious that Matthew would need outpatient care for many months. Finally, Mrs. L. threatened PMI that she would take out a full page newspaper ad complaining about the way Matthew had been treated. PMI then agreed to authorize 8 weeks of outpatient care.

Matthew went to the Institute of Living three times a week for 12 weeks. PMI workers were in frequent touch with Institute of Living employees and it was Mrs. L.'s understanding that this entire period of care would be covered. Approximately 1 year later, however, Mrs. L. received a letter dated July 23, 2001 from a collection attorney who demanded, totally without legal justification, that she make payment to the Institute of Living of an outstanding balance of \$3,563. PMI had, in fact, paid nothing towards Matthew's care. Mrs. L. telephoned PMI and the PMI worker assured her that this error would be promptly cleared up. Approximately a month later, however, Mrs. L. received a second letter from the collection attorneys, dated August 22, 2001, informing her that the lawyers had advised the Institute of Living to institute legal action against Mrs. L. to collect on the outstanding balance.

Although Matthew is now employed as a woodworker, he is still unable to read for any length of time. He has not recovered sufficient cognitive ability to enable him to return to school.

2. Melissa Fahey was Injured by PMI's Failure to Provide Coverage for Appropriate Psychiatric Hospital Care.

Melissa Fahey, now 22 years old, experienced some severe trauma when she was a child, and today she suffers from a condition called Post Traumatic Stress Disorder ("PTSD"). Melissa had a successful high school career. She was in the top 20% of her class and she received a partial scholarship to the University of Rhode Island. She was also athletic; she played basketball, softball and field hockey. After attending URI for a year, however, Melissa decided not to go back. In the fall of 1999 she ran away from home and Mrs. Fahey lost contact with Melissa for several months, until approximately April, 2000. For the first time she told her

mother about the abuse she had suffered as a child. Soon after, she experienced a severe psychotic breakdown.

Melissa has health insurance with Anthem Blue Cross and Blue Shield of Connecticut, which uses Psych Management Inc. to administer its mental health care benefit.

In October, 2000, Melissa's condition became so bad that her family decided to admit her to the Manchester Memorial Hospital in Manchester, Connecticut. The doctors there told her mother, Leslie Fahey, that Manchester Hospital was not the right place for Melissa. They had no programs appropriate for people suffering from PTSD. The Manchester Hospital social workers began talking to Psych Management Inc., trying to persuade them to approve coverage at Brattleboro Retreat, a psychiatric hospital in Vermont with an excellent PTSD treatment program. The Manchester Hospital doctors and nurses kept arguing with PMI but PMI refused to approve the care Melissa needed.

Melissa was at Manchester Memorial Hospital for 3½ weeks. Eventually PMI agreed to cover care at Brattleboro Retreat. For some reason, however, PMI went back on its promise, and refused to cover Brattleboro Retreat care after all. Leslie Fahey was shocked to learn one day that Melissa had been transferred by ambulance to Yale New Haven Hospital. Although Yale New Haven also was unable to provide a PTSD program for Melissa, she was required to stay there while PMI continued to refuse to cover the type of care Melissa needed.

At Yale New Haven, Melissa was mixed into a general psychiatric ward filled with very ill people. It was a chaotic and disturbing environment. Unable to get the care she needed, Melissa's condition deteriorated. Her self-destructive behavior became more intense. She would

hide sharp objects and later, when no one was looking, she would cut herself. When the nurses discovered her injuries, Melissa was placed in an isolation room. Melissa was scared, upset, and incoherent. Although she was visiting Melissa every day at Yale New Haven, Leslie Fahey was powerless to keep her from breaking down.

Finally, after a stay of 8 days at Yale New Haven, PMI agreed to cover a stay at the Elmcrest Hospital in Portland, Connecticut. Melissa was transferred to Elmcrest and spent 2 or 3 weeks as an inpatient there. She received care every day at the Women's Trauma Center run by Elmcrest Hospital. Melissa continued to attend the program at the Women's Trauma Center on an outpatient basis after she was discharged from Elmcrest. Finally, Melissa was receiving the intensive care she needed, targeted towards the type of trauma she had suffered.

Melissa received outpatient care at the Women's Trauma Center daily for 3½ months. Leslie Fahey is very angry at the way Melissa was treated by Psych Management Inc. and Anthem Blue Cross and Blue Shield: "As far as I'm concerned these companies put my daughter through hell. We were able to get effective treatment arranged only because the Attorney General's Office intervened. The question I would like to ask is 'What happens to people who don't have an advocate helping them?' "

**H. AT THE SAME TIME THAT HE FORCED DRAMATIC AND HARMFUL CUTBACKS IN COVERAGE AND CARE AVAILABLE TO PATIENTS, PETER BENET SPENT EXTRAVAGANTLY ON LUXURY OFFICE SPACE AND FURNITURE, AUTOMOBILES, LAVISH PARTIES, AND REDUNDANT AND OVER-PRICED NEW EXECUTIVES.**

Ironically, as PMI's financial condition deteriorated, Dr. Benet's tendency towards extravagant and wasteful spending increased. During his tenure, Mark Cesaro acted as PMI's

financial officer. Cesaro was willing to confront Dr. Benet over financial matters. Eventually, however, Benet stripped Cesaro of authority and forced his resignation.[89] Without Mark Cesaro's influence as a constraint, Dr. Benet's profligacy increased.

