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PEOPLE OF THE STATE OF CALIFORNIA

15  
16 SUPERIOR COURT OF THE STATE OF CALIFORNIA  
17 COUNTY OF SAN DIEGO  
18 UNLIMITED JURISDICTION – CENTRAL DIVISION

19 People of the State of California, acting  
by and through Mara W. Elliot, City  
Attorney of San Diego,

20 Plaintiff,

21 v.

22 Kaiser Foundation Health Plan, Inc.; and  
23 Does 1 Through 20,

24 Defendants.

Case No.

**Complaint**

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

3 **INTRODUCTION**

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

7 2. Despite these clear legal mandates, health insurance companies continue to  
8 advertise and publish highly inaccurate directories. These false listings create formidable,  
9 dangerous, and unlawful barriers to patient care, harming public health and California  
10 health insurance markets.

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

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

22 5. These inaccurate directories, known as "ghost networks," falsely describe the  
23 breadth of an insurer's provider network, promising consumers access to health care that in  
24 reality is unavailable under the plan. Californians who buy health insurance from plans with  
25 ghost networks rely on directories advertising robust provider networks, only to realize  
26 those networks are illusions when they try to use them. These consumers are left exasperated  
27 by fruitless hours spent trying to find an in-network provider taking new patients, and  
28







1 consumers highly value having their doctor in their insurance network when picking a  
2 health plan. Further illustrating the importance of accurate directories, a 2020 study  
3 concerning patient preferences for provider choice found that consumers are willing to pay  
4 substantially higher monthly premiums for both having their doctor in-network and for  
5 broader access to doctors in their area.<sup>1</sup>

6 25. The California Department of Health Care Services, (“DHCS”), which runs  
7 Medi-Cal, notes that some consumers rely “exclusively” on provider directories to choose a  
8 plan.<sup>2</sup>

9 26. In March 2019, the California State Auditor issued a report, *Millions of Children*  
10 *in Medi-Cal Are Not Receiving Preventive Health Services*. The Auditor concluded, “[p]rovider  
11 directories are one of the primary means by which beneficiaries can find health care  
12 providers,” and that inaccurate directories function as barriers to care.<sup>3</sup>

13 27. Consumers’ reliance on provider directories is in keeping with state agencies’  
14 own advice. Covered California, the agency that runs the California ACA marketplace,  
15 strongly urges consumers to use provider directories and networks when choosing a health  
16 plan. Covered California includes provider networks among the “five key points to  
17 consider” when picking a health plan, explaining, “[t]he larger the provider network, the  
18 more choices you’ll have.”<sup>4</sup> Additionally, its shop and compare tool has a required question  
19 allowing consumers to filter out plans that do not include their doctors and links directly to  
20 plans’ directories. DHCS also urges Medi-Cal consumers to “look at . . . provider directories”  
21

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22 <sup>1</sup> Eline M. van den Broek-Altenburg, PhD, Adam J. Atherly, PhD, *Patient Preferences for Provider*  
23 *Choice: A Discrete Choice Experiment*, 26(7) AM. J. MANAGED CARE 219-224 (July 2020). This study  
24 found that patients were willing to pay \$95 more per month to have their preferred provider  
in network and willing to pay \$72 more per month for a health insurance plan that covered 30  
percent more doctors in their area.

25 <sup>2</sup> California State Auditor, *Department of Health Care Services—Millions of Children in Medi-Cal*  
*Are Not Receiving Preventive Health Services*, Rep. No. 2018–111, at 39 (Mar. 2019).

26 <sup>3</sup> *Id.* at 38.

27 <sup>4</sup> Covered California, *5 Things to Consider When Shopping for Health Insurance* (Oct. 1, 2020),  
28 [https://www.coveredca.com/marketing-blog/5-things-to-consider-when-shopping-for-  
health-insurance/](https://www.coveredca.com/marketing-blog/5-things-to-consider-when-shopping-for-health-insurance/).

1 when choosing a plan, and its plan comparison tool—like Covered California’s—links  
2 directly to plans’ directories.<sup>5</sup>

3 California Law Requires Health Insurers to Provide Accurate Directories

4 28. California law requires that insurers provide up-to-date, accurate, and  
5 complete provider directories including the following information: the providers’ (a)  
6 location, (b) contact information, (c) specialty, (d) medical group, (e) any institutional  
7 affiliation; and (f) which providers are accepting new patients. (Cal. Health & Safety Code §  
8 1367.27.)

