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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. Kaiser Foundation Health Plan, Inc.; 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, 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 California health insurance markets.

3. Defendant Kaiser Foundation Health Plan, Inc. ("Kaiser" or "Defendant"), which has over nine million individuals enrolled in its health plans statewide, is among the worst actors in California when it comes to the inaccuracy of its provider networks. Kaiser has mental health care directory inaccuracy rates of over 30 percent **(32 percent for psychiatrists** and **38 percent for non-physician mental health care providers**) and an overall directory inaccuracy rate of **19.14 percent**. This is both unfair to consumers and unlawful.

4. These high levels of directory inaccuracy are particularly problematic because the bulk of these directory inaccuracies are related to the areas in which Kaiser outsources care—especially mental health care—to outside providers because they are unable (or unwilling) to handle the volume of care their patients require.

5. 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 illusions 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

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. In these ways, Kaiser insureds often face insurmountable barriers when seeking care, and particularly when seeking mental health care.

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 Kaiser 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 of 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. Kaiser's grossly inaccurate provider directories harm their own customers' personal health, as well as their pocketbooks, while unlawfully and unfairly enabling the company to shed more costly enrollees to the detriment of its 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, Business and Professions Code §§ 17204, 17206, 17535, and 17536.

10. Defendant Kaiser Foundation Health Plan, Inc. ("Kaiser") is a California corporation with its principal place of business in Oakland, California.

11. Kaiser sells health insurance in the State of California.

12. Kaiser 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.

13. In 2020, Kaiser reported revenue of over $92 billion and net income of over $6.3 billion.

14. In California, Kaiser provides health insurance through Covered California, the state's Affordable Care Act exchange. In addition, Kaiser provides health insurance products in California to individuals enrolled in Medicare and Medi-Cal.

15. 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.

16. The People are informed and believe that all 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.

17. 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

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

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

a. Defendant Kaiser Healthcare of California is a domestic corporation headquartered in Oakland, California;

b. Defendant conducts business across the State of California; and

c. Defendant otherwise has sufficient minimum contacts with and purposely avails itself of the markets of the State.

20. 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. Defendant conducts a significant portion of their business in San Diego County, where they provide health insurance to over 96,000 enrollees.

FACTUAL BACKGROUND

The Role of Provider Directories in the Health Insurance Market

21. 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 physician, specialists, psychiatrists, and pediatricians will be covered by the plan they purchase.

22. 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.

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

24. Industry, government, and academic studies demonstrate that provider network and plan cost 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 insurance 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.[1]

25. 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.[2]

26. 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.[3]

27. 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."[4] 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"

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[1] 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.

[2] 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).

[3] *Id.* at 38.

[4] 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/.

when choosing a plan, and its plan comparison tool—like Covered California's—links directly to plans' directories.[5]

California Law Requires Health Insurers to Provide Accurate Directories

28. 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.)

29. 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).)

30. 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).) It must prominently include contact information for providers and members of the public to report inaccuracies in the provider directory. (*Id.* § 1367.27 (f).) Additionally it must allow provider searches by provider name, practice address, city, ZIP Code, provider language or languages, provider group, hospital name, facility name, or clinic name, among other search terms. (*Id.* § 1367.27(c)(2).)

[5] 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.

31. 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.

32. 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").

33. 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.

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

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

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

37. 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").

38. 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 the survey year, the plans must survey either the entirety of the provider contact list, or a random statistically significant sample which 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.

39. Providers are only eligible for the TAS survey 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 survey 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 the providers 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.