One reason for his exorbitant expenditures was Dr. Benet's desire to secure the contract to provide behavioral health services to Physicians Health Services ("PHS," now renamed HealthNet). PHS was the largest Connecticut managed care company. The behavioral health management contract for PHS was at the time held by Pro Behavioral Health, a company competing with PMI. Dr. Benet embarked upon a campaign to hire away Pro Behavioral Health executives on the theory that these employees were well-regarded by PHS and would increase PMI's chances of winning the PHS contract. In pursuing these new employees Dr. Benet was influenced by the advice of Robert Natt, a former CEO of PHS. Mr. Natt had an extended, and highly compensated, relationship as a consultant and later as a Board member for PMI. Dr. Benet proceeded to hire five new employees with connections to Pro Behavioral Health or PHS. Chief among these new hires was Steven Ruth, who eventually became the CEO of PMI. Mr. Ruth was paid \$100,000 cash as a hiring bonus. He was given a \$12,000 per year automobile allowance and a country club membership.[90]

In many cases, the new hires were assigned to perform functions at PMI which were duplicative of those performed by PMI employees already in place, and at salaries exceeding those of existing PMI employees. For example, Jill Benson was hired from Pro Behavioral Health at a salary of \$100,000. At the time, Janet Izzo, a top PMI executive, was paid \$85,000.[91] Some

of Ms. Izzo's responsibilities were transferred to Ms. Benson. Ms. Izzo felt she did not have enough to do and eventually resigned.

Eventually, PMI leased seven cars for its executives, including a BMW, an Infinity, a Lexus, and a Saab.[92] Peter Benet arranged for PMI to lease a BMW 740 for his use. PMI paid \$595 per month in base payments for this car, plus insurance. PMI continued to make these payments for many months after Dr. Benet had resigned as CEO and Medical Director of PMI.

Dr. Benet also insisted upon luxury office space and furnishings when PMI moved from Farmington to West Hartford, Connecticut in February 2000. Mark Cesaro had located new space in Farmington for approximately \$12 per square foot. The West Hartford space Dr. Benet preferred cost \$25 per square foot. Dr. Benet bought “top of the line” furniture, furniture so lush that Mark Cesaro considered the executive suite “embarrassing to walk into.”[93] PMI’s existing, perfectly serviceable furniture, was put in the basement. “He replaced file cabinets that were in very good shape; he bought wood desks that you wouldn’t see in the largest Fortune 500 company, I mean, they were gorgeous but very expensive.”[94]

Dr. Benet also persisted in lavish expenditures for parties, trips, and restaurant meals. For example, on June 12, 2000, during the same time when he was putting the greatest pressure on care managers to restrict coverage granted, Peter Benet contracted to hire the cruise ship "Mark Twain" for a cruise which took place on June 24, 2000. The announcement invited friends of PMI to "join Psych Management staff for an evening of dining and dancing . . . ." The cost of the charter was \$6,035.[95] The response from the provider community was not altogether favorable. Alan J. Sholomskas, MD wrote to PMI protesting:

It is appalling to me as both a member of BlueCare and as a provider, that Anthem Blue Cross Blue Shield/PMI have decided to spend their money on frivolous entertainment; money that could be better used to reduce premiums for patients or improving your reimbursement for their clinicians. You might also consider paying me back the withhold that has never been paid for services provided last year.[96]

In October 2000, after Peter Benet had finally been forced to resign as Medical Director and CEO, PMI issued a Fiscal Recovery Plan describing its financial dilemma and the steps it was planning to remedy the situation.[97] The text of the plan cites the reasons for PMI's large deficit, and specifies that "new staff and consultants to document and support the PHS bid" cost the company \$500,000.[98] "Renovation, computers, and systems for new Anthem business," which presumably included the cost of the move to expensive new quarters in West Hartford, are said to have cost the company \$275,000.[99] Thus PMI, by its own admission, wasted hundreds of thousands of dollars and put itself in a severe and unnecessary financial predicament. The pressure to recover from this financial dilemma proved overwhelming to Peter Benet; he attempted to improve PMI's financial situation by radically restricting coverage and medically necessary care.

**I. WITH ITS FINANCIAL CONDITION DEGRADED BY GREED AND MISMANAGEMENT, PMI STOPPED REIMBURSING PROVIDERS FOR SERVICES RENDERED.**

In its role as a manager of behavioral health services, Psych Management, Inc. determines the medical necessity of services for which coverage is requested. Where coverage is approved, PMI pays the claims involved. The money flowing from PMI to therapists and hospitals pays for crucial psychiatric and substance abuse treatment.

Early in June 2000, Peter Benet directed PMI managers to “hold” checks due to be mailed to providers.[100] Dr. Benet was motivated by three factors. First, he was anxious to show Anthem that contractual reserves were being maintained at the required level.[101] As part of its agreement with Anthem, PMI had promised to maintain a cash reserve which would be available to pay claims if PMI exhausted its regular operating funds. Dr. Benet had failed to maintain the reserved funds, and he planned to replenish the reserve, at least temporarily, by diverting to the reserve the money which would ordinarily have been paid to providers. Second, Dr. Benet wished to build up PMI reserves so that PMI could compete more effectively for a new contract to provide behavioral health management to PHS.[102] As part of the bidding process, PMI was required to demonstrate its financial stability to PHS. Dr. Benet wished to misrepresent PMI’s strengths by artificially inflating the reserve accounts. Finally, PMI simply did not have enough money to pay providers on time.[103] PMI had underbid its contracts with Anthem Blue Cross; despite the restrictions imposed by Dr. Benet expenditures were still consistently exceeding income. In addition, PMI’s financial standing had been seriously compromised by its decision to pay a dividend to shareholders in March of 1999 and its extravagant office and employee costs.