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

15 30. Because of the importance of this information being provided in an up-to-date,  
16 accurate, and complete manner, the State of California has set forth explicit statutory  
17 requirements for provider directory updates. A health insurance plan must update its  
18 printed provider directories at least quarterly. (*Id.* § 1367.27 (d)(2).) It also must update its  
19 online provider directories at least weekly, when informed of any inaccuracies in  
20 information about a provider included in the provider directory. (*Id.* § 1367.27(e).) It must  
21 prominently include contact information for providers and members of the public to report  
22 inaccuracies in the provider directory. (*Id.* § 1367.27 (f).) Additionally it must allow provider  
23 searches by provider name, practice address, city, ZIP Code, provider language or  
24 languages, provider group, hospital name, facility name, or clinic name, among other search  
25 terms. (*Id.* § 1367.27(c)(2).)

26  
27 <sup>5</sup> Department of Health Care Services, *Tips to Help You Choose a Medical Plan*,  
28 <https://www.healthcareoptions.dhcs.ca.gov/choose/tips-help-you-choose-medical-plan>.

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

6           32. Regulation of health insurance in California is split among three agencies: the  
7 California Department of Managed Health Care (“DMHC”), the DHCS, and the Department  
8 of Insurance (“DOI”).

9           33. DMHC licenses and oversees Health Maintenance Organizations (“HMOs”),  
10 including the state’s Medicaid Managed Care Organizations (“Medicaid MCOs”). Sixty-  
11 seven percent of Californians are enrolled in DMHC-regulated plans.

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

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

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

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

23           38. In conducting the TAS, DMHC plans must generate a provider contact list from  
24 their December provider directory in the year preceding the survey. During the period April  
25 1st through December 31st of the survey year, the plans must survey either the entirety of  
26 the provider contact list, or a random statistically significant sample which has been  
27 generated according to specifications in DMHC’s guidance document, *Provider Appointment*  
28



1 *Availability Survey Methodology*. For example, for its 2021 TAS, a health care plan would  
2 survey its providers using a contact list generated from its December 2020 provider  
3 directory.

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

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

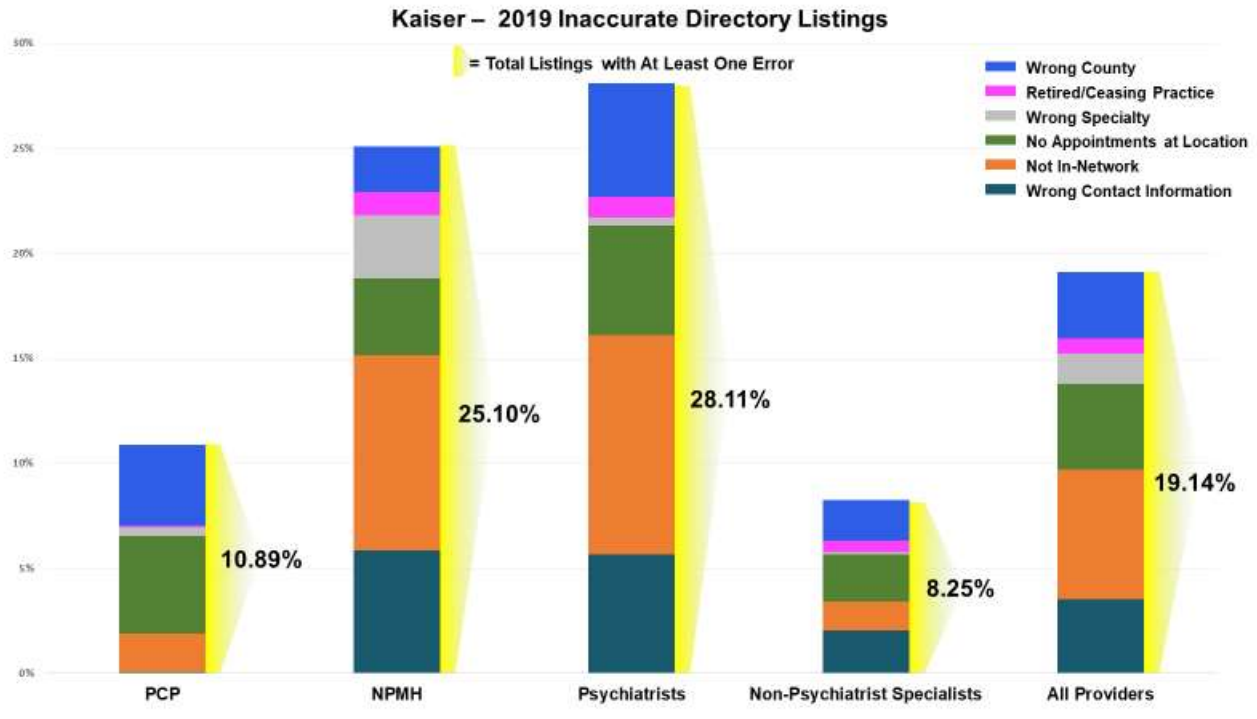
16 40. Kaiser's provider directories for its California plans are grossly inaccurate. For  
17 2019, according to the raw TAS data submitted to DMHC, Kaiser reported that almost 20  
18 percent of its overall provider listings were inaccurate, almost 30 percent of its psychiatrist  
19 listings were incorrect, and another 25 percent of its directory listings for NPMHs were  
20 inaccurate.<sup>6</sup>

