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PEOPLE OF THE STATE OF CALIFORNIA

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF SAN DIEGO
UNLIMITED JURISDICTION- CENTRAL DIVISION

People of the State of California, acting by and through Mara W. Elliot, City Attorney of San Diego, Plaintiff, v. Health Net LLC, Health Net of California, Inc., Health Net Community Solutions, Inc., California Health and Wellness Plan, and Does 1 Through 20, Defendants.	Case No. **Complaint**

The People of the State of California (the "People"), acting by and through San Diego City Attorney Mara W. Elliott, hereby allege as follows:

INTRODUCTION

1. State and federal laws require insurance companies to publish complete, accurate and up-to-date directories that list the plan's in-network providers and their contact information.

2. Despite these clear legal mandates, some health insurance companies continue to advertise and publish highly inaccurate directories. These false listings create formidable, dangerous, and unlawful barriers to patient care, harming public health and American health insurance markets. Their directories list providers who are not in network, not accepting appointments, retired, not practicing the listed specialty, or include incorrect address or contact information. Especially for older consumers, and those with limited internet access or literacy, when provider directories include wrong addresses and contact information, this often presents an insurmountable barrier to care. The federal Centers for Medicare & Medicaid Services ("CMS") has identified address, phone number, specialty, and network inaccuracies as inaccuracies "with the highest likelihood of preventing consumers' access to care."[1]

3. Defendants Health Net, LLC ("Health Net, LLC"), Health Net of California, Inc. ("Health Net"), Health Net Community Solutions, Inc. (Health Net CS"), and California Health and Wellness ("Health and Wellness") (collectively "Defendants") are all wholly owned subsidiaries of Centene Corporation, a Fortune 50 company. Combined, Defendants have over 2.3 million individuals enrolled in their health plans statewide and are among the worst actors in California when it comes to the inaccuracy of their provider network directories. In the latest year data is available, 2019, Health Net had an overall directory inaccuracy rate of 18.13 percent, with **inaccuracy rates of 35.07 percent for psychiatrists**. Health Net CS had an overall inaccuracy rate of 12.65 percent, with **inaccuracy rate of 26.44**

[1] Centers for Medicare and Medicaid Services, *Online Provider Directory Review Report* 5 (Jan. 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

percent for psychiatrists. Health and Wellness had an overall inaccuracy rate of 24.4 percent with an **inaccuracy rate of 49.55 percent for psychiatrists.** This is unfair to consumers and unlawful.

4. These inaccurate directories, known as "ghost networks," falsely describe the breadth of an insurer's provider network, promising consumers access to health care that, in reality, is unavailable under the plan. Californians who buy health insurance from plans with ghost networks rely on directories advertising robust provider networks, only to realize those networks are illusory when they try to use them. These consumers are left exasperated by fruitless hours spent trying to find an in-network provider taking new patients and are haunted by out-of-network provider charges. Some consumers will delay care or even forgo care entirely because of ghost networks, harming not only those consumers but also the broader public health.

5. Complaints concerning Defendants' inaccurate provider directories abound:

> Sam V. complained to the San Diego Office of the Better Business Bureau, "I made a huge mistake by changing my health insurance from blue shield to health net[.. . . **I just wanna let people know this company is there to just take your money and they don't give you anything in return I hope that BBB can do something regarding these scammers that play with people's life**. (emphasis added)
>
> Tom R. in San Diego, CA wrote on Yelp: "Consistently, the worst insurance experiences I've ever had. ….. **The list of approved providers on the health net website (under my plan) are incorrect. I cannot wait to change insurance companies."** (emphasis added).
>
> Justin S. in Los Angeles put it succinctly on Yelp: "Horrible. Denied by every place they've sent me to. Unreal wait times and customer service. Terrible."

6. Directory inaccuracies also distort health insurance markets. Insurance companies that invest the resources to maintain accurate provider directories are disadvantaged in marketing their plans to consumers when their competitors, like Defendants, do not invest resources to maintain accuracy and misrepresent their provider networks as broader and deeper than they are.

7. In addition, insurers with ghost directories drive higher-needs consumers out of their insurance plans, in what is effectively an end-run around protections for those with pre-existing conditions or greater needs. Consumers with greater health care needs are more likely to seek health care, discover directory errors, and be forced to spend significant time searching for covered, in-network providers.

8. The Defendants' grossly inaccurate provider directories harm enrollees' personal health, as well as their wallets, while unlawfully and unfairly enabling Defendants to shed more costly enrollees to the detriment of their market competitors.

PARTIES

9. The People of the State of California, by and through San Diego City Mara W. Elliott, prosecute this action pursuant to the Unfair Competition Law and the False Advertising Law ("FAL"), Business and Professions Code §§ 17204, 17206, 17535, and 17536.

10. Defendant Health Net, LLC ("Health Net LLC") is a California corporation with its headquarters in Los Angeles, California and is a wholly owned subsidiary of Centene.

11. Through its subsidiaries, Health Net LLC sells health insurance in the State of California, including over 94,000 enrollees in San Diego County.

12. Defendant Health Net of California, Inc. ("Health Net") is a wholly owned subsidiary of Defendant Health Net LLC and is a California corporation with its headquarters in Woodland Hills, California.

13. Health Net sells health insurance in the State of California with 23,557 enrollees in San Diego County.

14. Health Net sells individual plans through Covered California, it provides insurance to Medicaid eligible consumers through Medi-Cal, and it contracts with employers to offer group employee benefit plans.

15. In 2020, Health Net reported revenue of over $10 billion.

16. Defendant Health Net Community Solutions, Inc. ("Health Net CS") is a California corporation and a wholly owned subsidiary of Defendant Health Net LLC. It is headquartered in Los Angeles, California.

17. Health Net CS sells health insurance in the State of California, with 70,349 enrollees in San Diego County.

18. Health Net CS sells individual plans through Covered California, it provides insurance to Medicaid eligible consumers through Medi-Cal, and it contracts with employers to offer group employee benefit plans.

19. In 2020, Health Net CS reported revenue of over $7.6 billion.

20. Defendant California Health and Wellness Plan ("Health and Wellness") is a wholly owned subsidiary of Centene Corporation and a California corporation.

21. Health and Wellness sells health insurance in the State of California, with 192 enrollees in San Diego County.

22. Health and Wellness sells individual plans through Covered California; it provides insurance to Medicaid eligible consumers through Medi-Cal; and it contracts with employers to offer group employee benefit plans.

23. In 2020, Health and Wellness reported revenue of over $860 million.

24. The true names or capacities of defendants sued as Doe Defendants 1-20 are unknown to the People. The People are informed and believe, and on this basis allege, that each of the Doe Defendants are legally responsible for the conduct alleged herein. The People will seek leave of court to amend this Complaint to allege such names and capacities as soon as they are ascertained.

25. The People are informed and believe that all of the acts and omissions described in this Complaint by any Defendant were duly performed by, and attributable to, all Defendants, each acting as agent, employee, alter ego, and/or under the direction and control of the others, and such acts and omissions were within the scope of such agency, employment, alter ego, direction, and/or control.

