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9 **SUPERIOR COURT FOR THE STATE OF CALIFORNIA**
 10 **FOR THE COUNTY OF LOS ANGELES**

11 Case No. LC104357

12 DUAL DIAGNOSIS TREATMENT CENTER,
 INC., a California corporation; SATYA
 13 HEALTH OF CALIFORNIA, INC., a
 California corporation; ADEONA
 14 HEALTHCARE, INC., a California
 corporation; SOVEREIGN HEALTH OF
 15 FLORIDA, INC., a Delaware corporation;
 SOVEREIGN HEALTH OF PHOENIX, INC.,
 16 a Delaware corporation; SHREYA HEALTH
 OF CALIFORNIA, INC., a California
 17 corporation; SHREYA HEALTH OF
 FLORIDA, INC., a Florida corporation;
 18 SHREYA HEALTH OF ARIZONA, INC., an
 Arizona corporation; SOVEREIGN ASSET
 19 MANAGEMENT, INC., a Delaware
 corporation; and VEDANTA
 20 LABORATORIES, INC., a Delaware
 corporation,

[Assigned for all purposes to the Honorable Frank Johnson, Dept. T]

FIRST AMENDED COMPLAINT FOR:

- (1) BREACH OF CONTRACT
- (2) QUANTUM MERUIT
- (3) PROMISSORY ESTOPPEL
- (4) VIOLATION OF CAL. BUS. & PROF. CODE §§ 17200, ET SEQ.
- (5) BAD FAITH

21 Plaintiffs,

22 v.

23 HEALTH NET, INC., a Delaware corporation;
 24 HEALTH NET OF CALIFORNIA, INC., a
 California corporation; HEALTH NET LIFE
 25 INSURANCE COMPANY, a California
 corporation; MANAGED HEALTH
 26 NETWORK, INC., a Delaware corporation;
 and DOES 1 through 10, inclusive,

27 Defendants.

BY FAX

1 **INTRODUCTION**

2 1. Plaintiffs provide behavioral treatment services to recovering drug users and those
3 suffering from mental illness. Plaintiffs’ rehabilitative care model includes a range of services,
4 including residential and outpatient treatment, as well as toxicology testing. Plaintiffs are among the
5 leading players in the field.

6 2. Sadly, substance abuse is a national epidemic—one that destroys lives, families, and
7 communities. The National Institute on Drug Abuse (NIDA) at the National Institutes of Health
8 estimates that substance abuse exacts “more than \$700 billion annually in costs related to crime, lost
9 work productivity and health care.” *See* <https://www.drugabuse.gov/related-topics/trends-statistics#costs>. Serious mental illness presents a similarly sweeping societal problem, affecting people in
10 all walks of life, including teenagers, housewives, veterans, and seniors. *See, e.g.,* Behavioral Health
11 Barometer United States, 2015, http://www.samhsa.gov/data/sites/default/files/2015_National_Barometer.pdf (“Behavioral Report”).
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14 3. Addiction and mental illness have long been stigmatized conditions. Notwithstanding
15 the fact that addiction is an illness, and a grave one, drug addicts have long been unable to obtain
16 support and care equivalent to that provided to individuals with “normal” illnesses. Instead, persons
17 suffering from drug addiction (who often have mental health problems as well) have been stigmatized
18 and found their treatment options limited. Those with mental illnesses may face even greater
19 prejudice; sufferers are viewed not as sick but as “crazy.”

20 4. Over the past decade, that has been slowly changing. Because of “parity” laws
21 requiring that treatment for mental health and substance abuse be covered similarly to treatment for
22 traditional medical care, as well as the willingness of a community of providers (like Plaintiffs) to
23 devote their professional lives to attacking the problem patient by patient, more people are able to
24 obtain the care they need. As of 2013, for example, approximately 2.5 million people received
25 treatment from a specialty substance abuse facility. *See* 2013 National Survey on Drug Use and
26 Health: Summary of National Findings, at 7, <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf> (“Drug Report”).
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1 5. There is still a long way to go. Each year, approximately 20 million people who need
2 treatment for an illicit drug or alcohol use problem do not receive treatment at a specialty facility.
3 *See, e.g.*, Drug Report at 7. Regrettably, only some of those individuals seek treatment. Even worse,
4 however, is that almost 40% of the people who do seek treatment are unable to obtain it because of
5 a “lack of insurance coverage and inability to afford the cost.” *Id.* Similarly disappointing statistics
6 apply to those needing treatment for mental illness. *See, e.g.*, Behavioral Report at 11-12 (describing
7 frequency of illness and treatment).

8 6. Defendants are all Health Net insurance entities (and thus collectively referred to as
9 “Health Net”) who engaged in a disgraceful scheme to enrich themselves by backtracking on their
10 insurance promises to recovering addicts and the mentally ill at the expense of providers who have
11 devoted their professional lives to helping such individuals.

12 7. The scope of Health Net’s wrongdoing is staggering: Defendants have arbitrarily,
13 discriminatorily, and in bad faith refused to reimburse Plaintiffs for roughly fifty-five million dollars
14 (\$55,000,000) in medically necessary services that were rendered to hundreds of patients and covered
15 by policies issued by Defendants.