1. PMI Hid Unsent Checks in a "Closet."

During the summer of 2000, Dr. Benet on several occasions directed that checks be withheld from providers. On one occasion checks were held for five or six weeks.[104] The checks involved were “cut,” but then locked in metal cabinets at the PMI offices in West Hartford. As many as 10,000 checks,[105] representing more than \$1 million in reimbursements, piled up.[106] Care providers soon began to complain. In responding to irate providers and patients, PMI employees adopted an informal “squeaky wheel” policy; workers would sometimes go into the closet, locate the delayed check and send it out. As one PMI employee stated: “. . . when someone called and said PMI is 60% of my business and I haven’t had a check in 3 weeks and I need the money, I would send it out.”[107]

PMI’s delay of claims payment proved insufficient to solve its financial problems. At one point the bank telephoned and informed PMI executives that PMI had \$4.56 in its bank account.[108] The bank agreed to advance funds to cover outstanding checks, but the implications were clear: PMI simply did not have enough money to continue its day-to-day operations.

PMI managers and staff complained directly to Dr. Benet about his orders to hold provider reimbursement checks. Several staff members called this decision “unethical.” One manager complained to Dr. Benet in writing demanding changes.[109] Peter Benet’s response, however, was to assure staff that PMI could make ends meet by reducing coverage granted. Dr. Benet remarked that “if we could just reduce utilization everything would be fine;”[110] his plan was to reduce utilization sufficiently so that PMI would be able to pay two months of claims with one month of capitation payment from Anthem Blue Cross.[111]

2. By Misrepresenting That Payment to Providers Had Been Made, PMI was Able to Obtain Reimbursement from Anthem Under False Pretenses.

The holding of checks by PMI involved direct misrepresentation to Anthem Blue Cross. Each month PMI informed Anthem electronically that all claims had been paid, when in fact the checks had been cut but then closeted. Based on this assurance, Anthem paid PMI the amount supposedly paid by PMI for claims submitted for enrollees in self-insured plans. For these administrative services only (“ASO”) claims PMI was required to advance the coverage payment and report this fact to Anthem, which would then reimburse PMI. By misrepresenting that it had paid the ASO claims when in fact it had not, PMI was able to obtain money from Anthem to which it was not entitled.[112]

**J. HIS MISCONDUCT EXPOSED, PETER BENET WAS FORCED OUT OF PMI WITH A "GOLDEN HANDSHAKE" FROM ANTHEM.**

In the middle of September, 2000, when Anthem Blue Cross learned that PMI had been holding checks due to providers, Anthem's management became very concerned and upset. PMI staff suspect that an irate provider finally called Anthem directly and complained about not being paid. Anthem took steps to ensure that PMI would be able to pay provider claims on time. Anthem permitted PMI to use its reserves to pay claims, and granted PMI a retroactive increase in its capitation rate. Anthem sent PMI a "rescind" letter stating that PMI was in breach of its contract and had 45 days to correct the problem; this became known to PMI Board members and a crisis ensued.[113] Individual Board members consulted with PMI staff and learned that Dr. Benet had been consistently lying to Anthem and to the Board. It was the consensus of the Board that something had to be done.[114]

An emergency Board meeting was called for October 6, 2000 at the PMI offices in West Hartford. Most of the Board were determined that Benet be removed from his posts at PMI. PMI attorney Richard Keppelman argued against the firing, suggesting that the Board was "overreacting." [115] In the end, there were four Board votes in favor of removing Benet, and one abstention. Paul Mulkerrin voted against removal.

After Benet's firing, PMI began a long struggle to climb out of its financial hole. Paul Mulkerrin, despite his support of Peter Benet, was asked to help organize the recovery. On October 31, 2000 Mr. Mulkerrin aptly summarized PMI's predicament in an e-mail to fellow Board members:

“ . . . we had three problems in calendar year 2000. We spent \$400K pursuing the PHS contract (shame on our founder), \$900K giving back our working capital because BCBS found it intolerable that we gave [share]holders a dividend in a year that we kept a withhold (shame on PMI) and we were awarded a contract by Anthem under which we were losing \$125K a month (shame on everyone).”

Peter Benet, however, retained a controlling interest in PMI; he owned approximately 42% of its outstanding shares. Dr. Benet appeared at the PMI shareholders meeting on April 5, 2001 accompanied by his own slate of directors which, through the use of his voting power, he proceeded to install as the new PMI Board. All of the former PMI Board members, with the exception of Benet himself, were removed.[116]

That same week, however, former Board member Richard Berkley, MD wrote to Dr. Benet and the new Board members. Dr. Berkley asked the new Board to resign. He argued that Anthem Blue Cross would never continue to contract with PMI so long as Peter Benet controlled the Company. He appealed to Dr. Benet’s own self-interest by arguing that Dr. Benet stood to lose a great deal of money if PMI was destroyed.[117] Dr. Berkley’s appeal worked. Dr. Benet and one other new Board member resigned and Berkley himself soon came back onto the Board as Chairman.

Although he had resigned from the PMI Board, Peter Benet still retained a controlling interest in PMI shares. Anthem Blue Cross objected to Dr. Benet’s continued connection with PMI, and urged PMI to sever its association with Dr. Benet. PMI and Dr. Benet eventually entered into a promissory note whereby Dr. Benet surrendered his shares in PMI in exchange for PMI’s promise to pay him \$400,000.[118] Anthem then purchased the promissory note from Peter Benet, paying him \$400,000 in cash.[119] Anthem was willing to pay Peter Benet

\$400,000 to surrender his PMI shares, even though PMI experienced net losses of \$2,300,544 and \$1,072,902 for the years ended December 31, 2000 and 1999, respectively.[120] Thus Anthem, in its determination to distance itself from Peter Benet, provided a handsome reward to the man who had mismanaged PMI into a dangerous deficit, injured enrollees, and lied to Anthem and PMI Board members.