26. Additionally, or in the alternative, each Defendant has aided and abetted all other Defendants in violating the letter of and the public policy embodied in the laws set forth in this Complaint.

JURISDICTION & VENUE

27. The Superior Court has original jurisdiction over this action pursuant to Article VI, section 10 of the California Constitution.

28. The Superior Court has personal jurisdiction over Defendants because:

a. Defendants Heath Net LLC and Health Net CS are domestic corporations, headquartered in Los Angeles, California;

b. Defendant Health Net is a domestic corporation headquartered in Woodland Hills, California.

c. Defendant Health and Wellness is a domestic corporation;

d. Defendants conduct business across the State of California; and

e. Defendants otherwise have sufficient minimum contacts with and purposely avail themselves of the markets of the State.

29. Venue is proper under California Code of Civil Procedure section 393(a) because thousands of the illegal and unfair acts pled in this Complaint occurred in the City and County of San Diego. Defendants conduct a significant portion of their business in San Diego County, where they provide health insurance to over 94,098 enrollees.

FACTUAL BACKGROUND

The Role of Provider Directories in the Health Insurance Market

30. Provider directories are a prime advertising and recruitment mechanism for health care insurance providers to enroll new enrollees and increase market share. At their core, provider directories represent to consumers what they are purchasing when they choose a particular health insurance plan. It is important to consumers that they be able to easily seek—and easily find—in-network coverage and that they be able to accurately determine

whether their preferred primary care physicians, specialists, psychiatrists, and pediatricians will be covered by the plan they purchase.

31. Both state and federal law recognize the importance of these directories by requiring companies selling health insurance to make accurate provider directories available to the public and enrollees/consumers, both in hard copy (upon request) and online, regardless of whether they have purchased an insurance plan.

32. Consumers therefore review provider directories to determine whether their doctors will be in-network under a particular plan offering, as well as to determine how many in-network primary care physicians, mental health providers, specialists, and hospitals will be available within their geographic area. Consumers compare the costs of the plan offerings and the in-network provider coverage knowing that having to obtain health care out-of-network will vastly increase their health care costs.

33. Industry, government, and academic studies demonstrate that plan cost and provider network are top considerations for consumers when choosing a health plan, and, further, that consumers rely on provider directories to choose their plans. A 2016 Rand Corporation research report evaluating how consumers choose health plans found that consumers highly value having their doctor in their network when picking a health plan. Further illustrating the importance of accurate directories, a 2020 study concerning patient preferences for provider choice found that consumers are willing to pay substantially higher monthly premiums for both having their doctor in network and for broader access to doctors in their area.[2]

[2] Eline M. van den Broek-Altenburg, PhD, Adam J. Atherly, PhD, *Patient Preferences for Provider Choice: A Discrete Choice Experiment*, 26(7) AM. J. MANAGED CARE 219-224 (July 2020). This study found that patients were willing to pay $95 more per month to have their preferred provider in network and willing to pay $72 more per month for a health insurance plan that covered 30 percent more doctors in their area.

34. The California Department of Health Care Services, ("DHCS"), which runs Medi-Cal, notes that some consumers rely "exclusively" on provider directories to choose a plan.[3]

35. In March 2019, the California State Auditor issued a report, *Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*. The Auditor concluded, "[p]rovider directories are one of the primary means by which beneficiaries can find health care providers," and that inaccurate directories function as barriers to care.[4]

36. Consumers' reliance on provider directories is in keeping with state agencies' own advice. Covered California, the agency that runs the California ACA marketplace, strongly urges consumers to use provider directories and networks when choosing a health plan. Covered California includes provider networks among the "five key points to consider" when picking a health plan, explaining, "[t]he larger the provider network, the more choices you'll have."[5] Additionally, its shop and compare tool has a required question allowing consumers to filter out plans that do not include their doctors and links directly to plans' directories. DHCS also urges Medi-Cal consumers to "look at . . . provider directories" when choosing a plan, and its plan comparison tool—like Covered California's—links directly to plans' directories.[6]

California Law Requires Health Insurers to Provide Accurate Directories

37. California law requires that insurers provide up-to-date, accurate, and complete provider directories including the following information: the providers' (a) location, (b) contact information, (c) specialty, (d) medical group, (e) any institutional affiliation; and (f) which providers are accepting new patients. (Cal. Health & Safety Code § 1367.27.)

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[3] California State Auditor, *Department of Health Care Services—Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*, Rep. No. 2018–111, at 39 (Mar. 2019).

[4] *Id.* at 38.

[5] Covered California, *5 Things to Consider When Shopping for Health Insurance* (Oct. 1, 2020), https://www.coveredca.com/marketing-blog/5-things-to-consider-when-shopping-for-health-insurance/.

[6] Department of Health Care Services, *Tips to Help You Choose a Medical Plan,* https://www.healthcareoptions.dhcs.ca.gov/choose/tips-help-you-choose-medical-plan.

38. Additionally, inclusion of this information in a provider directory is a representation by the health plan to enrollees and potential enrollees that the provider is in-network. Accurate provider directories inform consumers which providers participate in which plans and provider networks. California law explicitly prohibits a provider directory from listing or including information on a provider that is not currently under contract with the plan. (*Id.* § 1367.27(e)(2).)

39. Because of the importance of this information being provided in an up-to-date, accurate, and complete manner, the State of California has set forth explicit statutory requirements for provider directory updates. A health insurance plan must update its printed provider directories at least quarterly. (*Id.* § 1367.27(d)(2).) It also must update its online provider directories at least weekly, when informed of any inaccuracies in information about a provider included in the provider directory. (*Id.* § 1367.27(e).) Additionally, it must prominently include contact information for providers and members of the public to report inaccuracies in the provider directory. (*Id.* § 1367.27(f).)

40. Health insurance plans are also obligated to "review and update the entire provider directory or directories for each product offered," (*id.* § 1367.27(l)), at least annually, including an affirmative obligation by the plan to confirm with providers and provider groups that the information set forth in the provider directories is up-to-date, accurate, and complete. The results of these full directory reviews are not publicly disclosed.

41. Regulation of health insurance in California is split among three agencies, the California Department of Managed Health Care ("DMHC"), the DHCS, and the Department of Insurance ("DOI").

42. DMHC licenses and oversees Health Maintenance Organizations ("HMOs"), including the state's Medicaid Managed Care Organizations ("Medicaid MCOs"). Sixty-seven percent of Californians are enrolled in DMHC-regulated plans.

43. DMHC also licenses plans under Medi-Cal, the state Medicaid program that insures 30 percent of Californians. Medi-Cal plans are also overseen by DHCS.

44. All plans not licensed by DMHC are licensed by DOI. Three percent of Californians are enrolled in DOI-licensed plans.

45. State law requires all plans regulated by DMHC and DHCS to submit an annual Timely Access ("TAS") to their respective regulating agency. Cal. Health & Safety Code § 1367.035.