16 8. This is more than an isolated coverage dispute. Defendants surely know that most
17 treatment facilities depend heavily on insured patients; the cost of providing care is high, and few
18 patients can afford to pay out of pocket. A refusal to honor claims can quickly threaten the ability of
19 many rehabilitation centers to keep their doors open and provide care to those who desperately need
20 it. Nonetheless, on information and belief and as recently reported in the press, Defendants have
21 baselessly refused to pay over 100 other rehabilitation treatment centers throughout California for
22 similar services, and are currently being investigated by the California authorities. Such conduct risks
23 driving some providers out of business—which would narrow the treatment options for patients and
24 reduce the frequency of claims Defendants would have to pay in the future.

25 9. Indeed, treatment facilities are a high-value target in another way: substance abusers
26 and the mentally ill remain socially stigmatized and have little political voice. Defendants likely
27 believed that an attack against the rehabilitation industry that cripples providers and reduces options
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1 for recovering drug users and those suffering from mental illness is one that will have little or no
2 public relations consequences for their corporate reputations. Plaintiffs can attest that persons with
3 behavioral health problems rarely get a fair shake in the national conversation, and Plaintiffs fear that
4 Defendants are simply hoping to exploit age-old prejudices as a way to fill their coffers, bonus their
5 executives, and plump their stock price.

6 10. As explained in more detail below, Defendants not only refused to reimburse Plaintiffs
7 (and other providers), but they did so without *any* credible effort to comply with governing law, fair
8 business practices, or common decency. Instead, Defendants have decided to cheat and smear an
9 entire community of providers dedicated to helping a vulnerable population—simply because they
10 think they can get away with it and make millions doing so. Indeed, Health Net was so brazen in its
11 intent to stonewall providers that it had executive Matthew Ciganek send out a form letter to scores
12 of treatment facilities setting forth (without reference to any specific evidence) an intent to withhold
13 payment because of “a number of potential concerns” about “false and/or fraudulent claims.” *See*
14 *Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers*, <http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers>.

16 11. Health Net’s current misconduct is part of a sad pattern of prioritizing dollars over
17 decency. While cynically refusing to pay providers like Plaintiffs tens of millions of dollars, for
18 example, industry press reported that Health Net nonetheless awarded its CEO Jay Gellert a
19 compensation package worth approximately \$30 million (and that apparently could become worth
20 as much as \$55 million). According to the trade press, regulators have repeatedly been forced to
21 discipline Health Net for its efforts to save a buck on the backs of the sick. For example, in 2007,
22 Health Net was fined \$1,000,000 for failing to disclose to California’s Department of Managed
23 Health Care (DMHC) the existence of a bonus program to pay employees for rescinding policies.
24 *See* DMHC Press Release, Nov. 15, 2007, <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2007/healthnetfinepr.pdf>. In 2008, the Los Angeles City Attorney
25 sued Health Net for issuing policies to applicants with no review, collecting premiums, and then,
26 only *after* policyholders submitted claims for medical services, retroactively conducting
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1 investigations into their medical history so as to delay payment or cancel coverage. *See* L.A. City
2 Attorney Sues Health Net Over Recission, [http://www.law360.com/articles/47952/1-a-city-attorney-](http://www.law360.com/articles/47952/1-a-city-attorney-sues-health-net-over-recission)
3 [sues-health-net-over-recission](http://www.law360.com/articles/47952/1-a-city-attorney-sues-health-net-over-recission). In 2013, Health Net was fined \$300,000 by the DMHC for violating
4 “parity” requirements. *See* DMHC Press Release, Nov. 18, 2013, [https://www.dmhc.ca.gov/](https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2013/HN_BS_ABC_CD_pr_111813.pdf)
5 [Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2013/HN_BS_ABC_CD_pr_111813.pdf](https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2013/HN_BS_ABC_CD_pr_111813.pdf).
6 And in 2016, the DMHC is investigating Health Net for a broad refusal to pay countless rehabilitation
7 providers like Plaintiffs. *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment
8 Providers, [http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-](http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers)
9 [drug-treatment-providers](http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers).

10 12. Plaintiffs are proud of the work that they (and their peers) do, and would prefer to
11 treat patients rather than litigate. But Health Net’s conduct has given them no other option, and they
12 are prepared to fight for what is right.

13 **JURISDICTION AND VENUE**

14 13. Jurisdiction is proper under section 410.10 of the California Code of Civil Procedure
15 and Article 4 of the California Constitution.

16 14. Venue is proper under section 395.5 of the California Code of Civil Procedure because
17 the principal place of business of Defendants, or some of them, is located in the County of Los
18 Angeles.

19 **PARTIES**

20 **A. Plaintiffs**

21 15. Plaintiffs are entities that provide substance abuse treatment, mental health treatment,
22 and/or toxicology testing services to recovering drug users. To the extent required, Plaintiffs possess
23 the necessary licenses and certifications to perform their operations.

24 16. Dual Diagnosis Treatment Center, Inc. (“Dual Diagnosis”) is a corporation duly
25 organized and existing under the laws of California. Dual Diagnosis does business as “Sovereign
26 Health of California,” and on occasion under other names as permitted by law. Dual Diagnosis
27 operates and maintains behavioral health treatment facilities in California.

1 17. Satya Health of California, Inc. (“Satya”) is a corporation duly organized and existing
2 under the laws of California. Satya does business as “Sovereign by the Sea II,” and on occasion under
3 other names as permitted by law. Satya operates and maintains behavioral health treatment facilities
4 in California.

5 18. Adeona Healthcare, Inc. (“Adeona”) is a corporation duly organized and existing
6 under the laws of California. Adeona does business as “Sovereign Health Rancho/San Diego.”
7 Adeona operates and maintains a children’s group home in El Cajon, California.