**K. ANTHEM EITHER KNEW OR SHOULD HAVE KNOWN OF PMI'S MISDEEDS, AND SHARES RESPONSIBILITY FOR THEM.**

Anthem and PMI can be likened to a general contractor and a subcontractor. Anthem, the general contractor, contracts with a customer such as an employer, a governmental agency, or a private person, and promises to provide a particular package of health care benefits in exchange for a monthly premium. Anthem then subcontracts the management of the behavioral health portion of the contract to PMI. Whether Anthem subcontracts or not, however, Anthem itself remains responsible for keeping the promises it has made. In other words, any failure by PMI is also Anthem's failure.

Once Anthem fully realized PMI's failure to meet its contractual obligations to Anthem and its customers Anthem took steps to correct PMI's mismanagement and its financial condition. However, PMI in essence was a creation of Anthem. Anthem raised PMI from obscurity, trained its staff, dictated the terms of its contracts, provided all its operating income, and imbued PMI with a cost cutting business culture that was a central goal of the company. In an effort to cut its own costs, Anthem accepted a PMI bid that was so low it virtually guaranteed that PMI would deny coverage for medically necessary treatment. Because Anthem chose to subcontract with

PMI, at the very least, Anthem had an obligation to oversee what its subcontractor was doing.

Hence it either knew or should have known of PMI's misconduct.

1. In an Effort to Improve its Bottom Line in Anticipation of "Going Public," Anthem Worked Hard to Increase Its Profitability at the Expense of Quality Care.

Anthem merged with Blue Cross and Blue Shield of Connecticut in 1997. Anthem executives from Indianapolis, Indiana were soon talking to Blue Cross employees about the importance of "focusing on the bottom line." [121] The importance of reducing costs and improving profit was explicitly linked to Anthem's intention to go from a non-profit to a for-profit company. By the end of 1997, Anthem executives were talking "about going public and what it would take to get there." [122] Anthem employees were required to pay less attention to what was medically necessary, and instead place greater weight on meeting particular "targets" of utilization -- for example, decreasing hospital lengths of stay. [123]

Where formerly physicians and nurses had been in charge of the coverage determination process, that function under Anthem was increasingly dominated by business people. [124] Anthem eventually developed specific targets of utilization, often expressed in numerical terms -- hospital inpatient days per 1,000 enrollees, for example. These utilization targets were arbitrary in the sense that they had no particular relation to the medical circumstances of the cases that would be reviewed by Anthem. [125] In some areas Anthem managers were requested to reduce utilization by as much as 25%. [126] The new targets were communicated to Anthem managers by Donna Moore, the Vice President of Medical Management. Where utilization targets were not

met, Ms. Moore was known to lose her temper and berate managers in a "yelling session." [127] It was made known to a particular Anthem manager that "if I couldn't get the utilization down by 25% in the next quarter, I would be looking for a job." [128]

Utilization targets at Anthem were lowered over time; they were made tougher and tougher. At the same time, administrative expense was reduced through layoffs. [129] With fewer employees available to do an increasing amount of work, Anthem performance deteriorated; medical authorizations could not be considered in a timely fashion and Anthem coverage reviewers were forced to spend less time on each case. [130] Reduction in the quality of the coverage determination process meant that Anthem enrollees sometimes failed to receive medically necessary care. The delay in obtaining authorizations for physical therapy services, for example, increased from one day to as many as five days. During that five day period, the enrollee would be unable to receive the physical therapy he or she needed. [131] When managers complained to Donna Moore, she replied "your problem, go figure it out. Work smarter." [132]

Anthem also instituted a "bonus system" whereby Anthem employees could receive a bonus of as much as 25% of their yearly salary if utilization targets were met. [133] Anthem employees were rewarded for their ability to help Anthem cut costs and increase profits. There was no bonus or reward for ensuring that the quality of care delivered to enrollees remained high. [134] Even the physicians serving as medical directors and assistant medical directors inside Anthem participated in the bonus system. [135] Physicians were also pressured to help meet utilization cutback targets. [136]

2. PMI Underbid Its Contracts with Anthem in an Attempt to Satisfy Anthem's Desire to Increase Its Profitability.

PsychCare's response to the 1996 Blue Cross Request for Information promised dramatic reductions in behavioral health utilization. PsychCare assured Blue Cross that "with intensive hospital diversion and clinical care management, inpatient procedures will be reduced over three years by 55% . . . "[137] Outpatient utilization was to "be reduced over three years by 12% and the average length of stay . . . reduced by 20%." [138]

As part of its proposal PsychCare proposed that it be compensated by Blue Cross at the rate of \$4.89 per member per month (PMPM). The final contract between Anthem and PMI, however, specified a maximum PMPM of \$4.35. Thus Anthem was willing to contract with PMI only if PMI substantially reduced the compensation rates it had initially proposed. In fact, Anthem compensation to PMI consistently failed to meet PMI's expenses.[139] According to PMI Board Chairman Richard Berkley, MD ". . .we were losing money from the first day of the contract. I mean [the contract] was quite a bit underbid. I mean, if the company had been run on a rail with extreme economy, it would still run into money problems." [140]

3. PMI was from the Start a Creature of Anthem's Own Making and Now in Many Ways is a Part of Anthem.

In many ways, Anthem created PMI. Although it had secured the right to perform behavioral health management for Blue Cross, PMI was ill-equipped to undertake the duties involved.[141] PMI was a start-up venture without the staff, equipment, or expertise necessary to perform the duties specified in the RFI. Blue Cross was very concerned about PMI's weakness

and provided intensive support to PMI during the early months of PMI's tenure.[142] PMI was housed at the Blue Cross offices in North Haven.[143] It used the Blue Cross phone system and information system in its start-up phases.[144] PMI used Blue Cross software.[145] For several months Blue Cross itself actually paid claims after PMI determined whether coverage should be available.[146] PMI did not begin paying claims until 1999.[147] In the initial months, Blue Cross also performed the customer service function; customer service was later delegated to PMI.[148]

PMI employees worked closely with Blue Cross workers. Blue Cross essentially trained PMI staff.[149] Some Blue Cross employees moonlighted after hours as PMI workers. PMI care managers consulted with Blue Cross employees about particular cases.[150] In essence, under Blue Cross's instruction, PMI was learning how to administer a claims system.