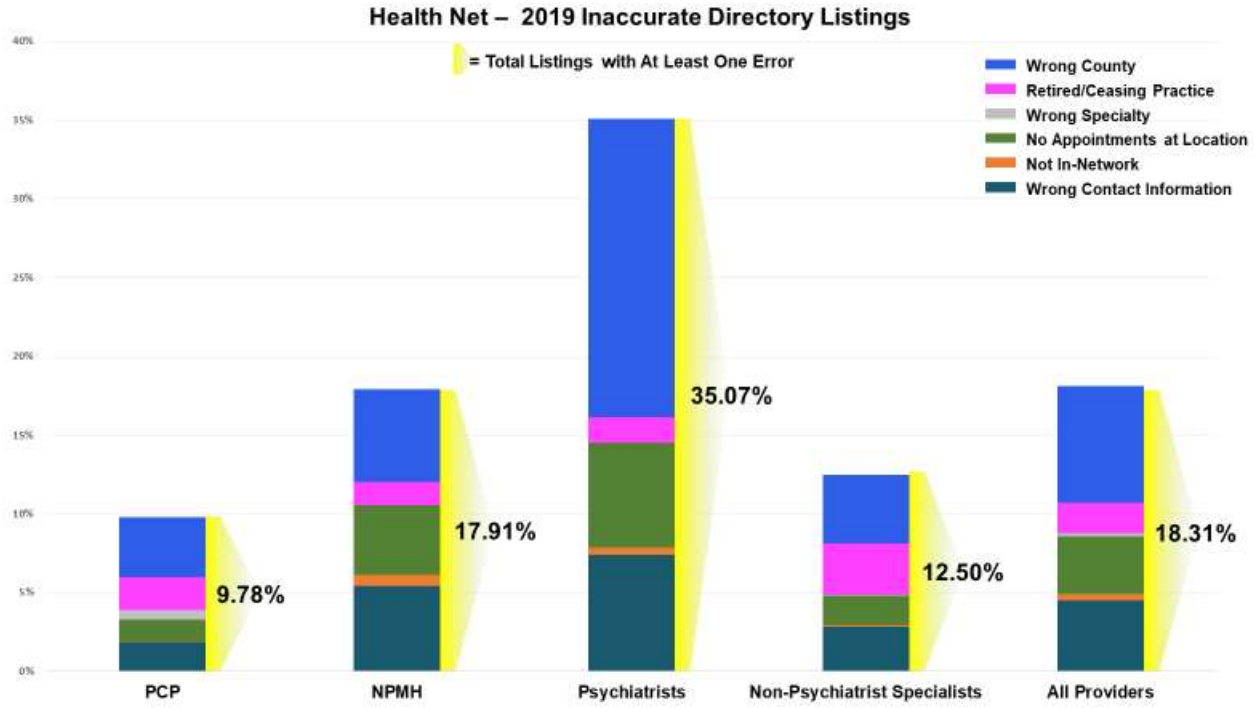
46. The TAS is a survey in which providers report on the maximum wait times for enrollees to obtain an appointment with a specific provider in certain categories: primary care practitioners, certain specialists, psychiatrists, and non-physician mental health care providers ("NMHPs").

47. In conducting the TAS, DMHC plans must generate a provider contact list from their December provider directory in the year preceding the survey. During the period April 1st through December 31st of each survey year, the plans must survey either the entirety of the provider contact list or a random statistically significant sample that has been generated according to specifications in DMHC's guidance document, *Provider Appointment Availability Survey Methodology*. For example, for its 2021 TAS, a health care plan would survey its providers using a contact list generated from its December 2020 provider directory.

48. Providers are only eligible for the TAS if they are in-network, are currently practicing their listed specialty in their listed county, are taking appointments with enrollees, and have correct contact information. While DMHC only uses this data to compile reports concerning insurers' compliance with California timely access standards, the TAS also functions as a provider directory accuracy survey. In addition to the final TAS results, insurers must submit to DMHC the raw survey data. The raw data lists all providers surveyed, including those that were "ineligible" for the survey as well as the reason for their ineligibility: their county was incorrect, their contact information was incorrect, their specialty was incorrect, they do not take appointments at that location or at all, they are not actually in-network, or they are no longer practicing.

Defendants' Own Data Reports Prove Their Provider Listings Are Inaccurate and that They Fail to Correct Known Errors

49. Defendants' provider directories for their California plans are grossly inaccurate. For 2019, according to the raw TAS survey data submitted to DMHC, Health Net's December 2019 directory had an overall error rate of 18.13 percent and a staggering 35.07 percent error rate for psychiatrists listed in its directories.[7] The following chart presents Health Net's inaccuracy rates in 2019[8]:



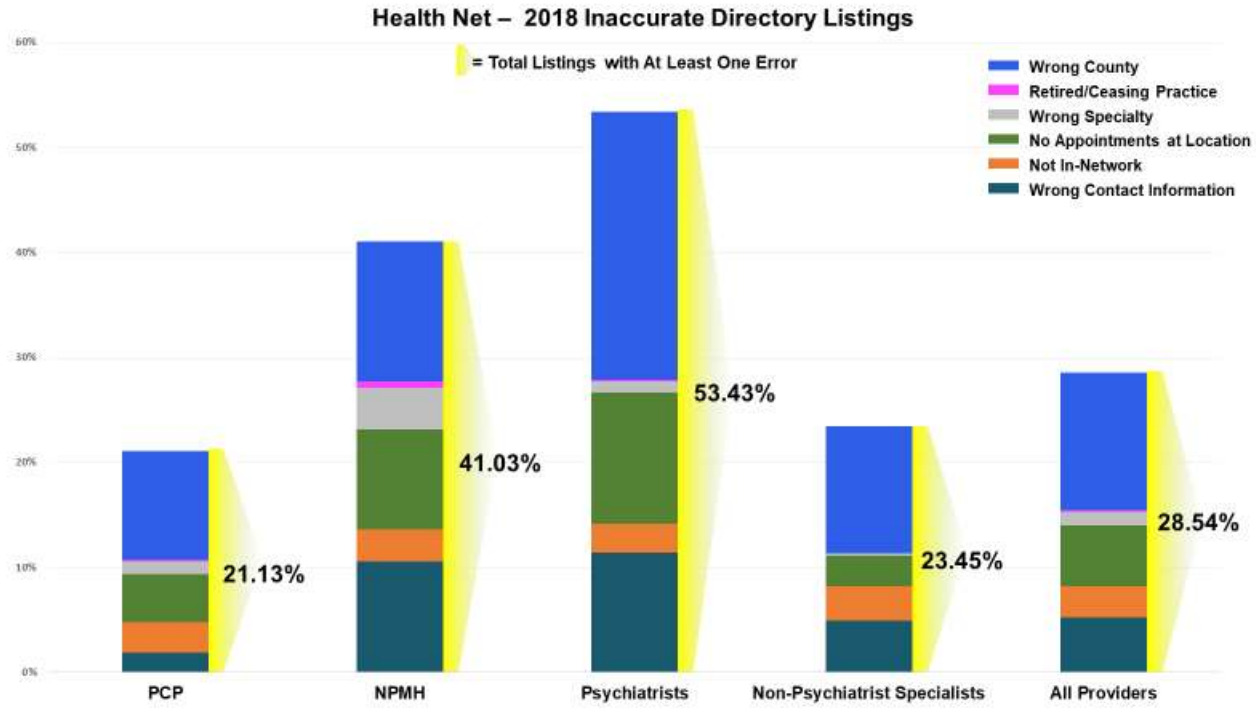
50. This data shows that, in 2019, a Health Net enrollee looking for a psychiatrist would have encountered an inaccurate listing more than one in three attempts. Further, if seeking behavioral health care from a NPMH, that enrollee would encounter an additional

[7] In the TAS, each location where a provider practices, and each plan in which a provider participates is a separate listing, a division that reflects the perspective of enrollees trying to find care.