21 41. The following chart presents Kaiser's error rates and reported reasons why  
22 each erroneous listing was inaccurate in 2019<sup>7</sup>:

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24  
25 <sup>6</sup> In the TAS, each location that a provider practices at and each plan a provider is enrolled in  
is a separate listing, a division that reflects the perspective of enrollees trying to find care.

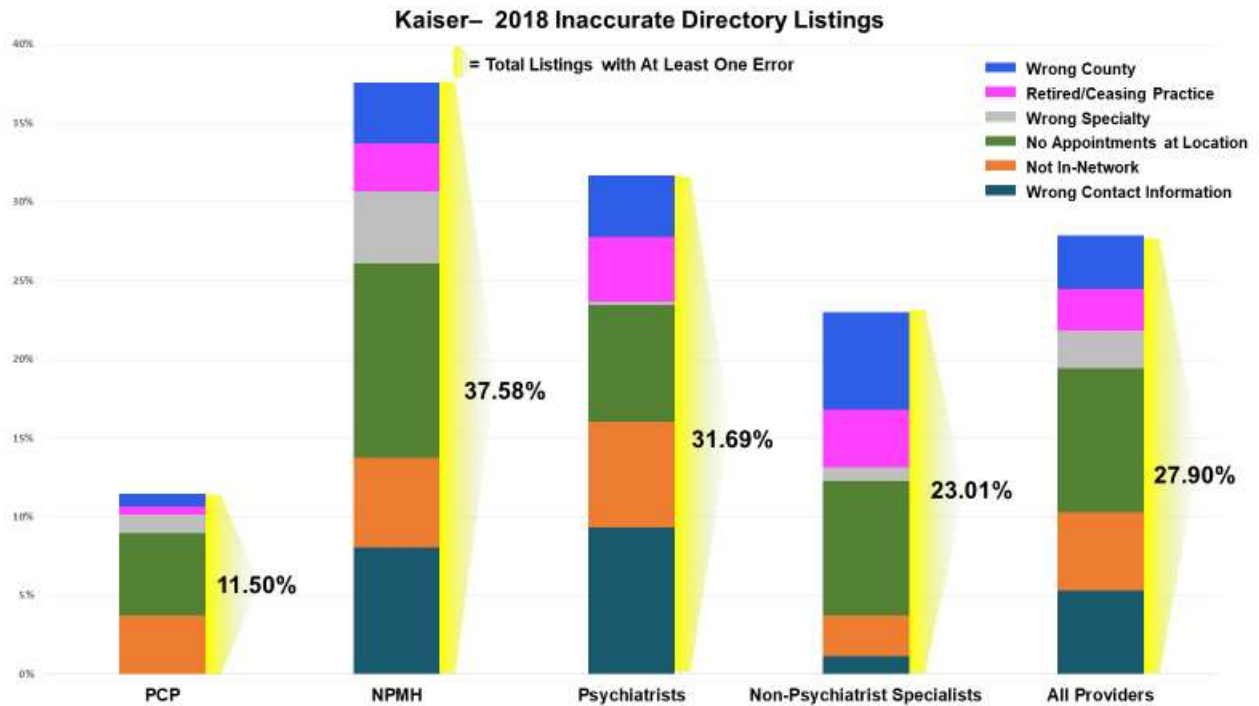
26 <sup>7</sup> Throughout this Complaint, unless otherwise stated, inaccuracy rates were calculated by  
27 calculating the number of TAS responses that recorded an ineligible response (and/or the  
28 specific ineligible set forth in the chart) reflecting a directory error divided by the total number  
of responses received (eligible and ineligible). Survey results that recorded "refused" were  
excluded for purposes of this calculation, but as a result inaccuracy rates may be understated.