In September 2000 Anthem finally learned that PMI had been failing to pay providers and had lied to Anthem in an attempted cover-up.[151] Anthem conducted an audit and realized that PMI was under funded.[152] Anthem first permitted PMI to use its reserves to pay claims. Then Anthem granted PMI a retroactive increase in its capitation rate; essentially Anthem gave PMI an additional \$1 million to partially make up the shortfall and end the delay in payments to providers.[153]

In exchange for Anthem's permission to use the reserve account to pay providers, as well as Anthem's agreement not to immediately terminate its contract with PMI, PMI granted Anthem an extensive security interest in all its property, including furniture, fixtures, computer software and equipment, as well as in all accounts and contract rights or receivables of any kind.[154] In

effect, Anthem would be able to foreclose on PMI at any time that Anthem, in its sole discretion, determined that PMI was not complying with all terms of the existing contract. In an important sense, Anthem could now be said to "own" PMI.

In the summer of 2001, Anthem put all three of its commercial behavioral health contracts -- the Blue Care, State Employee, and Century Preferred Contracts -- out to bid. PMI submitted bids on all three, quoting capitation rates significantly higher than those contained in its current contracts with Anthem.[155] Anthem chose to contract with PMI once again. According to Anthem manager Donna Moore, ". . . the reason we went with PMI in the beginning is because it was a local company; we could pick up and call local people. That continues to be our preference . . . ."[156]

#### 4. Anthem has Violated Its Contractual Obligations.

As previously discussed, managed care plans marketed by Anthem and administered by PMI promised to provide a certain package of health care services in exchange for a premium. None of the contractual materials -- neither the formal "Subscriber Agreements," nor Anthem's internet representations about its plans -- mention the arbitrary coverage rules employed by PMI or the tremendous pressure on and within PMI to cut back on medically necessary care. In fact, Anthem's written promises and assurances, in light of the facts now known, are affirmative misrepresentations to patients concerning the coverage available under its plans, and the circumstances of plan administration.

In its "BlueCare Subscriber Agreement," for example, Anthem sets out the requirements for coverage of behavioral health care. The Subscriber Agreement makes available, where medically necessary, "benefits for covered services for inpatient psychiatric crisis intervention and short-term treatment for episodes in a hospital or residential treatment facility with pre-certification from Anthem BCBS."<sup>[157]</sup> Medically necessary care is defined as care which is "appropriate for, and consistent with, the symptoms and proper diagnosis or treatment of the member's condition, illness, disease or injury."<sup>[158]</sup> Coverage for hospital care is available where "the member cannot receive safe or adequate care as an outpatient."<sup>[159]</sup> On its internet web site, Anthem states that it uses "utilization management criteria based on nationally-recognized Optimed protocols."

Crucially important is the fact that neither the Anthem Subscriber Agreements nor the Optimed protocols referred to on Anthem's web site make any mention of the abusive arbitrary coverage limitations which were imposed by PMI. There is no mention, for example, of any rule capping coverage at "only one residential or IOP [Intensive Outpatient] episode per calendar year."<sup>[160]</sup> These arbitrary PMI rules amount to violations of Anthem's contractual promises to enrollees.

**L. PETER BENET HAS BEEN "NEGLIGENT IN THE PRACTICE OF MEDICINE."**

Connecticut law provides that the Connecticut Medical Examining Board is authorized to suspend or revoke the license of any physician because of "negligent conduct in the practice of

medicine."[161] Courts have held that physicians employed by managed care organizations to review the medical necessity of care to be provided to plan enrollees are subject to the regulation of their states' licensure boards.[162] The expression of medical judgment by a managed care company medical director is the "practice of medicine." [163]

In Connecticut " . . . a physician is required by law to exercise the degree of skill, care and diligence that is customarily demonstrated by physicians in the same line of practice." [164] As we have seen, while medical director of PMI, Dr. Peter Benet embarked upon a campaign to force the denial of medically necessary coverage and care to Anthem enrollees without regard to the medical circumstances of the cases under consideration. Dr. Benet coerced PMI care managers to deny cases without regard to their merits, and caused the promulgation of arbitrary coverage rules having no relation to the medical necessity of the claims involved. Dr. Benet also stood to profit, and did profit personally from the denial of coverage and care to the patients PMI was obligated to deal with fairly and in good faith. Dr. Benet has been guilty of negligent conduct in the practice of medicine; he has fallen short of the degree of skill, care and diligence required by a physician in the position of medical director of a managed care organization.

**M. PMI'S USE OF ARBITRARY COVERAGE GUIDELINES CONTINUES TO THE PRESENT DAY.**

Although Peter Benet's connection to PMI has been terminated, our investigation reveals that many of the arbitrary coverage rules and caps he instituted during his tenure remain in force. For example, the arbitrary cap of nine covered intensive outpatient visits in 30 days for patients in

need of substance abuse treatment remains in effect, even though a particular patient might have a legitimate medical need for more than nine inpatient treatments within 30 days. Likewise, coverage remains capped at one residential or intensive outpatient episode per calendar year, regardless of how much care a patient may actually need. Thus, it appears that PMI continues to deny medically necessary coverage and care in reliance upon the inappropriate coverage rules established while Peter Benet was Medical Director of PMI.