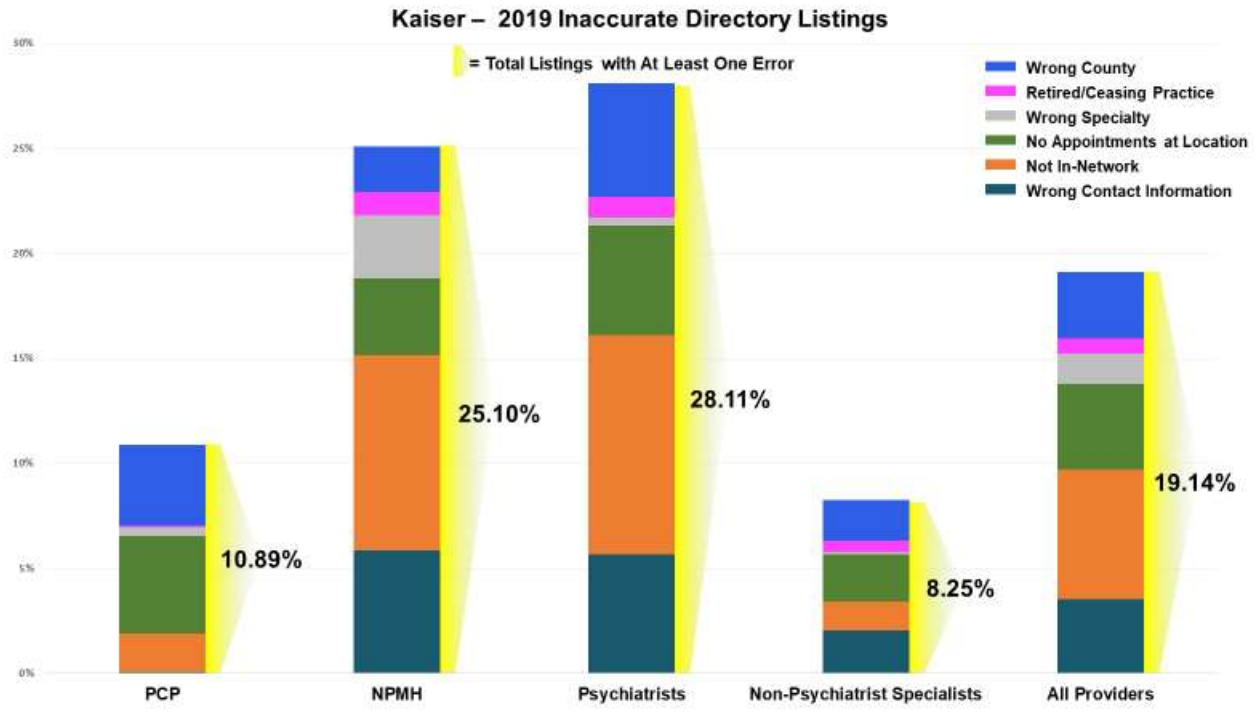
Data Provided to the State Confirms that Kaiser Knowingly Publishes Highly Inaccurate Provider Directories Repeating Known Errors from Year to Year

40. Kaiser's provider directories for its California plans are grossly inaccurate. For 2019, according to the raw TAS data submitted to DMHC, Kaiser reported that almost 20 percent of its overall provider listings were inaccurate, almost 30 percent of its psychiatrist listings were incorrect, and another 25 percent of its directory listings for NPMHs were inaccurate.[6]

41. The following chart presents Kaiser's error rates and reported reasons why each erroneous listing was inaccurate in 2019[7]:

