PETER K. STRIS (SBN 216226)
peter.stris@strismaher.com
BRENDAN S. MAHER (SBN 217043)
brendan.maher@strismaher.com
DANA BERKOWITZ (SBN 303094)
dana.berkowitz@strismaher.com
VICTOR O'CONNELL (SBN 288094)
victor.oconnell@strismaher.com
STRIS & MAHER LLP
725 South Figueroa Street, Suite 1830
Los Angeles, CA 90017
Telephone: (213) 995-6800
Facsimile: (213) 261-0299

Attorneys for Plaintiffs

SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

DUAL DIAGNOSIS TREATMENT CENTER, INC., a California corporation; SATYA HEALTH OF CALIFORNIA, INC., a California corporation; ADEONA HEALTHCARE, INC., a California corporation; SOVEREIGN HEALTH OF FLORIDA, INC., a Delaware corporation; SOVEREIGN HEALTH OF PHOENIX, INC., a Delaware corporation; SHREYA HEALTH OF CALIFORNIA, INC., a California corporation; SHREYA HEALTH OF FLORIDA, INC., a Florida corporation; SHREYA HEALTH OF ARIZONA, INC., an Arizona corporation; SOVEREIGN ASSET MANAGEMENT, INC., a Delaware corporation; and VEDANTA LABORATORIES, INC., a Delaware corporation,

Plaintiffs,

v.

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

Defendants.

Case No. LC104357

[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

INTRODUCTION

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

2. Sadly, substance abuse is a national epidemic—one that destroys lives, families, and communities. The National Institute on Drug Abuse (NIDA) at the National Institutes of Health estimates that substance abuse exacts "more than $700 billion annually in costs related to crime, lost 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 all walks of life, including teenagers, housewives, veterans, and seniors. *See, e.g.*, Behavioral Health Barometer United States, 2015, http://www.samhsa.gov/data/sites/default/files/2015_National_Barometer.pdf ("Behavioral Report").

3. Addiction and mental illness have long been stigmatized conditions. Notwithstanding the fact that addiction is an illness, and a grave one, drug addicts have long been unable to obtain support and care equivalent to that provided to individuals with "normal" illnesses. Instead, persons suffering from drug addiction (who often have mental health problems as well) have been stigmatized and found their treatment options limited. Those with mental illnesses may face even greater prejudice; sufferers are viewed not as sick but as "crazy."

4. Over the past decade, that has been slowly changing. Because of "parity" laws requiring that treatment for mental health and substance abuse be covered similarly to treatment for traditional medical care, as well as the willingness of a community of providers (like Plaintiffs) to devote their professional lives to attacking the problem patient by patient, more people are able to obtain the care they need. As of 2013, for example, approximately 2.5 million people received treatment from a specialty substance abuse facility. *See* 2013 National Survey on Drug Use and Health: Summary of National Findings, at 7, http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf ("Drug Report").

5. There is still a long way to go. Each year, approximately 20 million people who need treatment for an illicit drug or alcohol use problem do not receive treatment at a specialty facility. *See, e.g.*, Drug Report at 7. Regrettably, only some of those individuals seek treatment. Even worse, however, is that almost 40% of the people who do seek treatment are unable to obtain it because of a "lack of insurance coverage and inability to afford the cost." *Id.* Similarly disappointing statistics apply to those needing treatment for mental illness. *See, e.g.*, Behavioral Report at 11-12 (describing frequency of illness and treatment).

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

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

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

9. Indeed, treatment facilities are a high-value target in another way: substance abusers and the mentally ill remain socially stigmatized and have little political voice. Defendants likely believed that an attack against the rehabilitation industry that cripples providers and reduces options

for recovering drug users and those suffering from mental illness is one that will have little or no public relations consequences for their corporate reputations. Plaintiffs can attest that persons with behavioral health problems rarely get a fair shake in the national conversation, and Plaintiffs fear that Defendants are simply hoping to exploit age-old prejudices as a way to fill their coffers, bonus their executives, and plump their stock price.