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

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



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

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

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

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

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

7 47. Kaiser's directory inaccuracies are not mere technicalities. Rather, they are  
8 serious errors with real consequences for consumers' economic well-being, patients' mental  
9 health as well as other medical conditions, and public health. The federal Centers for  
10 Medicare & Medicaid Services ("CMS") has identified address, phone number, specialty,  
11 and network inaccuracies as inaccuracies "with the highest likelihood of preventing access  
12 to care."<sup>8</sup> CMS noted that "[d]irectories that include locations where a provider does not  
13 practice or state that providers are accepting new patients when they are not call into  
14 question the adequacy and validity of the MAO's [(Medicare Advantage Organization's)]  
15 network as a whole. These inaccuracies create barriers for members to receive services  
16 critical for their health and well-being."<sup>9</sup> Contact information errors also seriously obstruct  
17 consumers' access to care because they "prevent plan members from contacting the provider;  
18 therefore, the member cannot make an appointment even if the provider is at that location,  
19 in the network, and accepting new patients."<sup>10</sup>

20 48. Compounding the harm to consumers in ACA and employer plans is the fact  
21 that in almost all cases, once a health plan is selected and purchased, the consumer is stuck  
22 with that plan until the following year's open enrollment period, or until a qualifying event,  
23 such as getting married or losing a job, allows them to change plans. As such enrollees are  
24 stuck with limited access to in-network care and are often confronted with the choice of

25 <sup>8</sup> Centers for Medicare and Medicaid Services, *Online Provider Directory Review Report 5* (Jan.  
26 2018), [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/  
Provider\\_Directory\\_Review\\_Industry\\_Report\\_Year2\\_Final\\_1-19-18.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf).

27 <sup>9</sup> *Id.* at 6.

28 <sup>10</sup> *Id.* at 7.

1 either foregoing care entirely or paying out-of-pocket until they can change plans.  
2 Consumers report paying out-of-pocket both because they cannot find in-network care, or  
3 because they relied on directories stating that care they sought was in-network, only to be  
4 hit with big bills for out-of-network care.

5 Kaiser’s Ghost Networks Disproportionately Harm Vulnerable Populations

6 49. For low-income consumers, receiving an unexpected medical bill or having to  
7 pay out-of-pocket to see a provider because they cannot find one that accepts their insurance  
8 can be catastrophic. Alarming, 40 percent of Americans would be unable to pay an  
9 unexpected \$400 bill without going into debt.<sup>11</sup> Some report forgoing food and necessary  
10 health care and medications to afford health care bills.<sup>12</sup>

11 50. Enrollees in Affordable Care Act exchange plans are disproportionately low-  
12 income. Nationally in 2020, 87 percent of the 8.3 million individuals who purchased  
13 exchange plans received government subsidies based on income eligibility. As of August  
14 2020, Covered California reported that 88 percent of individuals who purchased plans  
15 through its individual health insurance marketplace received government subsidies.<sup>13</sup> Forty-  
16 eight percent of those receiving those subsidies were either Asian or Hispanic American (21.9  
17 percent and 26.6 percent respectively). An additional 2.2 percent of enrollees in Covered  
18 California plans who received government subsidies were African American, and 2.4  
19 percent reported as nonwhite, mixed race.

20 51. The financial dangers of Kaiser’s inaccurate directories are particularly acute  
21 for people of color in the United States, especially Black and Hispanic families, who on  
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23 <sup>11</sup> Division of Consumer and Community Affairs, *Economic Well-Being of U.S. Households in 2020*  
24 88 (May 2020), <https://www.federalreserve.gov/publications/files/2020-report-economic-well-being-us-households-202105.pdf>.

25 <sup>12</sup> L. Hamel et al., *Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored*  
26 *Insurance*, 2 KAISER FAMILY FOUNDATION (May 2019), [https://files.kff.org/attachment/Report-](https://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance)  
27 [KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance](https://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance).