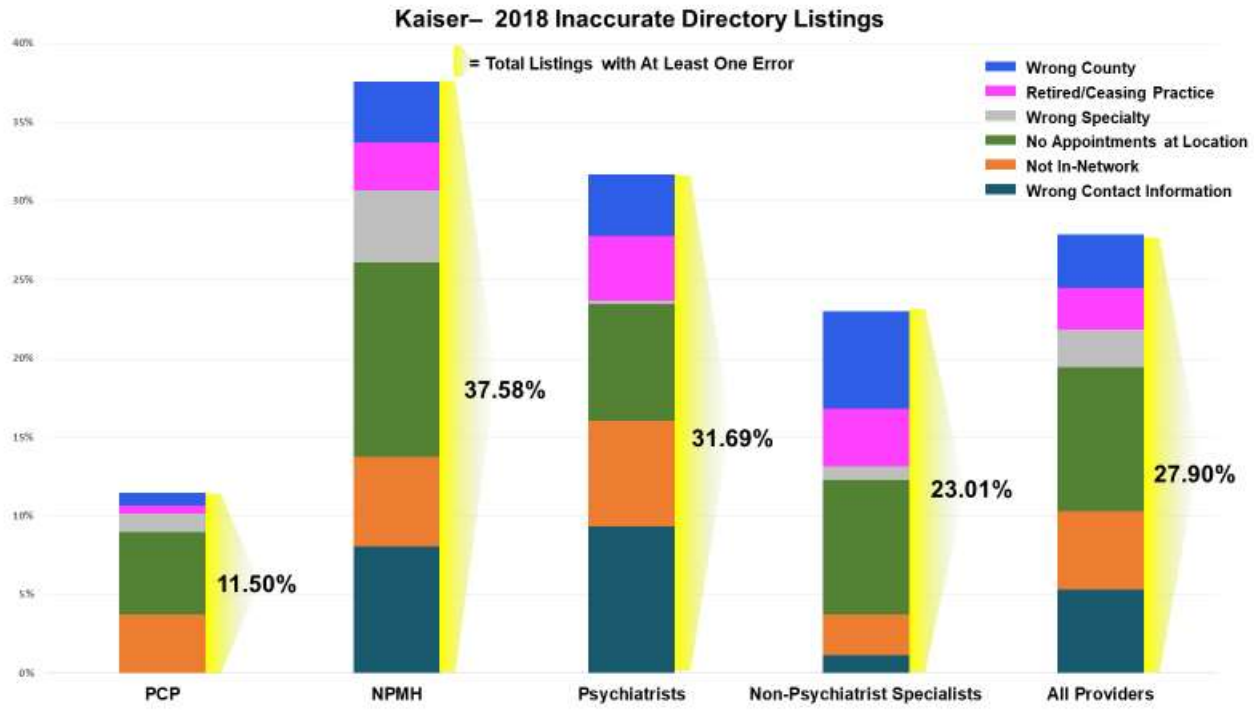
[6] In the TAS, each location that a provider practices at and each plan a provider is enrolled in is a separate listing, a division that reflects the perspective of enrollees trying to find care.

[7] 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.



42. This data shows that, in 2019, a Kaiser enrollee looking for a psychiatrist would hit an inaccurate directory listing more than once each four attempts. More than one in ten of the listings for psychiatrists in Kaiser's directories were for psychiatrists who were outside Kaiser's network, and thus not covered by its health insurance plans. Listings for the only other Kaiser option for mental health care—through NPMHs—were just as bad. Over a quarter of those listings were inaccurate, with close to ten percent of the listed providers not in-network, three percent listed as the wrong specialty, and another three percent who were taking no appointments. Other common errors included failing to remove retired physicians from directories, wrong phone numbers, and wrong addresses.

43. Kaiser's 2018 error rates were even worse. The overall directory error rate was 27.9 percent. Error rates for mental health practitioners were 31.69 percent for psychiatrists, and 37.58 percent for NPMHs—meaning for Kaiser insureds seeking mental health care, there was a one in three chance of encountering at least one directory error. The following chart presents Kaiser's 2018 inaccuracy rates and its reported reasons why each erroneous listing was inaccurate:



44. Indeed, the DMHC data shows that Kaiser repeatedly and consistently failed to correct provider information after learning of inaccuracies through TAS data collection. For example, of the 33 primary care physicians with unique National Provider Identifiers ("NPIs") that recorded at least one inaccurate directory listing in the 2018 TAS that were surveyed again in 2019, ***nearly all*** (specifically 30 physicians, or ***91 percent*** of the total) remained in Kaiser's provider directory with incorrect information for Kaiser's 2019 TAS. Stated differently, even though Kaiser learned in its 2018 survey that these 30 provider listings were inaccurate, Kaiser failed to address deficiencies for these providers in the succeeding year.