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

11. Health Net's current misconduct is part of a sad pattern of prioritizing dollars over decency. While cynically refusing to pay providers like Plaintiffs tens of millions of dollars, for example, industry press reported that Health Net nonetheless awarded its CEO Jay Gellert a compensation package worth approximately $30 million (and that apparently could become worth as much as $55 million). According to the trade press, regulators have repeatedly been forced to discipline Health Net for its efforts to save a buck on the backs of the sick. For example, in 2007, Health Net was fined $1,000,000 for failing to disclose to California's Department of Managed Health Care (DMHC) the existence of a bonus program to pay employees for rescinding policies. *See* DMHC Press Release, Nov. 15, 2007, https://www.dmhc.ca.gov/Portals/0/AbouttheDM HC/NewsRoom/PressReleases/2007/healthnetfinepr.pdf. In 2008, the Los Angeles City Attorney sued Health Net for issuing policies to applicants with no review, collecting premiums, and then, only *after* policyholders submitted claims for medical services, retroactively conducting

investigations into their medical history so as to delay payment or cancel coverage. *See* L.A. City Attorney Sues Health Net Over Recission, http://www.law360.com/articles/47952/l-a-city-attorney-sues-health-net-over-recission. In 2013, Health Net was fined $300,000 by the DMHC for violating "parity" requirements. *See* DMHC Press Release, Nov. 18, 2013, https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2013/HN_BS_ABC_CD_pr_111813.pdf. And in 2016, the DMHC is investigating Health Net for a broad refusal to pay countless rehabilitation providers like Plaintiffs. *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers, http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers.

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

JURISDICTION AND VENUE

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

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

PARTIES

A. Plaintiffs

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

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

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

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

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

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

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

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

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

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

25. Vedanta Laboratories, Inc. ("Vedanta") is a corporation duly organized and existing under the laws of Delaware. Vedanta conducts laboratory testing services for rehabilitation treatment

centers (including other Sovereign entities). Vedanta is authorized to provide laboratory services by COLA (formerly the Commission on Office Laboratory Accreditation), an accreditation organization for clinical laboratories under the Clinical Laboratory Improvement Amendments (CLIA) program.

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

B. Significant Non-Party Agents of Plaintiffs

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

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

C. Defendants

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

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

31. Plaintiffs are informed and believe that Defendant Health Net, Inc. is a Delaware corporation with a principal place of business of 21650 Oxnard Street, Woodland Hills, California 91367.

32. Plaintiffs are informed and believe that Defendant Health Net Life Insurance Company is a California corporation with a principal place of business of 21650 Oxnard Street, Woodland Hills, California 91367.

33. Plaintiffs are informed and believe that Defendant Health Net of California, Inc. is a California corporation with a principal place of business of 21650 Oxnard Street, Woodland Hills, California 91367.

34. Plaintiffs are informed and believe that Defendant Managed Health Network, Inc. is a Delaware corporation with a principal place of business of 11931 Foundation Place, Building D, Rancho Cordova, California 95670.

35. Plaintiffs are informed and believe that, at all relevant times, each of Defendants was and is the agent, servant, representative, and/or alter ego of their codefendants, and in doing the things hereinafter alleged were acting in the scope of their authority as such agent, servant, and/or representative and with the permission and consent of their codefendants.

FACTS

A. Sovereign Is a Leading Provider of Award-Winning Treatment Services.

36. Substance abuse and addiction is a national scourge that affects individuals of all races and economic backgrounds. Politicians from across the spectrum have increasingly recognized the importance of treating the disease.

37. Sovereign is a leading provider of comprehensive addiction and mental health treatment programs to individuals in California and other states.

38. It is widely accepted that the services rendered by Sovereign and similar providers are extremely important. For example, according to the National Institute on Drug Abuse, every dollar spent on substance abuse treatment saves $4.87 in health care costs and $7.00 in crime costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Limitations on treatment.

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

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

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

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

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

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

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

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

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

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

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

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

58. The NUBC approved the UB-04 in February 2005. Department of Health & Human Services, CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 1104 (Nov. 3, 2006) ("Transmittal 1104"), at 3. The UB-04 form is now the "'de facto' institutional claim standard."

About NUBC; *see also* Transmittal 1104 at 3 ("The Form UB-04 (CMS-1450) answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program . . . .").