[8] Throughout this Complaint, unless otherwise stated, inaccuracy rates were calculated by calculating the number of TAS responses that recorded an ineligible response (and/or the specific ineligible set forth in the chart) reflecting a directory error divided by the total number of responses received (eligible and ineligible). Survey results that recorded "refused" were excluded for purposes of this calculation, but as a result inaccuracy rates may be understated.

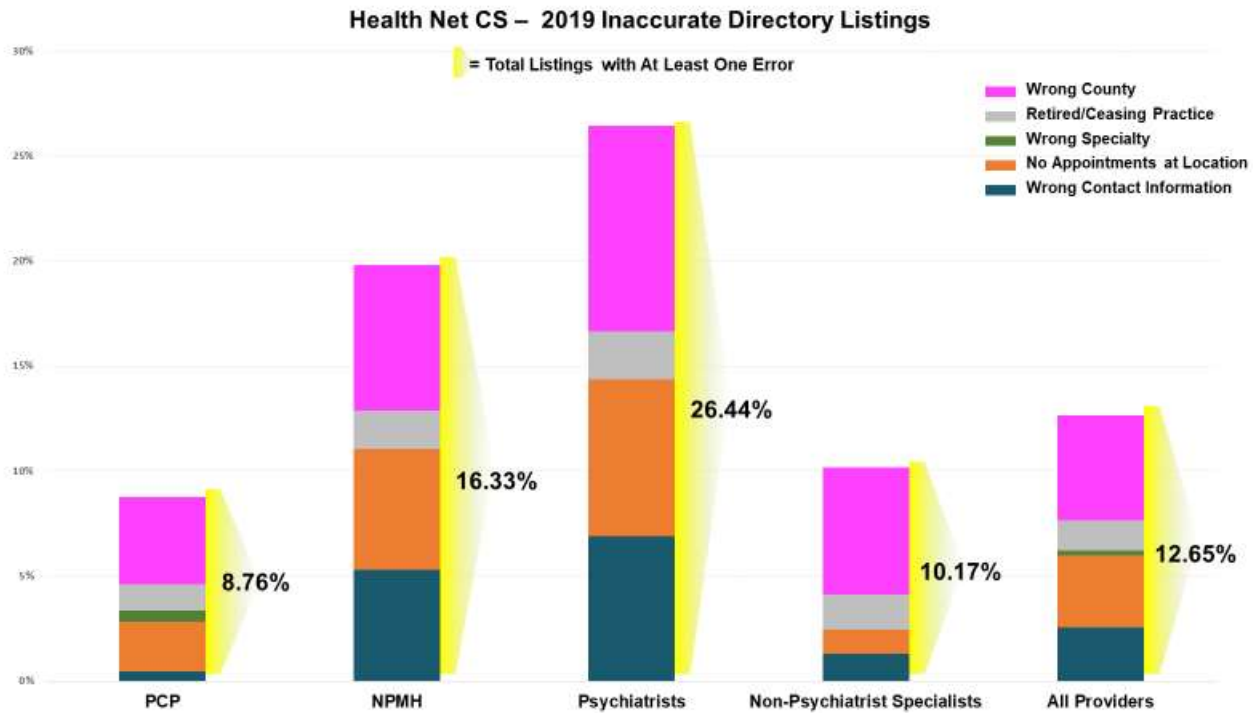
almost 18 percent chance of encountering inaccurate listings. Health Net's listings for provider directories were rife with entries for providers who were listed as located in the wrong county or otherwise inaccurate contact information and 6.64 percent were not taking appointments at all. A Health Net enrollee trying to find a non-psychiatrist specialist would hit an inaccuracy 12.5 percent of their attempts.

51. Health Net's 2018 error rates were even worse. The overall directory error rate was 28.54 percent, with a 53.43 percent error rate for psychiatrists. The following chart presents Health Net's reported reasons why each erroneous listing was inaccurate:

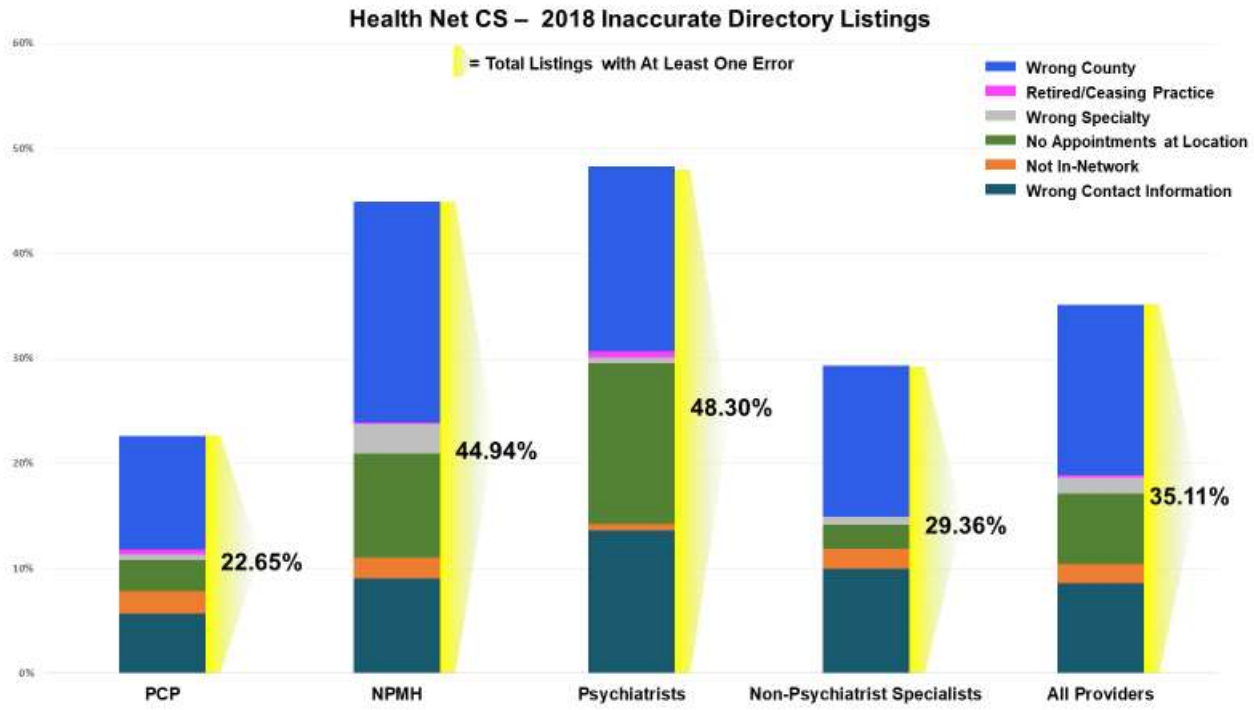


52. In 2018, a Health Net enrollee trying to secure behavioral health care would have had an over 50 percent likelihood of hitting an inaccurate directory listing for a psychiatrist and over 40 percent for an NPMH. Almost 13 percent of listings for psychiatrists and 6 percent of NPMH were not accepting appointments. Other specialist listings were also highly inaccurate with almost a quarter of the listings incorrect. Over 20 percent of primary care provider listings were wrong, with 10 percent listed in the wrong county and 4.6 percent not taking appointments.