45. Likewise, of the 300 non-physician mental health providers Kaiser surveyed and deemed ineligible in the 2018 TAS and who were surveyed in Kaiser's 2019 TAS, ***50 percent*** (specifically 150) remained ineligible the next year. For the 177 psychiatrist specialists surveyed and deemed ineligible in connection with the 2018 TAS who were again surveyed in 2019, ***more than 40 percent*** (specifically 71 psychiatrists) remained ineligible. Finally, of

the 77 non-psychiatrist specialists that Kaiser surveyed and deemed ineligible in 2018 who also had recorded TAS survey data in 2019, 20 of those specialists, or approximately ***26 percent***, remained ineligible.

46. The conclusion is inescapable: Kaiser persists in publishing and advertising provider information that Kaiser knows to be false and misleading.

Kaiser's Unlawful, Unfair, and Fraudulent Conduct Harms Consumers

47. Kaiser's directory inaccuracies are not mere technicalities. Rather, they are serious errors with real consequences for consumers' economic well-being, patients' mental health as well as other medical conditions, and public health. 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 access to care."[8] 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 create barriers for members to receive services critical for their health and well-being."[9] Contact information errors also 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."[10]

48. Compounding the harm to consumers in ACA and employer plans is the fact that in almost all cases, once a health plan is selected and purchased, the consumer is 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 such enrollees are stuck with limited access to in-network care and are often confronted with the choice of

[8] 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.

[9] *Id.* at 6.

[10] *Id.* at 7.

either foregoing care entirely or paying out-of-pocket until they can change plans. 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.

Kaiser's Ghost Networks Disproportionately Harm Vulnerable Populations

49. 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 can be catastrophic. Alarmingly, 40 percent of Americans would be unable to pay an unexpected $400 bill without going into debt.[11] Some report forgoing food and necessary health care and medications to afford health care bills.[12]

50. 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 health insurance marketplace received government subsidies.[13] 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.

51. The financial dangers of Kaiser's inaccurate directories are particularly acute for people of color in the United States, especially Black and Hispanic families, who on

[11] 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.

[12] 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.

[13] 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/.

average have significantly less wealth than White families.[14] 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.[15] 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).[16]

52. 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.[17] Adults with disabilities are more than twice as likely than adults without disabilities to report skipping or delaying health care because of the cost.[18] Adults with disabilities and older adults are also more likely to experience poor health and use health care at higher rates.[19]

53. 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

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[14] 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.

[15] 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.

[16] 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.

[17] 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.

[18] 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/.

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

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.[20]

54. 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.

Kaiser Benefits Financially from its Inaccurate Directories

55. Kaiser financially benefits from its provider directory inaccuracies in at least three ways.

56. *First*, because a significant portion of Kaiser's directory listings are erroneous, Kaiser's provider networks appear to be broader and more attractive to potential enrollees than they are. Kaiser financially benefits from this because enrollees pay more for access to this illusory broader network than they would have paid for the actual narrower network, providing Kaiser with unjust windfall.

57. *Second*, Kaiser financially benefits 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 Kaiser's provider directory inaccuracies, obtaining care as a Kaiser insured 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 Kaiser the costs associated with coverage.

[20] 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.

Enrollees with significant health care needs may elect to abandon Kaiser at the next opportunity and purchase better, more accurate insurance coverage. In this way, Kaiser benefits 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 Kaiser plans, because they are unable to find suitable providers in network.

58. *Third*, Kaiser saves on the labor costs associated with auditing and updating its directories.

59. Additionally, by making its provider networks appear significantly larger than they are, Kaiser tricks consumers into significantly overvaluing its 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 its products according to its true network, Kaiser promises and charges 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, who has the wrong address or contact information, represents coverage that Kaiser enrollees paid for but never received. Further, even when Kaiser plan 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.

