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

11 Case No. **LC104357**

COMPLAINT FOR:

- 12 (1) **EQUITABLE RELIEF FOR**
- 13 **CLAIMS VIOLATIONS**
- 14 (2) **BREACH OF CONTRACT**
- 15 (3) **QUANTUM MERUIT**
- 16 (4) **VIOLATION OF CAL. BUS. &**
- 17 **PROF. CODE §§ 17200, ET SEQ.**
- 18 (5) **BAD FAITH**

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

28 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.

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ORIGINAL FILED
Superior Court of California
County of Los Angeles

JUN 30 2016

Sherri R. Carter, Executive Officer/Clerk
By: Mario A. Orozco, Deputy

COPY

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”).

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

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

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. *See*,
3 *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 a
5 “lack of insurance coverage and inability to afford the cost.” *Id.* at 7. 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
28 for recovering drug users and those suffering from mental illness is one that will have little or no

1 public relations consequences for their corporate reputations. Plaintiffs can attest that persons with
2 behavioral health problems rarely get a fair shake in the national conversation, and Plaintiffs fear that
3 Defendants are simply hoping to exploit age-old prejudices as a way to fill their coffers, bonus their
4 executives, and plump their stock price.

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

15 11. Health Net’s current misconduct is part of a sad pattern of prioritizing dollars over
16 decency. While cynically refusing to pay providers like Plaintiffs tens of millions of dollars, for
17 example, industry press reported that Health Net nonetheless awarded its CEO Jay Gellert a
18 compensation package worth approximately \$30 million (and that apparently could become worth as
19 much as \$55 million). According to the trade press, regulators have repeatedly been forced to
20 discipline Health Net for its efforts to save a buck on the backs of the sick. For example, in 2007,
21 Health Net was fined \$1,000,000 for having and failing to disclose to California’s Department of
22 Managed Health Care (DMHC) the existence of a bonus program to pay employees for rescinding
23 policies. *See* DMHC Press Release, Nov. 15, 2007, [https://www.dmhc.ca.gov/Portals/0/AbouttheDM](https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2007/healthnetfinepr.pdf)
24 [HC/NewsRoom/PressReleases/2007/healthnetfinepr.pdf](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, only
26 *after* policyholders submitted claims for medical services, retroactively conducting investigations
27 into their medical history so as to delay payment or cancel coverage. *See* L.A. City Attorney Sues
28 Health Net Over Recission, <http://www.law360.com/articles/47952/1-a-city-attorney-sues-health-net->

1 over-recission. In 2013, Health Net was fined \$300,000 by the DMHC for violating “parity”
2 requirements. *See* DMHC Press Release, Nov. 18, 2013, [https://www.dmhc.ca.gov/Portals/0/About](https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/PressReleases/2013/HN_BS_ABC_CD_pr_111813.pdf)
3 [theDMHC/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). And in 2016, the
4 DMHC is investigating Health Net for a broad refusal to pay countless rehabilitation providers like
5 Plaintiffs. *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers,
6 [http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment](http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers/)
7 [t-providers/](http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers/).

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

11 **JURISDICTION AND VENUE**

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

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

17 **PARTIES**

18 **A. Plaintiffs**

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

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

26 17. Satya Health of California, Inc. (“Satya”) is a corporation duly organized and existing
27 under the laws of California. Satya does business as “Sovereign by the Sea II,” and on occasion under
28

1 other names as permitted by law. Satya operates and maintain behavioral health treatment facilities
2 in California.

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

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

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

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

15 22. Shreya Health of Florida, Inc. (“Shreya Florida”) is an active Florida corporation. Its
16 principal place of business is 3331 E. Riverside Dr., Fort Myers, Florida 33916. Shreya Florida
17 provides certain outpatient treatments.

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

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

23 25. Vedanta Laboratories, Inc. (“Vedanta”) is a corporation duly organized and existing
24 under the laws of Delaware. Vedanta conducts laboratory testing services for rehabilitation treatment
25 centers (including other Sovereign entities). Vedanta is authorized to provide laboratory services by
26 COLA (formerly the Commission on Office Laboratory Accreditation), an accreditation organization
27 for clinical laboratories under the Clinical Laboratory Improvement Amendments (CLIA) program.
28

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

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

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

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

19 **C. Defendants**

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

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

25 31. Plaintiffs are informed and believe that Defendant Health Net, Inc. is a Delaware
26 corporation with a principal place of business of 21650 Oxnard Street, Woodland Hills, California
27 91367.