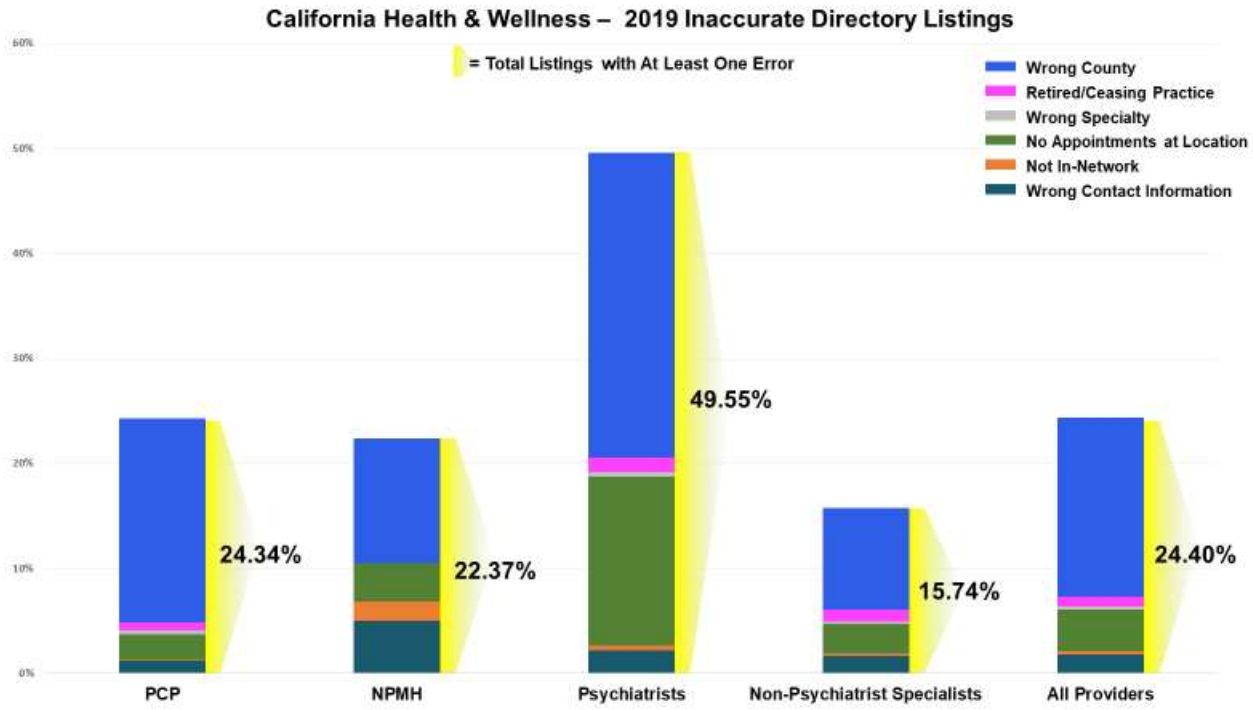
53. Health Net CS submissions also reveal high error rates. For 2019, Health Net CS reported an overall error rate of 12.65 percent. Psychiatrist listings were 26.44 percent inaccurate and NPMH listings were 16.33 percent inaccurate. Almost 10 percent of psychiatrists were listed in the wrong county, and another 7.47 percent were not scheduling appointments. Almost 6 percent of NPMHs listed were not scheduling appointments. The error rate for non-psychiatrist specialists was 14.18 percent.



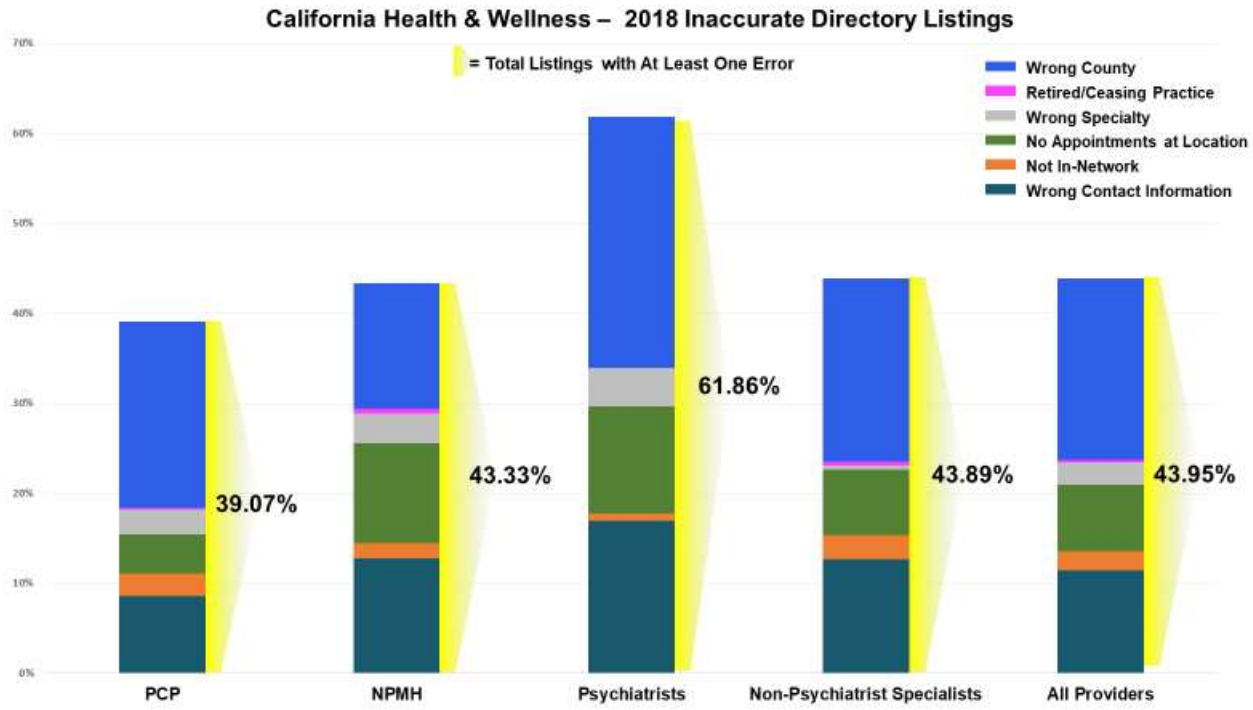
54. Health Net CS's 2018 accuracy rates were also abysmal. The overall error rate was 35.11 percent, with an astonishing 48.30 percent error rate for psychiatrists, and a 44.94 percent error rate for NPMHs. 15.34 percent of psychiatrists listed were not making appointments and another 9.87 percent of NPMH providers were not making appointments. Twenty-one percent of NPMHs were listed in the wrong county, and 17.61 percent of psychiatrists were listed in the wrong county, and another 13.64 percent had otherwise incorrect contact information listed. The following chart presents Health Net CS's reported reasons why each erroneous listing was inaccurate:



55. Health and Wellness' submissions also reveal high error rates. For 2019, Health and Wellness reported an overall error rate of 24.4 percent. Psychiatrist listings were 49.55 percent inaccurate, and NPMH listings were 22.37 percent inaccurate. Over 16 percent of psychiatrists were not making appointments and almost 30 percent were listed in the wrong county. Other specialist listings were almost 44 percent inaccurate, and primary care provider listings were almost 39 percent inaccurate with over 20 percent listed in the wrong county.