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

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

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

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

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

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

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

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

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

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

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

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

70. Specifically, upon information and belief (and based upon reports in trade press), Defendants sent out form letters in January 2016 to dozens of treatment centers in California setting forth an intent to withhold payment because of "a number of potential concerns" about "false and/or fraudulent claims." *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers, http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatmen t-providers.

71. A generic, industry-wide form letter is not a legally defensible reason to delay or withhold payment. Nonetheless, upon information and belief, Defendants have apparently refused to pay over one hundred treatment facilities in California on that basis. *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers, http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers.

F. Defendants' Misconduct Violates Their Statutory and Regulatory Duties.

72. California common and statutory law requires that health insurers handle submitted claims carefully, promptly, transparently, and in good faith.[1] *See, e.g.*, Cal. Health & Safety Code § 1371 (providing for a 30-day time limit to either pay a claim, or contest a claim and seek more information but requiring that "[t]he notice that a claim is being contested *shall identify the portion of the claim that is contested and the specific reasons for contesting the claim*" (emphasis added)); Cal. Ins. Code § 10123.13(a) (similar); Cal. Health & Safety Code § 1363.5 ("A plan shall disclose . . . the process the plan . . . uses to authorize, modify, or deny health care services under the benefits provided by the plan . . . ."); Cal. Ins. Code §§ 1023.137(a), (b) (similar); 28 Cal. Code Reg. § 1300.77.4 ("Every plan shall institute procedures whereby all claim forms received by the plan

[1] It is unclear whether Defendants are subject to the Knox-Keene Act (i.e., the Health and Safety Code) or the Insurance Code. Even entities "organized and operating pursuant to a certificate issued by the Insurance Commissioner" may be subject to the Knox-Keene Act if the entity "directly provid[es] the health care services through . . . contracting health facilities and providers." Cal. Health & Safety Code § 1343(e)(1); *see, e.g., Regents of Univ. of Cal. v. Principal Fin. Grp.*, 412 F. Supp. 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.

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

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

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

75. According to industry press, in late May 2016, in response to Defendants' disgraceful conduct, providers other than Plaintiffs complained to the California Department of Managed Health Care and the Department of Insurance about Defendants' improper refusal to reimburse treatment providers. *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers, http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers. The DMHC and DOI subsequently opened formal inquiries. *Id.*

76. Plaintiffs seek relief for all claims they have submitted to Defendants since January 1, 2015.

CLAIMS FOR RELIEF

Count 1: Breach of Contract

(All Plaintiffs v. All Defendants)

77. Plaintiffs incorporate by reference all paragraphs alleged above.

78. Under California law, a cause of action for breach of contract requires "(1) the contract, (2) plaintiff's performance or excuse for nonperformance, (3) defendant's breach, and (4) the resulting damages to plaintiff." *Reichert v. Gen. Ins. Co. of Am.*, 68 Cal. 2d 822, 830 (1968). Other states' law is in accord.

79. Beginning in January 2015, Plaintiffs treated hundreds of Former Patients after confirming with Defendants that the Former Patients were covered under Defendants' policies and obtaining an assignment from each Former Patient materially identical to the assignment attached as Exhibit A.

80. As assignees of the claims of the Former Patients, Plaintiffs are entitled to reimbursement for the services rendered based on the existence and terms of the insurance policies that cover the Former Patients.

81. In the alternative, Plaintiffs are express and intended third-party beneficiaries of the subject insurance contracts and are entitled to recover on that basis. "For purposes of determining whether a third party is an intended beneficiary, the relevant intent is that of the promisee, and it is sufficient if the promisor understood that the promisee had that intent." *Serv. Emps. Int'l Union,*

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

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

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

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

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

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

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

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

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

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

Count 2: Quantum Meruit

(All Plaintiffs v. All Defendants)

90. Plaintiffs incorporate by reference all paragraphs alleged above.

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

[2] Although equitable estoppel is not an independent cause of action under California law, it can 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).

92. Here, Defendants' scheme was clear. They intended to sell the subject policies and pocket the premiums, sit back as their insureds sought medically necessary behavioral health treatment, confirm to Plaintiffs that the subject patient-insureds were covered (thereby inducing Sovereign's provision of treatment through that express or implied invitation for Sovereign to treat the patient-insureds), and then, on unspecified and/or technical grounds, refuse to fully compensate Plaintiffs for the services that were rendered to and that benefited Defendants' patient-insureds. Defendants were and are enriched by keeping premiums without having to pay for the care that they expressly or impliedly requested by confirming coverage. Defendants further benefited by satisfying their customers, as the Former Patients actually received the needed care.