28

1 the Joint Commission, an independent not-for-profit organization that is the nation's oldest and largest
2 standard-setting and accrediting body in health care. And the California Board of Behavioral Health
3 Sciences, the California Association for Alcohol/Drug Educators, and the National Association for
4 Alcoholism and Drug Abuse Counsels have approved Sovereign entities to provide continuing
5 education to licensed professionals.

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

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

14 ***Sovereign Confirms Coverage, Renders Services, and Seeks Payment.***

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

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

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

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

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

- 7 a. The existence and scope of any substance abuse or mental health coverage
8 (including fields regarding deductible for out-of-network services and
9 maximum out-of-pocket payments for out-of-network services, among other
10 things);
- 11 b. The general characteristics of the health insurance policy (including fields for
12 effective date and renewal date, the type of plan, and whether it covers
13 preexisting conditions, among other things); and
- 14 c. Limitations on treatment.

15 47. After the insurance verification process, Sovereign then contacted each Former Patient
16 to discuss his or her insurance policy and to make appropriate arrangements for treatment.

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

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

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

27 50. PPO policies tend to be significantly more expensive than health maintenance
28 organization (“HMO”) coverage because they give insureds the option to visit the providers of their

1 choice, who are typically entitled to reimbursement at the “usual and customary rate” for their
2 services and not a lower negotiated rate. Many insureds are nevertheless willing to pay a premium
3 for PPO coverage to, *inter alia*, gain access to a bigger and better pool of providers.

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

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

7 52. As a matter of intended general practice, Sovereign or its agents obtain a valid
8 assignment of benefits (“Assignment”) from all patients before treating them. The Assignments give
9 Sovereign the right to be paid directly for any services rendered to patients, and also entitle Sovereign
10 to assert patients’ legal rights to recover benefits. These legal rights include the right to file claims
11 and appeals, to request and obtain information and documents relating to coverage, and to bring suit
12 on all related claims (including extra-contractual relief). In the claims process described below,
13 Sovereign duly asserted that it was an assignee. In addition and in the alternative, apart any
14 assignment, Sovereign is an express or intended third-party beneficiary of the insurance contracts at
15 issue.

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

18 54. Sovereign or its agent timely submitted its claims for payment to Defendants using
19 industry-standard protocols.

20 55. For example, Sovereign or its agent submitted many claims for treatment of the
21 Former Patients on UB-04 forms.

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

26 57. The NUBC approved the UB-04 in February of 2005. Department of Health & Human
27 Services, CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 1104 (Nov. 3,
28 2006) (“Transmittal 1104”), at 3. The UB-04 form is now the “‘de facto’ institutional claim standard.”

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

9 60. 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 and
14 payers. *See* About NUCC. The NUCC approved the revised Form 1500 in February of 2012.

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

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

26 63. In 2016, Defendants’ behavior got worse. In the first few months of 2016, Plaintiffs
27 treated many Former Patients and rendered approximately \$34,000,000 in services. To date, Plaintiffs
28

1 have received only about 3% of the total reimbursement they have requested from Defendants for
2 those services.

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

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

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

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

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

25 69. Specifically, upon information and belief (and based upon reports in trade press),
26 Defendants sent out form letters in January of 2016 to dozens of treatment centers in California setting
27 forth an intent to withhold payment because of “a number of potential concerns” about “false and/or
28 fraudulent claims.” *See* Regulators Probing Whether Health Net Is Stiffing Drug Treatment Providers,

1 <http://californiahealthline.org/news/regulators-probing-whether-health-net-is-stiffing-drug-treatment-providers/>.

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

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

14 72. Plaintiffs seek relief for all claims they have submitted to Defendants since January 1,
15 2015.

16 **CLAIMS FOR RELIEF**

17 **Count 1: Equitable Relief for Violation of Claims Handling Laws**

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

19 73. Plaintiffs incorporate by reference all paragraphs alleged above.

20 74. California common and statutory law requires that health insurers handle submitted
21 claims carefully, promptly, transparently, and in good faith. *See, e.g.*, Cal. Health and Safety Code
22 § 1371 (providing for a 30 day time limit to either pay claim, or contest a claim and seek more
23 information but requiring that “[t]he notice that a claim is being contested *shall identify the portion*
24 *of the claim that is contested and the specific reasons for contesting the claim.*”); Cal. Health and
25 Safety Code § 1363.5 (“A plan shall disclose . . . the process the plan . . . uses to authorize, modify,
26 or deny health care services under the benefits provided by the plan”); 28 Cal. Code Reg.
27 § 1300.77.4 (“Every plan shall institute procedures whereby all claim forms received by the plan
28 from providers of health care services for reimbursement on a fee-for-service basis . . . are maintained

1 and accounted for in a manner which permits the determination of the date of receipt of any claim,
2 the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any
3 claim.”).