We also find it a cause for concern that PMI, at Anthem's behest, worked to restrict coverage even more tightly after Peter Benet was discharged as CEO and Medical Director. After Anthem discovered that PMI was failing to pay providers on time, it instituted a thorough financial audit of the situation at PMI. Anthem's audit summary proposed that PMI expenses be reduced, stating that "utilization management should be a key component of the recovery plan. Without a reduction in medical costs, PMI should be expected to continue to incur significant losses." [165] In its October 11, 2000 "Fiscal Recovery Plan" PMI proposed specific steps to decrease utilization:

- A. Increased use of preferred inpatient & substance abuse settings with more effective lengths of stay and case rates.
- B. Reduction of expensive and inefficient partial hospitalization programs in favor of more community-based and efficient IOP [Intensive Outpatient] programs.
- C. Speed the introduction of outpatient management strategies to Century Preferred and certain high-utilization groups including:
  - i. Decreased reliance on weekly therapy in favor of bi-weekly and monthly therapy for mild to moderate indications. [166]

Thus PMI planned to reduce care by shortening lengths of stay, shifting from partial hospitalization to community-based care, and slashing the frequency of outpatient therapy visits.

#### **IV. CONCLUSION AND RECOMMENDATIONS**

##### **A. CONCLUSION**

Our investigation of PMI and Anthem has illuminated several troubling and dangerous features of the managed care landscape:

1. There is a stunning absence of safeguards serving to insulate the coverage determination process from the bias of decision makers with a personal financial interest in denying coverage and care. Although managed care may necessarily involve a motivation to deliver care more economically, the present environment is without appropriate patient protections that would prevent the grievous misconduct documented by this Interim Report.

2. Enrollees seeking medical care are extremely vulnerable to exploitation and mistreatment. Ill by definition, these patients are usually unable to advocate effectively for the care they need. Legal protections for patients are weak or non-existent.

3. The lack of effective regulation enables a managed care company to use a carveout subcontractor to ratchet down costs at the same time that the principal company is able to distance itself from knowledge and responsibility for any abuse or patient injury that may result.

4. Inadequate oversight permits a managed care company to "manage by the numbers." PMI permitted arbitrary utilization targets to dominate the actual care needs of

patients. The company chose unreasonably low numbers and then attempted to force utilization to conform to those arbitrary goals.

**B. RECOMMENDATIONS**

1. That the State initiate litigation to ensure that state employees enrolled in managed care plans administered by Anthem and PMI are protected from arbitrary and unfair coverage determinations liable to deny them medically necessary behavioral health services.
2. That the Commissioner of the Connecticut State Department of Public Health initiate proceedings to suspend or revoke the license of Dr. Peter Benet to practice medicine on the grounds of "negligent conduct in the practice of medicine."
3. That the legislature enact a law protecting patients from carveout bias and greed, and ensuring that managed care companies are held accountable for their misdeeds.

<b>I.</b>	<b>EXECUTIVE SUMMARY</b> .....	<b>1</b>
<b>II.</b>	<b>INTRODUCTION</b> .....	<b>6</b>
<b>III.</b>	<b>REPORT</b> .....	<b>7</b>
<b>A.</b>	<b>PETER BENET AND PSYCH MANAGEMENT INC. MISAPPROPRIATED THE ASSETS OF THE NON-PROFIT PSYCHCARE, INC.</b> .....	<b>7</b>
<b>B.</b>	<b>THROUGH STOCK MANIPULATION, PETER BENET CAME TO OWN A DISPROPORTIONATE SHARE OF PSYCH MANAGEMENT, INC.</b> .....	<b>12</b>
<b>C.</b>	<b>IN NEED OF MONEY, PETER BENET PERSUADED PMI TO ISSUE A DIVIDEND IT COULD NOT AFFORD.</b> .....	<b>14</b>
<b>D.</b>	<b>PMI IMPROPERLY WITHHELD PART OF THE REIMBURSEMENT DUE PROVIDERS IN 1998.</b> .....	<b>17</b>
<b>E.</b>	<b>PETER BENET PRESSURED PMI EMPLOYEES TO CUT BACK ON COVERAGE FOR MEDICALLY NECESSARY CARE.</b> .....	<b>20</b>
<b>F.</b>	<b>AT PETER BENET’S DIRECTION, PMI IMPLEMENTED A PRACTICE OF ARBITRARY DENIAL OF MEDICALLY NECESSARY CARE THROUGH THE USE OF COVERAGE “CAPS” AND “GUIDELINES” UNRELATED TO THE ACTUAL CARE NEEDS OF ENROLLEES.</b> .....	<b>23</b>
<b>G.</b>	<b>PMI’S TACTICS HAVE INJURED CONNECTICUT CITIZENS STRUGGLING TO RECOVER FROM SERIOUS ILLNESS.</b> .....	<b>26</b>
	1. Matthew L. was Injured by PMI's Refusal to Pay for Medically Necessary Intensive Outpatient Treatment .....	<b>28</b>
	2. Melissa Fahey was Injured by PMI's Failure to Provide Coverage for Appropriate Psychiatric Hospital Care. ....	<b>30</b>
<b>H.</b>	<b>AT THE SAME TIME THAT HE FORCED DRAMATIC AND HARMFUL CUTBACKS IN COVERAGE AND CARE AVAILABLE TO PATIENTS, PETER BENET SPENT EXTRAVAGANTLY ON LUXURY OFFICE SPACE AND FURNITURE, AUTOMOBILES, LAVISH PARTIES, AND REDUNDANT AND OVER-PRICED NEW EXECUTIVES.</b> .....	<b>33</b>