56. Health and Wellness' 2018 accuracy rates were worse than its 2019 error rates. The overall error rate was 43.95 percent, with an astonishing 61.86 percent error rate for psychiatrists, and 43.33 percent error rate for NPMH. Almost 12 percent of psychiatrists listed were not making appointments and another 11 percent of NPMH providers were not making appointments. Almost 28 percent of psychiatrists were listed in the wrong county, and another almost 17 percent had other contact information wrong. Almost 14 percent of NPMH were listed in the wrong county. Primary care provider listings were almost 40 percent inaccurate. The following chart presents Health and Wellness reported reasons why each erroneous listing was inaccurate in 2018:



57. Indeed, the DMHC data shows that Defendants repeatedly and consistently failed to correct inaccurate directory data after learning of its inaccuracy through their TAS data collection. For example, of the 332 psychiatrist specialists surveyed by Health Net and deemed ineligible in connection with the 2018 TAS (because either their contact or specialty information was wrong or the provider was not in-network or was retiring) who were also surveyed in 2019, ***over 45 percent*** (specifically 151 psychiatrists) remained ineligible. Meaning that even though the insurer learned in its 2018 survey that these provider listings were erroneous, Health Net continued to list them as available to provide care to Health Net's enrollees and potential enrollees in the succeeding year.

58. Likewise, of the 406 unique non-physician mental health providers Health Net surveyed and deemed ineligible in the 2018 TAS, who were surveyed in Health Net's 2019 TAS, ***over 33 percent*** (specifically 134) remained ineligible the following year. While the failures are most stark with regard to psychiatrist and mental health service providers, Health Net's year-over-year inaccuracies are reflected across all practice areas.

59. The other Health Net LLC subsidiaries were plagued with similar issues. For example, of the 36 primary care physicians with unique National Provider Identifiers ("NPIs") that recorded at least one inaccurate directory listing in the Health Net CS survey for 2018 that were surveyed again in 2019, ***25 percent*** remained in Health Net CS's provider directory with incorrect information for the plan's 2019 TAS.

60. Finally, for Health and Wellness, of the 55 non-psychiatrist specialists, surveyed and deemed ineligible in the 2018 TAS who were also surveyed in 2019, ***more than 36 percent*** (specifically 20 non-psychiatrist specialists) remained ineligible. Strikingly, of the 20 psychiatrists who were surveyed and deemed ineligible in connection with Health and Wellness' 2018 TAS, nearly ***50 percent*** (nine) remained ineligible in the 2019 TAS.

61. Defendants do not correct their directories using their own data, and they also fail to prominently include contact information so that consumers can report directory inaccuracies. Indeed, they do not provide any on-line contact to report directory errors at all.

62. The conclusion is inescapable: Defendants persist in publishing and advertising provider information that they know to be false and misleading.

Defendants' Unlawful, Unfair, and Fraudulent Conduct Harms Consumers

63. Defendants' directory inaccuracies are not mere technicalities. Rather, they are serious errors with real consequences for consumers' economic well-being, patients' medical conditions, and public health. Recognizing directory inaccuracies to impose "the highest likelihood of preventing access to care."[9] CMS noted that "[d]irectories that include locations where a provider does not practice or state that providers are accepting new patients when they are not call into question the adequacy and validity of the MAO's [(Medicare Advantage Organization's)] network as a whole. These inaccuracies can create barriers for members to receive services critical for their health and well-being."[10] Contact information errors can also

[9] Centers for Medicare and Medicaid Services, *Online Provider Directory Review Report* 5 (Jan. 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

[10] *Id.* at 6.

seriously obstruct consumers' access to care because they "prevent plan members from contacting the provider; therefore, the member cannot make an appointment even if the provider is at that location, in the network, and accepting new patients."[11]

64. Compounding the harm to consumers in ACA and employer plans is the fact that once a health plan is selected and purchased, the consumer is nearly always stuck with that plan until the following year's open enrollment period, or until a qualifying event, such as getting married or losing a job, allows them to change plans. As a result, enrollees are stuck with limited access to in-network care, may be required to pay out-of-pocket for the preferred care they thought was covered, or may even forego care entirely for that entire period. Consumers report paying out-of-pocket both because they cannot find in-network care or because they relied on directories stating that care they sought was in-network, only to be hit with big bills for out-of-network care.

Defendants' Ghost Networks Disproportionately Harm Vulnerable Populations

65. For low-income consumers, receiving an unexpected medical bill or having to pay out-of-pocket to see a provider because they cannot find one that accepts their insurance or because a provider was listed as in network, but was not actually covered under their insurance plans, can be catastrophic. Alarmingly, 40 percent of Americans would be unable to pay an unexpected $400 bill without going into debt.[12] Some report forgoing food and necessary health care and medications to afford health care bills.[13]

66. Enrollees in Affordable Care Act exchange plans are disproportionately low-income. Nationally in 2020, 87 percent of the 8.3 million individuals who purchased exchange plans received government subsidies based on income eligibility. As of August 2020, Covered California reported that 88 percent of individuals who purchased plans through its individual

[11] *Id.* at 7.

[12] Division of Consumer and Community Affairs, *Economic Well-Being of U.S. Households in 2020* 88 (May 2020), https://www.federalreserve.gov/publications/files/2020-report-economic-well-being-us-households-202105.pdf.

[13] L. Hamel et al., *Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored Insurance*, 2 KAISER FAMILY FOUNDATION (May 2019), https://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance.

health insurance marketplace received government subsidies.[14] Forty-eight percent of those receiving those subsidies were either Asian or Hispanic-American (21.9 percent and 26.6 percent, respectively). An additional 2.2 percent of enrollees in Covered California plans who received government subsidies were African American, and 2.4 percent reported as nonwhite, mixed race.