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

7 76. Here, Defendants failed on both counts. For each claim Plaintiffs submitted to
8 Defendants in connection with treating the Former Patients, Defendants issued a summary rejection
9 without conducting any meaningful inquiry into the relevant facts or into the underlying terms of the
10 covering policy; summarily underpaid on claims without any meaningful or legally permissible
11 justification; and/or summarily delayed payment on claims without any meaningful or legally
12 permissible justification. *Cf.* Cal. Health and Safety Code § 1371.37 (prohibiting “unfair payment
13 pattern[s]” by health insurers, where “unfair payment pattern” includes “(1) Engaging in a
14 demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete
15 and accurate claims that result in payment delays. (2) Engaging in a demonstrable and unjust pattern,
16 as defined by the department, of reducing the amount of payment or denying complete and accurate
17 claims. (3) Failing on a repeated basis to pay the uncontested portions of a claim within the
18 timeframes specified in Section 1371, 1371.1, or 1371.35. (4) Failing on a repeated basis to
19 automatically include the interest due on claims pursuant to Section 1371.”). Defendants’ obfuscation
20 and arbitrary denials misled and confused Plaintiffs.

21 77. Because Defendants failed to provide Plaintiffs with timely, specific, good-faith
22 explanations of their refusal to fully reimburse Plaintiffs for services rendered to any Former
23 Patient—in repeated and willful violation of the relevant claims handling obligations imposed by
24 law—Defendants should, under applicable equitable principles such as promissory estoppel, waiver,
25 and/or reformation:

- 26 a. be ordered to pay Plaintiffs, in full, for the services rendered; and/or
- 27 b. be equitably barred from asserting any newly minted defenses to payment that
28 were not set forth, in writing, at the appropriate time in the claims process.

1 **Count 2: Breach of Contract**

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

3 78. Plaintiffs incorporate by reference all paragraphs alleged above.

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

8 80. Beginning in January 2015, Plaintiffs treated hundreds of Former Patients after
9 confirming with Defendants that the Former Patients were covered under Defendants’ policies and
10 obtaining an assignment from each Former Patient.

11 81. As assignees of the claims of the Former Patients, Plaintiffs are entitled to
12 reimbursement for the services rendered based on the existence and terms of the insurance policies
13 that cover the Former Patients. In the alternative, Plaintiffs are express and intended third-party
14 beneficiaries of the subject insurance contracts and are entitled to recover on that basis.

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

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

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

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

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1 rendered to, and benefited, Defendants' patient-insureds. Defendants were and are enriched by
2 keeping premiums without having to pay for care. Defendants further benefited by satisfying their
3 customers, as the Former Patients actually received the needed care. Defendants' practices were unfair
4 and deceptive to Plaintiffs, who were misled into believing that they would be paid fairly for rendering
5 expert services.

6 94. Defendants' practices were also unlawful in that, as a part of their scheme to not pay
7 or underpay Plaintiffs, and to prevent Plaintiffs from learning of their scheme as long as possible,
8 they violated their claims handling obligations under California law by providing no, baseless, or
9 dilatory reasons for not paying Plaintiffs. *See* Claim 1, *supra*.

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

14 a. The MHPAEA and its implementing regulations make clear that any "financial
15 requirements" or "treatment limitations" an insurer applies to mental health or
16 substance abuse policy benefits must be no more restrictive than the financial
17 requirements or treatment limitations applied to medical and surgical policy
18 benefits.

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

23 c. Absent a clinically appropriate justification, an insurer may not impose a non-
24 quantitative treatment limitation on mental health or substance abuse benefits
25 unless, under the terms of the plan as written and in operation, the factors used
26 in applying the non-quantitative treatment limitation to mental health or
27 substance use disorder benefits are comparable to, and are applied no more
28

1 stringently than, the factors used in applying the limitation with respect to
2 medical/surgical benefits in the same classification.

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

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

13 96. Defendants' policyholders and patients were also fraudulently misled into believing
14 that under Defendants' policies they could choose, and Defendants would pay for, care supplied by
15 providers such as Plaintiffs, and by other providers like Plaintiffs, when in fact Defendants intended
16 to illegally underpay residential treatment centers throughout California. The policies Defendants
17 sold were worth far less than what a reasonable person buying the policy would have believed.

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

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

2 (All Plaintiffs v. All Defendants)

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

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

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

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

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

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

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

14 **PRAYER FOR RELIEF**

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

17 1. Declare Defendants' conduct unlawful;

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

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

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

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

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DEMAND FOR JURY TRIAL

Plaintiffs demand a jury trial for all claims so triable.

Dated: June 29, 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.