<b>I.</b>	<b>WITH ITS FINANCIAL CONDITION DEGRADED BY GREED AND MISMANAGEMENT, PMI STOPPED REIMBURSING PROVIDERS FOR SERVICES RENDERED. . . . .</b>	<b>36</b>
1.	PMI Hid Unsent Checks in a "Closet." . . . . .	37
2.	By Misrepresenting That Payment to Providers had Been Made, PMI was Able to Obtain Reimbursement from Anthem Under False Pretenses. . . . .	38
<b>J.</b>	<b>HIS MISCONDUCT EXPOSED, PETER BENET WAS FORCED OUT OF PMI WITH A "GOLDEN HANDSHAKE" FROM ANTHEM. . . . .</b>	<b>39</b>
<b>K.</b>	<b>ANTHEM EITHER KNEW OR SHOULD HAVE KNOWN OF PMI'S MISDEEDS, AND SHARES RESPONSIBILITY FOR THEM. . . . .</b>	<b>41</b>
1.	In An Effort to Improve Its Bottom Line in Anticipation of "Going Public," Anthem Worked Hard to Increase Its Profitability at the Expense of Quality Care. . . . .	42
2.	PMI Underbid Its Contracts with Anthem in an Attempt to Satisfy Anthem's Desire to Increase Its Profitability. . . . .	44
3.	PMI was from the Start a Creature of Anthem's Own Making and Now in Many Ways is a Part of Anthem . . . . .	44
4.	Anthem has Violated Its Contractual Obligations . . . . .	46
<b>L.</b>	<b>PETER BENET HAS BEEN "NEGLIGENT IN THE PRACTICE OF MEDICINE." . . . .</b>	<b>48</b>
<b>M.</b>	<b>PMI'S USE OF ARBITRARY COVERAGE GUIDELINES CONTINUES TO THE PRESENT DAY. . . . .</b>	<b>49</b>
<b>IV.</b>	<b>CONCLUSION AND RECOMMENDATIONS . . . . .</b>	<b>50</b>

## END NOTES

- [1] Pollack at 45-46.
- [2] Beauregard at 53.
- [3] Harbison, at 11.
- [4] Harbison, at 12-15.
- [5] Finn, at 14.
- [6] Harbison, at 21.
- [7] Memorandum from Richard T. Keppelman dated August 20, 1996 to the members of PsychCare, Inc. (emphasis added).
- [8] *Id.*, at 1 (emphasis added).
- [9] *Id.*, at 5.
- [10] *Id.*, at 5.
- [11] *Id.*, at 6 (emphasis added).
- [12] Memorandum from Richard T. Keppelman to Peter Benet and Mark Cesaro, May 14, 1999, at 2 (emphasis added).
- [13] Ruth Statement, at 35.
- [14] Conn. Gen. Stat. Sec. 33-1104(a)(3).
- [15] Conn. Gen. Stat. Sec. 33-1105(a).
- [16] Joint Meeting of the Members and the Board of Directors of PsychCare, Inc., November 23, 1996.
- [17] *Id.*
- [18] Berkley, at 13. [Find additional cite for Claire Benet having 2,500 shares in return].

PMI list of shareholders as of January 31, 1997.

- [20] Behavioral Health Services Agreement between Anthem Blue Cross and Blue Shield of Connecticut and Psych Management, Inc., dated November 21, 1997.
- [21] *Id.* at 12.
- [22] December 19, 1997, letter from Paul J. Maleri to Paul F. Mulkerrin.
- [23] December 31, 1997, Letter from Peter Benet to Psych Management, Inc. shareholders.
- [24] Berkley, at 12.
- [25] Cesaro, at 40.
- [26] Cesaro, at 42.
- [27] Cesaro, at 41 - 44.
- [28] Cesaro, at 56.
- [29] Cesaro, at 57.
- [30] Cesaro, at 58.
- [31] Berkley, at 18.
- [32] Berkley, at 19.
- [33] *Id.*
- [34] Berkley, at 20.
- [35] Letter from Steven Ruth and Richard Berkley, MD, to Peter Benet, April 16, 2001  
(emphasis added).
- [36] Letter from Peter Benet, MD, to PMI shareholders, May 26, 1999.
- [37] Cesaro, at 32.
- [38] *Id.*
- [39] PsychCare, Inc. Participating Provider Agreement (non-facility), Exhibit C-1, Page 10,

to contract between Anthem Blue Cross and Blue Shield of Connecticut and Psych Management, Inc., effective January 1, 1997.

[40] Cesaro, at 51.

[41] Draft of Psych Management, Inc. and PsychCare, Inc. Combined Audited Financial Statements, years ended December 31, 1998 and 1997.

[42] Psych Management, Inc. and PsychCare, Inc. Combined Audited Financial Statements, years ended December 31, 1998 and 1997, at 7.

[43] Minutes, Board of Directors Meeting of Psych Management, Inc., October 28, 1999.

[44] Gizzie, at 28.

[45] Letter from Diana Harbison, MD, to Richard T. Keppleman, October 4, 1999.

[46] Gizzie, at 28.

[47] September 7, 2000 Cover letter from PMI to providers accompanying withhold return.

[48] Pierce, at 17.

[49] Pierce, at 17.

[50] Pierce, at 18.

[51] Pierce, at 30.

[52] Gizzie, at 31.

[53] Pierce, at 50.

[54] Pierce, at 77-78.

[55] Gizzie, at 42.