93. Plaintiffs are entitled to receive the full value of the treatment services they provided to the patient-insureds, every unpaid cent of which inequitably enriched Defendants.

Count 3: Promissory Estoppel

(All Plaintiffs v. All Defendants)

94. Plaintiffs incorporate by reference all paragraphs alleged above.

95. Promissory estoppel is an equitable doctrine whereby "'[a] promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise.'" *Kajima/Ray Wilson v. L.A. Cnty. Metro. Transp. Auth.*, 23 Cal. 4th 305, 310 (2000) (citation omitted). The elements are: "(1) a promise, (2) the reasonable expectation by the promisor that the promise will induce reliance or forbearance, (3) actual reliance or forbearance, and (4) the avoidance of injustice by enforcing the promise." *Fleet v. Bank of Am. N.A.*, 229 Cal. App. 4th 1403, 1412 (2014).

96. The facts here readily satisfy those elements. The series of communications between Plaintiffs and Defendants evinced a clear promise that Defendants would pay Plaintiffs for Plaintiffs' expert treatment of the Former Patients, and, in reliance on Defendants' representations, Plaintiffs expended substantial resources providing treatment. What is more, Plaintiffs' reliance on Defendants' representation was not merely foreseeable; it was precisely what Defendants hoped would happen as

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

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

Count 4: Unfair Business Practices

(All Plaintiffs v. All Defendants)

98. Plaintiffs incorporate by reference all paragraphs alleged above.

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

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

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

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

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

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

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

a. The MHPAEA and its implementing regulations make clear that any "financial requirements" or "treatment limitations" an insurer applies to mental health or substance abuse policy

benefits must be no more restrictive than the financial requirements or treatment limitations applied to medical and surgical policy benefits.

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

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

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

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

104. As a remedy for their unlawful, unfair, and fraudulent practices, Defendants should be ordered to pay restitution, and for all claims Sovereign may present in the future, as well as for any pending claims, to the degree such relief is appropriate, Defendants should also be ordered to: inform Sovereign, promptly and in writing, whether the claim is approved, partially approved, or denied; inform Sovereign, promptly and in writing, of the particular contractual provision upon which any denial or partial denial of a claim is based; inform Sovereign of the mathematical basis upon which it has calculated the amount it has proposed to reimburse Sovereign, if that

reimbursement is less than 100% of the submitted charge; promptly provide Sovereign with a complete copy of the operative policy from which any provision has been cited as justification for the denial, in whole or in part, of a submitted claim; and otherwise strictly follow all governing state law concerning the handling of claims.

Count 5: Bad Faith Insurance Denial

(All Plaintiffs v. All Defendants)

105. Plaintiffs incorporate by reference all paragraphs alleged above.

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

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

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

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

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

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

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

PRAYER FOR RELIEF

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

1. Declare Defendants' conduct unlawful;

2. Award equitable relief as necessary to stop Defendants' pattern of unlawful, unfair, and deceptive conduct;

3. Award damages, in an amount to be proven at trial but no less than $55,000,000, plus all applicable interest and costs;

4. Award all attorney's fees and costs incurred in bringing this action, to the extent recoverable by law;

5. Issue all other relief the Court deems appropriate, proper, and just.

DEMAND FOR JURY TRIAL

Plaintiffs demand a jury trial for all claims so triable.

Dated: October 25, 2016

STRIS & MAHER LLP

/s/ Peter K. Stris
Peter K. Stris

Attorneys for Plaintiffs
Dual Diagnosis Treatment Center, Inc.; Satya Health of California, Inc.; Adeona Healthcare, Inc.; Sovereign Health of Florida, Inc.; Sovereign Health of Phoenix, Inc.; Shreya Health of California, Inc.; Shreya Health of Florida Inc.; Shreya Health of Arizona, Inc.; Sovereign Asset Management, Inc.; and Vedanta Laboratories, Inc.