8 19. Sovereign Health of Florida, Inc. (“Sovereign Florida”) is a corporation duly
9 organized and existing under the laws of Delaware, doing business as “Sovereign Health of Florida.”
10 Sovereign Florida operates and maintains a residential care facility in Fort Myers, Florida.

11 20. Sovereign Health of Phoenix, Inc. (“Sovereign Phoenix”) is a corporation duly
12 organized and existing under the laws of Delaware, doing business as “Sovereign Health of Phoenix.”
13 Sovereign Phoenix operates and maintains a behavioral health residential facility in Chandler,
14 Arizona.

15 21. Shreya Health of California, Inc. (“Shreya California”) is an active California
16 corporation. Its principal place of business is 1211 Puerta Del Sol, Suite 260, San Clemente,
17 California 92673. Shreya California provides certain outpatient treatments.

18 22. Shreya Health of Florida, Inc. (“Shreya Florida”) is an active Florida corporation. Its
19 principal place of business is 3331 E. Riverside Drive, Fort Myers, Florida 33916. Shreya Florida
20 provides certain outpatient treatments.

21 23. Shreya Health of Arizona, Inc. (“Shreya Arizona”) is an active Arizona corporation.
22 Its principal place of business is 111 S. Hearthstone Way, Chandler, Arizona 85226. Shreya Arizona
23 provides certain outpatient treatments.

24 24. Sovereign Asset Management, Inc. (“SAM”) is a corporation duly organized and
25 existing under the laws of Delaware, doing business as “Sovereign Health Group.”

26 25. Vedanta Laboratories, Inc. (“Vedanta”) is a corporation duly organized and existing
27 under the laws of Delaware. Vedanta conducts laboratory testing services for rehabilitation treatment
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1 centers (including other Sovereign entities). Vedanta is authorized to provide laboratory services by
2 COLA (formerly the Commission on Office Laboratory Accreditation), an accreditation organization
3 for clinical laboratories under the Clinical Laboratory Improvement Amendments (CLIA) program.

4 26. For purposes of this Complaint, Dual Diagnosis, Satya, Adeona, Sovereign Florida,
5 Sovereign Phoenix, Shreya California, Shreya Florida, Shreya Arizona, and Vedanta are collectively
6 referred or individually referred to as “Sovereign,” as context requires. The Sovereign entities are
7 also collectively referred to as “Plaintiffs.”

8 **B. Significant Non-Party Agents of Plaintiffs**

9 27. Medical Concierge, Inc. (“Medlink”) is a corporation duly organized and existing
10 under the laws of California, doing business as “Medlink.” Medlink is licensed to operate and
11 maintain an adult residential facility (“ARF”) for ambulatory mentally ill adults. At pertinent times,
12 Medlink agreed to provide rehabilitation services to Sovereign as a fully furnished and appropriately
13 licensed ARF, and to act as Sovereign’s agent in certain intake and claim matters, and Sovereign
14 agreed to provide extensive non-medical management and administrative services, in exchange for
15 fair consideration.

16 28. MedPro Billing, Inc. (“MedPro”) is a corporation duly organized and existing under
17 the laws of Florida. MedPro provides benefits verification and eligibility information, utilization
18 review, and medical billing and collection services to mental health and substance abuse treatment
19 providers. At pertinent times, MedPro agreed to provide benefits verification and eligibility
20 information, utilization review, and medical billing and collection services to, and in certain ways
21 act as an agent for, Sovereign, in exchange for fair consideration.

22 **C. Defendants**

23 29. This lawsuit involves behavioral health treatment services rendered by Plaintiffs to
24 many individuals (“Former Patients”) who Plaintiffs are informed and believe possessed health
25 insurance covering some or all of the services that Plaintiffs provided at all relevant times.

26 30. Plaintiffs are informed and believe that the relevant health insurance of each Former
27 Patient was provided by Defendants or entities controlled by Defendants.

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1 See National Institute on Drug Abuse, Principles of Drug Addiction Treatment: A Research-Based
2 Guide (3d ed.) (October 1999).

3 39. Sovereign’s approach to addiction and other mental health treatment is consistent with
4 best practices in the industry. Its proven track record has also earned Sovereign accolades from trade
5 and government groups. Dual Diagnosis, for example, has received the Gold Seal of Approval from
6 the Joint Commission, an independent not-for-profit organization that is the nation’s oldest and
7 largest standard-setting and accrediting body in health care. Sovereign has been recognized by the
8 National Alliance on Mental Illness (NAMI), the nation’s largest mental health advocacy group, for
9 providing “the gold standard in mental health treatment for patients in Orange County and throughout
10 the country.”

11 40. Sovereign is also a well-recognized educator of behavioral health professionals. The
12 Association of Psychology Postdoctoral and Internship Centers (“APPIC”) has approved Sovereign
13 as a training facility, placing it in the company of distinguished academic centers such as Harvard
14 Medical School and Johns Hopkins. The University of Southern California sends its Master of Social
15 Work students to receive training at Sovereign facilities. And the California Board of Behavioral
16 Health Sciences, the California Association for Alcohol/Drug Educators, and the National
17 Association for Alcoholism and Drug Abuse Counsels have approved Sovereign entities to provide
18 continuing education to licensed professionals.

19 41. Sovereign only wishes to provide services that prospective patients can afford.
20 Unfortunately, many individuals in need of treatment cannot afford to pay for Sovereign’s services
21 by themselves. Sovereign is only able to treat such individuals who have health insurance that covers
22 some or all of its services.