[56] Pollack, at 33-34.

[57] Pollack, at 31-32.

[58] Pierce, at 58.

- [59] Beauregard, at 25-26.
- [60] Pollack, at 30.
- [61] Pierce, at 59-60; Pollack, at 31.
- [62] Gizzie, at 46-47.
- [63] Beauregard, at 27.
- [64] Pierce, at 79.
- [65] Memorandum from Peter Benet, MD, to PMI Care Managers, July 13, 1999.
- [66] Pierce, at 31.
- [67] Pierce, at 32.
- [68] Memorandum from Peter Benet, MD, to PMI Care Managers, July 13, 1999.
- [69] Pierce, at 37-38.
- [70] Beauregard, at 28 - 29.
- [71] Finn, at 37.
- [72] Gizzie, at 38.
- [73] Gizzie, at 38-39.
- [74] *Id.*
- [75] Pierce, at 27.
- [76] Pierce, at 27.
- [77] Pierce, at 30.
- [78] Izzo, at 54.
- [79] Pollack, at 23.
- [80] Beauregard, at 35-36.
- [81] Moore, at 71.

- [82] Psych Management, Inc. authorized utilization, October 4, 2000.
- [83] Gizzie, at 42.
- [84] Pollack, at 28-29.
- [85] Pierce, at 25.
- [86] Pierce, at 26.
- [87] Pierce, at 70, 95.
- [88] Affidavit of Mary L., September 10, 2001; Affidavit of Leslie Fahey, September 28, 2001.
- [89] Mark Cesaro resigned from PMI effective February 25, 2000 (Cesaro, at 75).
- [90] Ruth, at 15-16.
- [91] Izzo, at 66-68.
- [92] Notations by Donna Moore, October 11, 2000.
- [93] Cesaro, at 80.
- [94] Pollack, at 36.
- [95] Charter Agreement between Deep River Navigation Company, Inc., and Psych Management, Inc., June 12, 2000.
- [96] Letter from Alan J. Sholomskas, MD, June 22, 2000.
- [97] Psych Management, Inc. Fiscal Recovery Plan, October 11, 2000.
- [98] *Id.*
- [99] *Id.*
- [100] D'Ambrose, at 22.
- [101] D'Ambrose, at 33.
- [102] *Id.*

- [103] *Id.*
- [104] DeMars, at 40.
- [105] D'Ambrose, at 36.
- [106] DeMars, at 46.
- [107] Demars, at 45.
- [108] D'Ambrose, at 39.
- [109] Finn, at 49.
- [110] D'Ambrose, at 45.
- [111] D'Ambrose, at 47.
- [112] D'Ambrose, at 31; Finn, at 41-44.
- [113] Berkley, at 29.
- [114] Berkley, at 29-30.
- [115] Berkley, at 38.
- [116] Berkley, at 48.
- [117] Letter from Richard Berkley, MD, to Peter Benet, MD, [date?]
- [118] Promissory Note between Psych Management, Inc., and Peter Benet,  
Lisa Benet and Claire Benet, August 6, 2001.
- [119] Ruth, at 62.
- [120] Draft PMI Audit, May 18, 2001, at Note 1.
- [121] \_\_\_\_\_, at 11. [Name of witness withheld pursuant to Conn. Gen. Stat. § 4-61dd(a)].
- [122] *Id.*
- [123] *Id.*, at 13.
- [124] *Id.*

[125] *Id.*, at 17.

[126] *Id.*, at 21.

[127] *Id.*, at 34.

[128] *Id.*

[129] *Id.*, at 35-36.

[130] *Id.*, at 37-38.

[131] *Id.*, at 37-38.

[132] *Id.*, at 42.

[133] *Id.*, at 44.

[134] *Id.*, at 45.

[135] *Id.*, at 50.

[136] *Id.*, at 51.

[137] Response to Blue Care Request for Information, July 22, 1996, at Section J.10

Financial -- Page 3.

[138] *Id.*

[139] Ruth, at 41.

[140] Berkley, at 16.

[141] Cesaro, at 8.

[142] *Id.*, at 11.

[143] Cesaro, at 24.

[144] *Id.*

[145] *Id.*

[146] DeMars, at 14.

- [147] *Id.*, at 20.
- [148] DeMars, at 16.
- [149] *Id.*, at 14.
- [150] *Id.*, at 11.
- [151] Berkley, at 28-30.
- [152] Berkley, at 41.
- [153] Berkley, at 43.
- [154] Consent and Security Agreement, November 3, 2000.
- [155] Ruth, at 57-58.
- [156] Moore, at 72.
- [157] BlueCare Subscriber Agreement, at 33.
- [158] *Id.*, at 10.
- [159] *Id.*, at 10.
- [160] July 13, 1999 memo to PMI Care Managers from Peter Benet, MD.
- [161] Conn. Gen. Stat. 20-13c(4).
- [162] *State Board of Registration for the Healing Arts, v. Richard Fallon, MD*,  
41 S.W. 3d 474, 476 (S.Ct.Mo. 2001); *John F. Murphy, MD v. The Board of Medical  
Examiners of the State of Arizona*, 190 Ariz. 441, 447 (1997); *Kirshner v. Mills*,  
274 A.D. 2d 786, 788 (2000).
- [163] *Id.*
- [164] *Edwards v. Tardif*, 240 Conn. 610, 614 (1997).
- [165] Anthem Audit Summary [check Moore examination for details].
- [166] Psych Management, Inc. Fiscal Recovery Plan, October 11, 2000, at 3.
- "Editor's note: Peter Benet's attorneys have written to dispute our conclusion that they invoked the fifth amendment on Dr. Benet's behalf."