28 <sup>13</sup> Press Release, California’s Efforts to Build on the Affordable Care Act Lead to a Record-Low  
Rate Change for the Second Consecutive Year, Aug. 4, 2020, *at* <https://www.coveredca.com/newsroom/news-releases/2020/08/04/californias-efforts-to-build-on-the-affordable-care-act-lead-to-a-record-low-rate-change-for-the-second-consecutive-year/>.

1 average have significantly less wealth than White families.<sup>14</sup> According to a 2017 study by  
2 the Urban Institute, Black Americans are 2.6 times more likely to have a medical debt than  
3 their White counterparts.<sup>15</sup> A 2018 study by the University of Chicago revealed that both  
4 Black and Hispanic Americans are significantly more likely to have a medical debt sent to  
5 collections than White Americans (44 percent and 37 percent, respectively, versus 22 percent  
6 for White Americans).<sup>16</sup>

7 52. Ghost networks also disproportionately affect Americans with disabilities,  
8 who, on average, have less household wealth than Americans without disabilities, making  
9 them less able to absorb unexpected medical costs.<sup>17</sup> Adults with disabilities are more than  
10 twice as likely than adults without disabilities to report skipping or delaying health care  
11 because of the cost.<sup>18</sup> Adults with disabilities and older adults are also more likely to  
12 experience poor health and use health care at higher rates.<sup>19</sup>

13 53. There is also a heightened impact on people seeking behavioral and mental  
14 health care, a specialty where directory errors are particularly pervasive and frequently drive  
15 people to seek costly out-of-network care or abandon their search and forgo health care  
16 entirely. A study conducted by public health researchers showed that people seeking

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18 <sup>14</sup> Neil Bhutta et al., *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer*  
19 *Finances*, THE FEDERAL RESERVE BOARD OF GOVERNORS IN WASHINGTON D.C.,  
<https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm>.

20 <sup>15</sup> Signe-Mary McKernan et al., *Past-Due Medical Debt a Problem, Especially for Black Americans*,  
21 URBAN INSTITUTE (Mar. 27, 2017), <https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans>.

22 <sup>16</sup> Jennifer Benz et al., *Americans' Views of Healthcare Costs, Coverage, and Policy*, NORC AT THE  
23 UNIVERSITY OF CHICAGO 6 (2018), <https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf>.

24 <sup>17</sup> Nanette Goodman et al., *Financial Capability of Adults with Disabilities* (National Disability  
25 Institute 2017), <https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/01/ndi-finra-report-2017.pdf>.

26 <sup>18</sup> Gloria L. Krahn et al., *Persons With Disabilities as an Unrecognized Health Disparity Population*,  
105 *Am J Public Health* S198 (Apr. 2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/>.

27 <sup>19</sup> Mary Lou Breslin & Silvia Yee, *The Current State of Health Care for People with Disabilities*.  
28 (2009), <https://www.ncd.gov/publications/2009/Sept302009#>.

1 behavioral health care who encounter directory errors are twice as likely to end up obtaining  
2 care from an out-of-network provider, often because they cannot access an in-network  
3 provider.<sup>20</sup>

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

10 Kaiser Benefits Financially from its Inaccurate Directories

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

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

18 57. *Second*, Kaiser financially benefits by having inaccurate directories, because  
19 those enrollees who seek to take advantage of their health insurance to obtain health care  
20 services are stymied in their attempts to find in-network providers. Because of the pervasive  
21 nature of Kaiser’s provider directory inaccuracies, obtaining care as a Kaiser insured entails  
22 many failed attempts to contact providers and schedule appointments. Ultimately, enrollees  
23 faced with this harm may abandon their efforts to obtain care altogether or they might obtain  
24 out-of-network care, because they are unable to find a doctor in network and reasonably  
25 accessible that has available appointments, saving Kaiser the costs associated with coverage.

26 <sup>20</sup> Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-*  
27 *Network Mental Health Care And Outpatient Surprise Bills: An Examination of the Role Inaccurate*  
28 *Provider Directories Play in out-of-Network Mental Health Treatment and Surprise Bills.*, 39 HEALTH  
AFFAIRS 975 (2020), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01501>.

1 Enrollees with significant health care needs may elect to abandon Kaiser at the next  
2 opportunity and purchase better, more accurate insurance coverage. In this way, Kaiser  
3 benefits financially by forcing out enrollees who are more expensive to insure and by forcing  
4 enrollees to obtain out-of-network care while they are insured by Kaiser plans, because they  
5 are unable to find suitable providers in network.