23 42. As explained below, before agreeing to provide treatment, Sovereign’s practice is to
24 contact a patient’s insurer to confirm that the treatment it offers is covered; the claims here arise from
25 services provided to Former Patients for which Sovereign received such a coverage confirmation
26 from Defendants.

1 **B. Sovereign Confirms Coverage, Renders Services, and Seeks Payment.**

2 43. Whenever a prospective patient seeks to pay Sovereign with his or her health
3 insurance benefits, Sovereign investigates whether and to what extent the patient’s insurance policy
4 covers its various services.

5 44. This litigation involves Former Patients who agreed to pay for Sovereign’s services
6 through health insurance coverage provided by Defendants. When each Former Patient first sought
7 treatment, before providing treatment, Sovereign or its agents verified that he or she was insured and
8 ascertained the scope of his or her coverage through the following procedures.

9 45. Sovereign or its agents first secured the Former Patient’s consent to contact his or her
10 health insurance company, along with the identifying information necessary for Sovereign to interact
11 with the insurer. Sovereign or its agents also asked for the dedicated phone number for healthcare
12 providers associated with the Former Patient’s insurance policy (“Provider Hotline”). Sovereign or
13 its agents recorded this information in a comprehensive document entitled “Verification of Benefits.”
14 Plaintiffs are informed and believe that each Former Patient authorized Sovereign to contact the
15 Provider Hotline (or similar phone line) of Defendants.

16 46. Sovereign or its agents called the Provider Hotline and relayed the Former Patient’s
17 identifying information and requested details about his or her coverage. Sovereign or its agents
18 recorded the information learned from Defendants or their agents on a Verification of Benefits form.

19 47. To complete Sovereign’s Verification of Benefits form, Sovereign or its agents
20 routinely and exhaustively inquired into the characteristics of the Former Patient’s health insurance
21 coverage, including with respect to:

22 a. The existence and scope of any substance abuse or mental health coverage
23 (including fields regarding deductibles for out-of-network services and maximum out-of-pocket
24 payments for out-of-network services, among other things);

25 b. The general characteristics of the health insurance policy (including fields for
26 effective date and renewal date, the type of plan, and whether it covers preexisting conditions, among
27 other things); and

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1 c. Limitations on treatment.

2 48. For each Former Patient, Defendants or their agents confirmed that Sovereign’s
3 treatment of the Former Patient would be covered under the Former Patient’s health insurance policy
4 with Defendants, and that each Former Patient needed Sovereign’s behavioral health services. By
5 confirming coverage and authorizing treatment, Defendants thus encouraged Sovereign to, and were
6 aware that Sovereign would, provide such treatment. In short, until it actually came time to pay the
7 bill, Defendants’ course of dealing led Sovereign to believe it would be compensated for its services.

8 **C. Each Former Patient Had Out-of-Network Coverage for Substance Abuse and Mental**
9 **Health Treatment Services.**

10 49. When Sovereign or its agents called Defendants, it learned that each Former Patient’s
11 health insurance policy had at least the following key features: (1) coverage for substance
12 abuse/mental health treatment offered by Sovereign, and (2) “out-of-network” coverage, often
13 through a preferred provider organization (“PPO”) model.

14 50. A PPO plan covers medical expenses incurred when the insured visits either an “in-
15 network” provider (i.e., a provider who has a contractual relationship with the insurance company)
16 or an “out-of-network” provider (i.e., one who does not have a contractual relationship with the
17 insurance company).

18 51. PPO policies tend to be significantly more expensive than health maintenance
19 organization (“HMO”) coverage because they give insureds the option to visit the providers of their
20 choice, who are typically entitled to reimbursement at the “usual and customary rate” for their
21 services rather than a lower negotiated rate. Many insureds are nevertheless willing to pay a premium
22 for PPO coverage to, *inter alia*, gain access to a bigger and better pool of providers.

23 52. Sovereign is out-of-network with respect to all Defendants. In other words, Sovereign
24 has not contracted with Defendants to provide services to their insureds at a discounted rate.

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1 **D. After Providing Covered Services, Sovereign Properly Submitted Claims to the**
2 **Defendants.**

3 53. As a matter of intended general practice, Sovereign or its agents obtain a valid
4 assignment of benefits (“Assignment”) from all patients before treating them. Each Assignment was
5 in the form of, or materially identical to, the representative assignment attached hereto as Exhibit A.
6 As the plain terms of Exhibit A reflect, the Assignments give Sovereign all of the patients’ substantive
7 and procedural rights to obtain insurance benefits and proceeds, including the right to be paid directly
8 for any services rendered to patients and to assert patients’ legal rights to recover benefits. These
9 legal rights include the right to file claims and appeals, to request and obtain information and
10 documents relating to coverage, and to bring suit on all related claims (including extra-contractual
11 relief). In the claims process described below, Sovereign duly asserted that it was an assignee. In
12 addition and in the alternative, apart from any assignment, Sovereign is an express or intended third-
13 party beneficiary of the insurance contracts at issue.

14 54. Sovereign provided medically necessary services to the Former Patients that were
15 covered by their policies.

16 55. Sovereign or its agents timely submitted its claims for payment to Defendants using
17 industry-standard protocols.

18 56. For example, Sovereign or its agents submitted many claims for treatment of the
19 Former Patients on UB-04 forms.

20 57. UB forms are promulgated by the National Uniform Billing Committee (“NUBC”),
21 an organization formed in 1975 “to develop and maintain a single billing form and standard data to
22 be used nationwide by institutional, private and public providers and payers for handling health care
23 claims.” NUBC, About Us, <http://www.nubc.org/aboutus/index.dhtml> (“About NUBC”).