67. The financial dangers of Defendants' inaccurate directories are particularly acute for people of color in the United States, especially Black and Hispanic families, who on average have significantly less wealth than White families.[15] According to a 2017 study by the Urban Institute, Black Americans are 2.6 times more likely to have a medical debt than their White counterparts.[16] A 2018 study by the University of Chicago revealed that both Black and Hispanic Americans are significantly more likely to have a medical debt sent to collections than White Americans (44 percent and 37 percent, respectively, versus 22 percent for White Americans).[17]

68. Ghost networks also disproportionately affect Americans with disabilities, who, on average, have less household wealth than Americans without disabilities, making them less able to absorb unexpected medical costs.[18] Adults with disabilities are more than twice as likely

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[14] Press Release, California's Efforts to Build on the Affordable Care Act Lead to a Record-Low Rate Change for the Second Consecutive Year, Aug. 4, 2020, *at* https://www.coveredca.com/newsroom/news-releases/2020/08/04/californias-efforts-to-build-on-the-affordable-care-act-lead-to-a-record-low-rate-change-for-the-second-consecutive-year/.

[15] Neil Bhutta et al., *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances*, THE FEDERAL RESERVE BOARD OF GOVERNORS IN WASHINGTON D.C., https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm.

[16] Signe-Mary McKernan et al., *Past-Due Medical Debt a Problem, Especially for Black Americans*, URBAN INSTITUTE (Mar. 27, 2017), https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans.

[17] Jennifer Benz et al., *Americans' Views of Healthcare Costs, Coverage, and Policy*, NORC AT THE UNIVERSITY OF CHICAGO 6 (2018), https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf.

[18] Nanette Goodman et al., *Financial Capability of Adults with Disabilities* (National Disability Institute 2017), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/01/ndi-finra-report-2017.pdf.

than adults without disabilities to report skipping or delaying health care because of the cost.[19] Older adults and adults with disabilities are also more likely to experience poor health and use health care at high rates.[20]

69. There is also a heightened impact on people seeking behavioral and mental health care, a specialty where directory errors are particularly pervasive and frequently drive people to seek costly out-of-network care or abandon their search and forgo health care entirely. A study conducted by public health researchers showed that people seeking behavioral health care who encounter directory errors are twice as likely to end up obtaining care from an out-of-network provider, often because they cannot access an in-network provider.[21]

70. Lastly, women disproportionately bear the burden of ghost networks, because they are more likely to perform unpaid care work for others. Women are twice as likely as men to act as caregivers for their parents and are also more likely to be informal caregivers for people with mental illnesses. Directory errors add to these women's already heavy caregiving tasks, forcing them to spend hours on the phone calling through provider lists seeking care.

Defendants Benefit Financially From Their Inaccurate Directories

71. Defendants financially benefit from their provider directory inaccuracies in at least three ways.

72. *First*, because a significant portion of Defendants' directory listings are erroneous, Defendants' provider networks appear to be broader and more attractive to potential enrollees than they are. Defendants financially benefit from this because enrollees

[19] Gloria L. Krahn et al., *Persons With Disabilities as an Unrecognized Health Disparity Population*, 105 Am J Public Health S198 (Apr. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/.

[20] Mary Lou Breslin & Silvia Yee, *The Current State of Health Care for People with Disabilities.* (2009), https://www.ncd.gov/publications/2009/Sept302009#.

[21] Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills: An Examination of the Role Inaccurate Provider Directories Play in out-of-Network Mental Health Treatment and Surprise Bills.*, 39 HEALTH AFFAIRS 975 (2020), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01501.

pay more for access to this illusory broader network than they would have paid for the actual narrower network, providing Defendants with unjust windfalls.

73. *Second*, Defendants financially benefit by having inaccurate directories, because those enrollees who seek to take advantage of their health insurance to obtain health care services are stymied in their attempts to find in-network providers. Because of the pervasive nature of Defendants' provider directory inaccuracies, obtaining care as an insured of a Defendant entails many failed attempts to contact providers and schedule appointments. Ultimately, enrollees faced with this harm may abandon their efforts to obtain care altogether or they might obtain out-of-network care, because they are unable to find a doctor in network and reasonably accessible that has available appointments, saving Defendants the costs associated with coverage. Enrollees with significant health care needs may elect to abandon Defendants at the next opportunity and purchase better, more accurate insurance coverage. In this way, Defendants benefit financially by forcing out enrollees who are more expensive to insure and by forcing enrollees to obtain out-of-network care while they are insured by Defendants' plans, because they are unable to find suitable providers in network.

74. *Third*, the Defendants save on the labor costs associated with auditing and updating their directories.

75. Additionally, by making their provider networks appear significantly larger than they are, Defendants trick consumers into significantly overvaluing their coverage. Network breadth is vital to consumers' valuation of plans: a study of Covered California enrollees found that they were willing to pay substantially more per month to have access to a broad network of doctors. In turn, plans with smaller networks are worth less to consumers. But rather than price their products according to their true network, Defendants promise and charge enrollees for far more care than they will be able to access. Every provider who is not actually in-network, who is not actually taking appointments, or who has a wrong address or contact information listed, represents coverage that Defendants' enrollees paid for but never received. Further, even when Defendants' enrollees are technically able to access in-network

care, that care may be located far from their homes or work, which adds another set of barriers for those who lack access to regular transportation or who may have to take time off work to travel to a distant provider.

76. Network size and premium price are particularly important in California because the state mandates standard benefits packages for all plans. The only characteristics that plans compete on—and consumers can base their choice between plans on—are thus premium cost and network breadth.

77. Defendants know their provider directories are inaccurate. In addition to their data demonstrating inaccuracies, DMHC fined Health Net in 2019 for "surreptiously" including out-of-network providers in its directory. In 2014, Health Net was sued by enrollees for misrepresenting the extent of its plan's networks. Similarly, in 2017, Washington State fined the state's Centene subsidiary, Health Net LLC of Washington, $1.5 million following consumer complaints about inadequate networks, including inaccurate directories. Centene's Washington subsidiary was also sued by enrollees who allege that the companies' directories misrepresented the extent of the plan's actual network. And in in 2019, Centene's Oregon subsidiary was sued by a hospital system for repeatedly falsely stating that the system was in Centene's network. Despite this plethora of warnings about their own failures to provide accurate provider directories to consumers and those of its sister insurers, Defendants' provider directories targeted to California consumers are replete with persistent, glaring errors.

78. Consumer complaints concerning Defendants' misleading and faulty provider directories are common and legion:

> Conchita D. in Berkeley, CA confirmed: "Ditto to everything everyone else said on [Yelp]. I've called almost every person on the list of specialists they sent me for an annual exam (except a few who had terrible reviews that included "inappropriate sexual contact") and ZERO actually take my plan OR they don't provide the service I need. I hope the marketplace determines that you are a [expletive deleted] company and you fold miserably as a result."
>
> Lana H. in Fountain Valley, CA complained on Yelp: "Worst insurance ever. . . . Recently, I called to get information on urgent

> cares I could go to. The representative provided me with inaccurate information. He suggested an urgent care that doesn't even exist. I googled the name, address, and location, but it was a restaurant! I tried calling the number he gave me; it was a fax number! . . . Needless to say, I will be switching my insurance at the next open enrollment."
>
> David complained to the Better Business Bureau: "Just bought a $700 HMO and went to my son's new doctor to get his vaccinations. It's the same doctor Health Net lists as accepting their insurance. The admin behind the desk said the plan that I have does not apply to them and that he could not get care without paying cash. I called HealthNet, held for an hour then got a message that their mailbox was full. No service, no care, not [sic] help. No wonder healthcare is such a **** mess."
>
> An excerpt from a Better Business Bureau complaint from an unnamed Health Net insured details her inaccurate directory experience: "The one time I tried to use my insurance since joining Health Net, I had fallen on the stairs down to my house and was in extreme pain all night long. In the morning, I called [HealthNet] to find out where to go for emergency treatment and was given the addresses of three clinics in my area. I parked and hobbled to one, waited 30 minutes, and was told they did not accept my insurance. After hobbling back to my car, I called the other two clinics I had been given and neither of them accepted my insurance. I wound up driving home, in tears, and never saw a doctor."