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

8 59. Additionally, by making its provider networks appear significantly larger than  
9 they are, Kaiser tricks consumers into significantly overvaluing its coverage. Network  
10 breadth is vital to consumers' valuation of plans: a study of Covered California enrollees  
11 found that they were willing to pay substantially more per month to have access to a broad  
12 network of doctors. In turn, plans with smaller networks are worth less to consumers. But  
13 rather than price its products according to its true network, Kaiser promises and charges  
14 enrollees for far more care than they will be able to access. Every provider who is not actually  
15 in-network, who is not actually taking appointments, who has the wrong address or contact  
16 information, represents coverage that Kaiser enrollees paid for but never received. Further,  
17 even when Kaiser plan enrollees are technically able to access in-network care, that care may  
18 be located far from their homes or work, which adds another set of barriers for those who  
19 lack access to regular transportation or who may have to take time off work to travel to a  
20 distant provider.

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

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



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

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

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

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

16          66.     Kaiser is particularly reliant on contracted mental health providers, which it  
17 uses to compensate for its ongoing mental health care practitioner shortage.<sup>21</sup>

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

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

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

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



1           75.     These violations include, but are not limited to, those impacting each and every  
2 Kaiser enrollee in connection with each and every enrollment in Kaiser health insurance  
3 plans, their monthly payment of insurance premiums for services, access to care, and other  
4 benefits Kaiser has advertised and failed to provide, and each and every publication of  
5 inaccurate provider directories over the statutory period.

6  
7                                   **CAUSE OF ACTION ONE**  
8                                   **Violation of Unfair Competition Law**  
9                                   **(Cal. Bus. & Prof. Code § 17200, et seq.)**

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

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

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

- 16           a.     Affordable Care Act guarantees of access to "an up-to-date, accurate,  
17                   and complete provider directory." (45 C.F.R. § 156.230(b)(2).)
- 18           b.     The Federal Mental Health Parity and Addiction Equity Act, which  
19                   requires that non-quantitative treatment limits on mental health care  
20                   be the result of practices that are comparable to and no more stringent  
21                   than those used for medical and surgical benefits (45 C.F.R. §  
22                   146.136(c)(4)(i).)
- 23           c.     California statutory requirements that ACA plan provider directories  
24                   be accurate. (Cal. Health & Safety Code § 1367.27.)
- 25           d.     California statutory requirements related to the reporting of data  
26                   related to directory accuracy. (Cal. Health & Safety Code § 1367.27.)
- 27           e.     California statutory requirements related to providing prominent on-  
28                   line contact information for consumers to report directory errors. (Cal.  
                  Health & Safety Code § 1367.27.)

- 1 f. California statutory requirements related to the searchability of
- 2 network providers on-line. (Cal. Health & Safety Code § 1367.27.)
- 3 g. California statutory requirements and regulations related to the
- 4 reporting of timely access and physician data. (Cal. Health & Safety
- 5 Code §§ 1367.03, 1367.035.)
- 6 h. Federal regulations requiring Medicaid provider directories be
- 7 accurate and regularly updated. (42 C.F.R. § 438.10(h).)
- 8 i. False Advertising of products and services. (Cal. Bus. & Prof. Code §
- 9 17500.)
- 10 j. Kaiser's conduct is also unlawful because it constitutes a tort of
- 11 fraudulent inducement to contract.

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

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

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

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

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

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

4  
5                                   **CAUSE OF ACTION TWO**  
6                                   **Violation of False Advertising Law**  
7                                   **(Cal. Bus. & Prof. Code § 17500, et seq.)**

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

9           86.     California’s False Advertising Law [FAL], Business and Professions Code §§  
10 17500 et seq., prohibits the dissemination of untrue or misleading advertising concerning the  
11 performance of services.

12           87.     Defendants Kaiser Foundation Health Plan, Inc and Does 1 through 20, by their  
13 joint and several actions, have violated § 17500 by publicly disseminating false and  
14 misleading provider directories through which they hope to obtain customers.

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

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

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

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




1  
2 5. That the Court award restitution in an amount to be determined according to  
3 proof; and

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

6 Dated: June 24, 2021

Mara W. Elliott, City Attorney

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8  
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