24 58. The NUBC approved the UB-04 in February 2005. Department of Health & Human
25 Services, CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 1104 (Nov. 3,
26 2006) (“Transmittal 1104”), at 3. The UB-04 form is now the “‘de facto’ institutional claim standard.”
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1 About NUBC; *see also* Transmittal 1104 at 3 (“The Form UB-04 (CMS-1450) answers the needs of
2 many health insurers. It is the basic form prescribed by CMS for the Medicare program . . .”).

3 59. The UB-04 form includes information sufficient to allow insurance companies to
4 identify, process, and pay claims. For example, it contains fields for the service provided, the
5 appropriate code for that service, the charge for the service, and the relevant addresses. Sovereign
6 completed the pertinent fields for each claim.

7 60. Sovereign or its agents also submitted some claims for treatment of the Former
8 Patients and all claims for laboratory services rendered to the Former Patients on Form 1500s.

9 61. Form 1500s are promulgated by the National Uniform Claims Committee (“NUCC”),
10 a committee “created to develop a standardized data set for use by the non-institutional health care
11 community to transmit claim and encounter information to and from all third-party payers.” NUCC,
12 Who Are We?, <http://www.nucc.org/index.php> (“About NUCC”). It is chaired by the American
13 Medical Association and includes a diverse group of industry stakeholders representing providers
14 and payers. *See* About NUCC. The NUCC approved the revised Form 1500 in February 2012.

15 62. The Form 1500 includes information sufficient to allow insurance companies to
16 identify, process, and pay claims. For example, it contains a field for the service provided, the
17 appropriate code for that service, the charge for the service, and the relevant addresses. Sovereign
18 accurately completed the pertinent fields for each claim.

19 **E. Defendants Fail to Pay Sovereign as Part of a Scheme to Enrich Themselves by**
20 **Categorically Denying Claims for Behavioral Health Services Rendered to Their**
21 **Insureds.**

22 63. Since Plaintiffs began accepting Defendants’ insureds in significant numbers in
23 January 2015, Defendants have *never* fully reimbursed Plaintiffs for their services. In 2015, Plaintiffs
24 treated many Former Patients and have sought reimbursement for approximately \$42,000,000 in
25 services. To date Plaintiffs have received far less than that (approximately 36% of the total sought
26 reimbursement) from Defendants, with the reimbursement percentage decreasing throughout the year.

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1 64. In 2016, Defendants' behavior got worse. In the first few months of 2016, Plaintiffs
2 treated many Former Patients and rendered approximately \$34,000,000 in services. To date, Plaintiffs
3 have received only about 3% of the total reimbursement they have requested from Defendants for
4 those services.

5 65. Defendants provided no timely, meritorious reasons for these *en masse* refusals to
6 fully pay (or sometimes pay at all) Sovereign for treating hundreds of Former Patients.

7 66. In most cases, Defendants refused to pay at all on the grounds that they had
8 "insufficient information" to process claims. They professed to require, among other things,
9 "evidence of payment for member deductible/co-ins/co pay" and "a copy of the applicable license of
10 the CA DHS non-medical alcoholism/drug abuse treating facility or CLIA certificate for lab." In
11 writing, Defendants often originally told Plaintiffs that their claims were simply "delayed."

12 67. Yet these purported requests for additional information were plainly pre-textual.
13 Defendants knew that Plaintiffs had no obligation to collect any "payment for member deductible/co-
14 ins/co pay" because most of the policies in question were zero-deductible policies. In other words,
15 most of the Former Patients owed nothing (or there was nothing for Sovereign to collect) under their
16 policies at the time that Defendants refused to pay. Defendants also knew that Plaintiffs' facilities
17 were appropriately licensed or certified because they had interacted with Plaintiffs at length in the
18 past.

19 68. When Plaintiffs or their agents periodically called Defendants to seek clarification
20 after receiving notices that their claims would be "delayed," Plaintiffs were told that these claims had
21 in fact been "denied." They were given no meaningful additional information and repeatedly denied
22 full payment.

23 69. To be clear: at no point have Defendants suggested to Plaintiffs that the treatment
24 services in question were not actually provided, because they obviously were. Instead, Defendants
25 appear to be categorically refusing to pay, on impossible-to-pin down technical grounds, as part of a
26 general corporate strategy intended to stonewall and smear providers.

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1 70. Specifically, upon information and belief (and based upon reports in trade press),
2 Defendants sent out form letters in January 2016 to dozens of treatment centers in California setting
3 forth an intent to withhold payment because of “a number of potential concerns” about “false and/or
4 fraudulent claims.” *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers,
5 <http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers>.
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7 71. A generic, industry-wide form letter is not a legally defensible reason to delay or
8 withhold payment. Nonetheless, upon information and belief, Defendants have apparently refused to
9 pay over one hundred treatment facilities in California on that basis. *See* Regulators Probing Whether
10 Health Net Is Stiffing Drug Treatment Providers, <http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers>.
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12 **F. Defendants’ Misconduct Violates Their Statutory and Regulatory Duties.**