60. 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.

61. In addition to its own data demonstrating the falsity of its directories, which pose significant barriers to enrollees obtaining care, Kaiser knows from outside sources that its provider directories are inaccurate.

62. In 2019, the State of Washington imposed a consent decree and a $600,000 fine on that state's Kaiser affiliate, Kaiser Health Care of Washington, Inc., in part because of Kaiser's failure to maintain an accurate provider directory.

63. The State of California has admonished Kaiser for decades for limiting patients' access to providers, especially mental health providers, by failing to provide adequate numbers of mental health care practitioners and instead imposing steep obstacles on access to care.

64. It is particularly problematic that Kaiser—which employs physicians in-house to provide care—has inaccurate directories. But these inaccuracies are largely related to mental health and other services where it is unable, or unwilling, to meet the needs of their patients.

65. While Kaiser employs some of its mental health practitioners directly through the Kaiser Foundation Hospitals and Permanente Medical Group, it also contracts with a number of external providers, both directly and through third-party companies such as Beacon Health and Magellan Healthcare.

66. Kaiser is particularly reliant on contracted mental health providers, which it uses to compensate for its ongoing mental health care practitioner shortage.[21]

67. Although Kaiser has sought to alleviate this shortage by providing its patients access to outside providers, this access is often illusory because of the shocking inaccuracy of its directory listings for these outside mental health practitioners.

68. Patients report reaching providers who have no appointments available. Many end up paying out of pocket for out-of-network providers.

69. Kaiser's inaccurate directories give current and prospective customers a false picture of the breadth and scope of health care services offered.

[21] Since 2005, DMHC has cited Kaiser five times for failing to provide timely access to mental health care, including a $4 million fine levied in 2013. Kaiser also continues to flout DMHC regulations governing access to care by setting up call centers that Kaiser claims are providing mental health appointments but are in fact only conducting cursory intake assessments.

70. Compounding Kaiser's disregard for their duty to maintain accurate directories, Kaiser fails to prominently display on-line the contact information for consumers to report inaccurate directory listings. On its main page it includes an email and phone number for complaints which is buried below several other required disclaimers. A consumer using Kaiser's separate primary care provider search function will not see any information about reporting errors, and they will not be able to search the directory using licensing information or the NPI number for the provider they seek.

71. Kaiser has been widely criticized in California for its failure to provide adequate and timely mental health services. But rather than actually fixing that problem, it has instead published illusory provider directories to dupe consumers into thinking that its problem with providing mental health care services is resolved, and it has a much larger network than it actually has. In reality, Kaiser's directories are false and misleading and misrepresent to consumers that they have access to providers that are not actually available in-plan.

* * *

72. Kaiser's 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.

73. Kaiser's advertisement of services that it fails to provide and its publication of false and misleading statements about its provider networks constitute unlawful, unfair, and fraudulent business practices under the UCL, as well as false advertising under the FAL.

74. The People seek restitution for those who have paid for Kaiser 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 for each and every violation of the UCL and FAL by Defendants' unfair and unlawful practices.

75. These violations include, but are not limited to, those impacting each and every Kaiser enrollee in connection with each and every enrollment in Kaiser health insurance plans, their monthly payment of insurance premiums for services, access to care, and other benefits Kaiser has 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.*)

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

77. 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.

78. 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 related to the searchability of network providers on-line. (Cal. Health & Safety Code § 1367.27.)

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

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

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

j. Kaiser's conduct is also unlawful because it constitutes a tort of fraudulent inducement to contract.

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

80. 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.

81. 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.

82. 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.

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

84. The People pursue these remedies and penalties statewide, as is permitted under the recent decision of 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.*)

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

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

87. Defendants Kaiser Foundation Health Plan, Inc 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.

88. 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.

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

90. 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.

91. 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.

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

93. The People pursue these remedies and penalties statewide, as is permitted under the recent California Supreme Court decision 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;

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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

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