The foregoing is a mere excerpt of the many consumer complaints regarding Defendants' inaccurate provider directories and serves as a small sample of the harms that they cause consumers.

* * *

79. Defendants' failure to provide an accurate provider network is unlawful under state and federal law and has harmed, and is continuing to harm, consumers in San Diego and throughout the State of California.

80. Defendants' advertisement of services they fail to provide and publication of false and misleading statements about their provider networks constitute unlawful, unfair, and fraudulent business practices under the UCL, as well as false advertising under the FAL.

81. The People seek restitution for those who have paid for Defendants' health insurance plans, but have not received that for which they paid; injunctive relief ordering Defendants to cease the misrepresentations made to consumers and promulgate accurate provider directories; and civil penalties as a result of each and every violation of the UCL and FAL by Defendants' unfair and unlawful practices.

82. These violations include, but are not limited to, those impacting each and every of Defendants' present and past enrollees in connection with each and every enrollment in Defendant health insurance plans, their monthly payment of insurance premiums for services, access to care, and other benefits Defendants have advertised and failed to provide, and each and every publication of inaccurate provider directories over the statutory period.

CAUSE OF ACTION ONE
Violation of Unfair Competition Law
(Cal. Bus. & Prof. Code § 17200, *et seq.*)

83. All preceding factual statements and allegations are incorporated by reference.

84. Defendants have engaged in unlawful, unfair, and fraudulent business practices by violating the letter and policy embodied in numerous provisions of California and federal law, as well as by employing business practices likely to deceive the public.

85. Defendants' conduct related to their provider directories is unlawful, as it violates numerous state and federal laws including but not limited to:

a. Affordable Care Act guarantees of access to "an up-to-date, accurate, and complete provider directory." (45 C.F.R. § 156.230(b)(2).)

b. The Federal Mental Health Parity and Addiction Equity Act, which requires that non-quantitative treatment limits on mental health care be the result of practices that are comparable to and no more stringent than those used for medical and surgical benefits (45 C.F.R. § 146.136(c)(4)(i).)

c. California statutory requirements that ACA plan provider directories be accurate. (Cal. Health & Safety Code § 1367.27.)

d. California statutory requirements related to the reporting of data related to directory accuracy. (Cal. Health & Safety Code § 1367.27.)

e. California statutory requirements related to providing prominent on-line contact information for consumers to report directory errors. (Cal. Health & Safety Code § 1367.27.)

f. California statutory requirements and regulations related to the reporting of timely access and physician data. (Cal. Health & Safety Code §§ 1367.03, 1367.035.)

g. Federal regulations requiring Medicaid provider directories be accurate and regularly updated. (42 C.F.R. § 438.10(h).)

h. False Advertising of products and services. (Cal. Bus. & Prof. Code § 17500.)

i. Defendants' conduct is also unlawful because it constitutes a tort of fraudulent inducement to contract.

86. By unlawfully and unfairly presenting its provider networks as accurate, when they are not, Defendants have an unfair advantage over law-abiding competitors.

87. The People therefore seek an appropriate civil penalty under the Business and Professions Code section 17206(a) for up to $2,500 per violation of the UCL to hold Defendants accountable for their unfair and unlawful business practices and to deter further violations of the UCL.

88. The People further seek an additional civil penalty for up to $2,500 under Business and Professions Code § 17206(a)(1) for each violation perpetrated against a senior citizen or disabled person.

89. The People seek entry of provisional and final remedies against Defendants including, without limitation, an injunction prohibiting Defendants from continuing their unlawful, unfair, and fraudulent activities.

90. The People seek an award of restitution in an amount to be determined according to proof.

91. The People pursue these remedies and penalties statewide, as is permitted under the recent decision by the California Supreme Court in *Abbott Laboratories v. Superior Court* (2020) 9 Cal.5th 642.

CAUSE OF ACTION TWO
Violation of False Advertising Law
(Cal. Bus. & Prof. Code § 17500, *et seq.*)

92. All preceding factual statements and allegations are incorporated by reference.

93. California's False Advertising Law, Business and Professions Code §§ 17500, *et seq.*, prohibits the dissemination of untrue or misleading advertising concerning the performance of services.

94. Defendants Health Net, LLC, Health Net, Health Net CS, Health and Wellness, and Does 1 through 20, by their joint and several actions, have violated § 17500 by publicly disseminating false and misleading provider directories through which they hope to obtain customers.

95. The statements are misleading in that they are likely to deceive a reasonable consumer into believing that the health care provider networks being offered were accurate, and that purchase of the advertised plan would provide ready in-network access both to the specific practitioners listed, and to a larger number of practitioners than were actually provided.

96. Defendants knew, or in the exercise of reasonable care should have known, that their statements in the provider directories were untrue or misleading.

97. The People therefore seek an appropriate civil penalty under the Business and Professions Code section 17536(a) for up to $2,500 per violation of the FAL to hold Defendants accountable for their false and misleading advertising and to deter further violations of the FAL.

98. The People seek entry of provisional and final remedies against Defendants including, without limitation, an injunction ordering Defendants to discontinue their false and misleading advertising.

99. The People seek an award of restitution in an amount to be determined according to proof.

100. The People pursue these remedies and penalties statewide, as is permitted under the recent decision by the California Supreme Court in *Abbott Laboratories v. Superior Court* (2020) 9 Cal.5th 642.

PRAYER FOR RELIEF

In light of the above, the People request the following remedies:

1. That, pursuant to Business & Professions Code § 17206, the Court assess a civil penalty in an amount up to two thousand, five hundred dollars for each violation of § 17200 by each Defendant and all of them;

2. That, pursuant to Business & Professions Code § 17206.1(a)(1), the Court assess an additional civil penalty in an amount up to two thousand, five hundred dollars for each violation of § 17200 perpetrated against a senior citizen or disabled person, by each Defendant and all of them;

3. That, pursuant to Business & Professions Code § 17536, the Court assess a civil penalty in an amount up to two thousand, five hundred dollars for each violation of § 17500 by each Defendant and all of them;

4. That the Court award provisional and final remedies against Defendants including, without limitation, an injunction prohibiting Defendants from continuing their unlawful, unfair, and fraudulent activities, and discontinue their false and misleading advertising;

5. That the Court award restitution in an amount to be determined according to proof; and

6. That the Court grant any further and additional relief the Court deems just and proper.

Dated: June 24, 2021

Mara W. Elliott, City Attorney

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