13 72. California common and statutory law requires that health insurers handle submitted
14 claims carefully, promptly, transparently, and in good faith.¹ *See, e.g.*, Cal. Health & Safety Code
15 § 1371 (providing for a 30-day time limit to either pay a claim, or contest a claim and seek more
16 information but requiring that “[t]he notice that a claim is being contested *shall identify the portion*
17 *of the claim that is contested and the specific reasons for contesting the claim*” (emphasis added));
18 Cal. Ins. Code § 10123.13(a) (similar); Cal. Health & Safety Code § 1363.5 (“A plan shall
19 disclose . . . the process the plan . . . uses to authorize, modify, or deny health care services under the
20 benefits provided by the plan . . .”); Cal. Ins. Code §§ 1023.137(a), (b) (similar); 28 Cal. Code Reg.
21 § 1300.77.4 (“Every plan shall institute procedures whereby all claim forms received by the plan
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23 ¹ It is unclear whether Defendants are subject to the Knox-Keene Act (i.e., the Health and Safety
24 Code) or the Insurance Code. Even entities “organized and operating pursuant to a certificate issued
25 by the Insurance Commissioner” may be subject to the Knox-Keene Act if the entity “directly
26 provid[es] the health care services through . . . contracting health facilities and providers.” Cal. Health
27 & Safety Code § 1343(e)(1); *see, e.g., Regents of Univ. of Cal. v. Principal Fin. Grp.*, 412 F. Supp.
28 2d 1037, 1048-49 (N.D. Cal. 2006) (holding that a fact issue precluded judgment regarding whether
the defendant PPO fell under Health and Safety Code Section 1343(e)(1)); *Cal. Physicians’ Serv. v. Aoki Diabetes Research Inst.*, 163 Cal. App. 4th 1506, 1511 (2008) (stating that Knox-Keene “sets strict standards for MCOs [i.e., managed care organizations],” including PPOs). Accordingly, Plaintiffs cite both sets of restrictions and plead them in the alternative.

1 from providers of health care services for reimbursement on a fee-for-service basis . . . are
2 maintained and accounted for in a manner which permits the determination of the date of receipt of
3 any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval
4 of any claim.”); 10 Cal. Code Reg. § 2695.3 (similar). Nor may an insurer rescind or modify its
5 authorization of treatment “after the provider renders the health care service in good faith and
6 pursuant to the authorization.” Cal. Health & Safety Code § 1371.8; *accord* Cal. Ins. Code § 796.04.

7 73. These rules (and similar rules in other states) seek to ensure that any denial or partial
8 payment of a submitted claim is based on a genuine analysis of the facts and of the underlying terms
9 of the insurance policy.

10 74. Here, Defendants failed on both counts, repeatedly and willfully failing to provide
11 Plaintiffs with timely, specific, good-faith explanations of their refusal to fully reimburse Plaintiffs
12 for services rendered to any Former Patient, as required by their legal obligations. For each claim
13 that Plaintiffs submitted to Defendants in connection with treating the Former Patients, Defendants
14 issued a summary rejection without conducting any meaningful inquiry into the relevant facts or into
15 the underlying terms of the covering policy, summarily underpaid on claims without any meaningful
16 or legally permissible justification, and/or summarily delayed payment on claims without any
17 meaningful or legally permissible justification. *Cf.* Cal. Health & Safety Code § 1371.37 (prohibiting
18 “unfair payment pattern[s]” by health insurers, where “unfair payment pattern” includes “(1)
19 Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or
20 processing complete and accurate claims that result in payment delays. (2) Engaging in a
21 demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment
22 or denying complete and accurate claims. (3) Failing on a repeated basis to pay the uncontested
23 portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35. (4) Failing
24 on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.”);
25 Cal. Ins. Code § 796.01 (insurers “shall, upon rejecting a claim from a health care provider or a
26 patient, and upon their demand, disclose the specific rationale used in determining why the claim
27 was rejected”). Defendants’ obfuscation and arbitrary denials misled and confused Plaintiffs.

1 *Local 99 v. Options—A Child Care & Human Servs. Agency*, 200 Cal. App. 4th 869, 879 (2011).
2 Individuals pay more for PPO plans precisely so that they can seek treatment from out-of-network
3 providers and for the certainty that their insurer will reimburse that provider for the treatment. The
4 terms of the Former Patients’ policies reflect that bargain and the intent that out-of-network providers
5 like Sovereign will be paid by Defendants for rendering treatment.

6 82. As alleged above, before rendering services, Plaintiffs confirmed that each Former
7 Patient was covered by a policy issued by Defendants. At great cost to themselves, Plaintiffs then
8 rendered medically necessary substance abuse or mental health treatment services and toxicology
9 testing services to the Former Patients.

10 83. After rendering those services, Plaintiffs submitted the appropriate claims forms to
11 Defendants or their agents, seeking compensation for the care and treatment they provided to the
12 patient-insureds.

13 84. Plaintiffs did not receive full or reasonable—or, in some cases, *any*—compensation
14 for the services they provided.

15 85. Plaintiffs are informed and believe that no legally operative term in the policies
16 governing the Former Patients entitles Defendants to deny Plaintiffs full and/or reasonable
17 compensation for services they rendered to the Former Patients in good faith. Plaintiffs duly
18 performed under the insurance contract, and are entitled to be paid.

19 86. Defendants are also equitably estopped from denying coverage and/or asserting any
20 newly minted defenses to payment that were not set forth, in writing, at the appropriate time in the
21 claims process. *See, e.g., City of Hollister v. Monterey Ins. Co.*, 165 Cal. App. 4th 455, 488 (2008)
22 (“In the insurance context especially, estoppel may arise from a variety of circumstances in which
23 the insurer’s conduct threatens to unfairly impose a forfeiture of benefits upon the insured.”).
24 Equitable estoppel occurs when: “(1) The party to be estopped has engaged in blameworthy or
25 inequitable conduct; (2) that conduct caused or induced the other party to suffer some disadvantage;

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1 and (3) equitable considerations warrant the conclusion that the first party should not be permitted to
2 exploit the disadvantage he has thus inflicted upon the second party.” *Id.*²

3 87. Defendants repeatedly and willfully violated the relevant claims-handling obligations
4 imposed by the laws identified above (*supra* ¶¶ 72-74) by failing to provide Plaintiffs with timely,
5 specific, good-faith explanations of their refusal to fully reimburse Plaintiffs for services rendered to
6 any Former Patient. Those regulatory violations provide a well-recognized basis for estoppel,
7 particularly in the insurance context. *See, e.g., Zembsch v. Superior Court*, 146 Cal. App. 4th 153,
8 168 (2006) (holding that a violation of the Knox-Keene Act “renders an arbitration agreement
9 unenforceable”); *Spray, Gould & Bowers v. Assoc. Int’l Ins. Co.*, 71 Cal. App. 4th 1260, 1268-74
10 (1999).

11 88. Defendants also waived any new defenses by not asserting them at the appropriate
12 times.

13 89. Defendants are in breach of the relevant insurance policies and have damaged
14 Plaintiffs by refusing to pay. Plaintiffs are entitled to compensatory damages equal to the full value
15 of their services, plus interest and costs.

16 **Count 2: Quantum Meruit**

17 **(All Plaintiffs v. All Defendants)**

18 90. Plaintiffs incorporate by reference all paragraphs alleged above.

19 91. Recovery in *quantum meruit* is appropriate when the plaintiff has enriched the
20 defendant such that the defendant cannot conscientiously refuse to make restitution to the plaintiff.
21 *See, e.g., Huskinson & Brown, LLP v. Wolf*, 32 Cal. 4th 453, 458 (2004) (“Quantum meruit refers to
22 the well-established principle that ‘the law implies a promise to pay for services performed under
23 circumstances disclosing that they were not gratuitously rendered.’” (citation omitted)); *Maglica v.*
24 *Maglica*, 66 Cal. App. 4th 442, 445-46 & n.2 (1998), as modified on denial of reh’g (Sept. 28, 1998).

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27 ² Although equitable estoppel is not an independent cause of action under California law, it can
28 be pleaded “as a part of the cause of action.” *Moncada v. W. Coast Quarts Corp.*, 221 Cal. App. 4th
768, 782 (2013) (citation and internal quotation marks omitted).

1 part of their unlawful scheme. Plaintiffs' reliance on Defendants' affirming pattern of conduct was
2 also eminently reasonable, especially in light of industry custom and the parties' past interactions.
3 Providers like the Plaintiffs routinely contact Defendants to verify that prospective patients have
4 coverage for their services and that Defendants agree that the patients require those services.
5 Providers then react to positive confirmation by providing the covered, medically necessary
6 treatment.

7 97. The parties' conduct also must be viewed against the backdrop of the comprehensive
8 regulatory scheme. As discussed, insurers must handle claims in good faith and cannot impermissibly
9 modify or rescind an authorization. *See supra* ¶¶ 72-74. As repeat players in this industry, Defendants
10 knew that Plaintiffs would interpret their communications regarding insurance coverage and
11 authorization in light of the regulations that circumscribe Defendants' conduct, and Plaintiffs
12 reasonably believed that Defendants would act in accordance with the law. Defendants' subsequent
13 failure to abide by their statutory and regulatory duties support the imposition of promissory estoppel.

14 **Count 4: Unfair Business Practices**

15 **(All Plaintiffs v. All Defendants)**

16 98. Plaintiffs incorporate by reference all paragraphs alleged above.

17 99. California's Unfair Competition Law (UCL), Bus. & Prof. Code §§ 17200, *et seq.*,
18 prohibits unlawful, unfair, and fraudulent business practices. Defendants' conduct violates all three
19 of those prongs.

20 100. Defendants' unfair and fraudulent scheme was clear.³ They intended to sell the subject
21 policies and pocket the premiums, sit back as their insureds sought medically necessary behavioral
22 health treatment, confirm to Plaintiffs that the subject patient-insureds were covered, and then, on
23 unspecified and/or technical grounds and in direct contravention of their prior statements to Plaintiffs
24 and their statutory and regulatory duties, refuse to fully compensate Plaintiffs for the services that
25 were rendered to, and benefited, Defendants' patient-insureds. Defendants were and are enriched by

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27 ³ Defendants' conduct was unfair under any and all of the three tests employed by California
28 courts. *See Graham v. Bank of Am., N.A.*, 226 Cal. App. 4th 594, 612-13 (2014).

1 keeping premiums without having to pay for care. Defendants further benefited by satisfying their
2 customers, as the Former Patients actually received the needed care. Defendants’ practices were
3 unfair and deceptive to Plaintiffs (as those practices would be to any reasonable consumer), who
4 were induced by Defendants’ misleading statements to treat the Former Patients and misled into
5 believing that they would be paid fairly for rendering those expert services. *Cf. Morgan v. AT&T*
6 *Wireless Servs., Inc.*, 177 Cal. App. 4th 1235, 1254 (2009) (“A fraudulent business practice is one in
7 which ‘members of the public are likely to be deceived.’” (citation omitted)). This harm is substantial
8 and is not outweighed by any countervailing benefits to consumers or society. To the contrary, as
9 discussed, Defendants’ conduct severely impacts vulnerable members of society and the healthcare
10 providers attempting to remedy the scourge of substance abuse and addiction.

11 101. The unfairness of Defendants’ conduct is underscored by its effects on policyholders
12 and patients, who were also fraudulently misled into believing that under Defendants’ policies they
13 could choose, and Defendants would pay for, care supplied by providers such as Plaintiffs, and by
14 other providers like Plaintiffs, when in fact Defendants intended to illegally underpay treatment
15 centers throughout California. The policies Defendants sold were worth far less than what a
16 reasonable person buying the policy would have believed. And these individuals are some of the
17 most vulnerable in society, with few options available for treatment of their diseases.

18 102. Defendants’ practices were also unlawful in that, as a part of their scheme to not pay
19 or underpay Plaintiffs, and to prevent Plaintiffs from learning of their scheme as long as possible,
20 they violated their claims handling obligations under California law by providing no, baseless, or
21 dilatory reasons for not paying Plaintiffs. *See supra* ¶¶ 72-74.

22 103. Defendants’ practices are also unlawful in that they violate the Mental Health Parity
23 and Addiction Equity Act of 2008 (“MHPAEA”). The MHPAEA is an antidiscrimination statute
24 intended to ensure that coverage of mental health and substance abuse care (such as that which
25 Plaintiffs provide) is in “parity” with coverage of medical and surgical care.

26 a. The MHPAEA and its implementing regulations make clear that any “financial
27 requirements” or “treatment limitations” an insurer applies to mental health or substance abuse policy
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1 benefits must be no more restrictive than the financial requirements or treatment limitations applied
2 to medical and surgical policy benefits.

3 b. Treatment limitations can be “quantitative” or “non-quantitative.”
4 Quantitative treatment limitations are expressed numerically (e.g., frequency of treatment, number
5 of visits, days of coverage, days in a waiting period); non-quantitative treatment limitations limit the
6 scope or duration of benefits for treatment.

7 c. Absent a clinically appropriate justification, an insurer may not impose a non-
8 quantitative treatment limitation on mental health or substance abuse benefits unless, under the terms
9 of the plan as written and in operation, the factors used in applying the non-quantitative treatment
10 limitation to mental health or substance use disorder benefits are comparable to, and are applied no
11 more stringently than, the factors used in applying the limitation with respect to medical/surgical
12 benefits in the same classification.

13 d. The relevant regulations make clear that reimbursement behavior, including
14 without limitation the rates and the methods for determining usual, customary, and reasonable
15 charges, are non-quantitative limitations governed by MHPAEA.

16 e. Upon information and belief, Defendants are treating Plaintiffs (and providers
17 of substance abuse treatment like Plaintiffs) differently than providers offering medical and surgical
18 services. Defendants have brazenly disregarded claims regulations, underpaid claims, delayed paying
19 claims, or denied claims based on the application of standards and conditions that Plaintiffs are
20 informed and believe they do not apply to medical and surgical claims.

21 104. As a remedy for their unlawful, unfair, and fraudulent practices, Defendants should
22 be ordered to pay restitution, and for all claims Sovereign may present in the future, as well as for
23 any pending claims, to the degree such relief is appropriate, Defendants should also be ordered to:
24 inform Sovereign, promptly and in writing, whether the claim is approved, partially approved, or
25 denied; inform Sovereign, promptly and in writing, of the particular contractual provision upon
26 which any denial or partial denial of a claim is based; inform Sovereign of the mathematical basis
27 upon which it has calculated the amount it has proposed to reimburse Sovereign, if that
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1 reimbursement is less than 100% of the submitted charge; promptly provide Sovereign with a
2 complete copy of the operative policy from which any provision has been cited as justification for
3 the denial, in whole or in part, of a submitted claim; and otherwise strictly follow all governing state
4 law concerning the handling of claims.

5 **Count 5: Bad Faith Insurance Denial**

6 **(All Plaintiffs v. All Defendants)**

7 105. Plaintiffs incorporate by reference all paragraphs alleged above.

8 106. “[T]he law implies in every contract a covenant of good faith and fair dealing,” which
9 “requires each contracting party to refrain from doing anything to injure the right of the other to
10 receive the benefits of the agreement.” *Egan v. Mut. of Omaha Ins. Co.*, 24 Cal. 3d 809, 818 (1979)

11 107. Plaintiffs, by assignment or operation of law, stand in the shoes of the Former Patients,
12 who were all insured under a policy of insurance issued by Defendants.

13 108. For each of the Former Patients, Plaintiff asserted a valid claim for the payment of
14 benefits covered by the subject insurance policy under which a particular Former Patient was treated.

15 109. Defendants failed to deal fairly and in good faith with Plaintiffs by unreasonably
16 failing to pay the claim or failing to pay fully, or by paying late.

17 110. Defendants’ failure to deal fairly and in good faith caused Plaintiffs to suffer damages.

18 111. Defendants’ bad faith was a deliberate part of a larger scheme to not pay providers,
19 like Plaintiffs, who treat recovering drug addicts.

20 112. Plaintiffs are entitled to compensatory and punitive damages as allowed by law.

21 **PRAYER FOR RELIEF**

22 WHEREFORE, Plaintiffs pray for judgment against Defendants, and that the Court award
23 the following relief:

- 24 1. Declare Defendants’ conduct unlawful;
25 2. Award equitable relief as necessary to stop Defendants’ pattern of unlawful, unfair,
26 and deceptive conduct;

