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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 Molina Healthcare of California; 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 plans' in-network providers and their
6 contact information.

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

11 3. Defendant Molina Healthcare of California ("Molina" or "Defendant"), has
12 nearly one million individuals enrolled in its health plans statewide, is among the worst
13 actors in California when it comes to the inaccuracy of its provider networks. Molina has an
14 overall directory inaccuracy rate of **over 50 percent** and a truly staggering inaccuracy rate of
15 **over 80 percent for psychiatrists**. This is both unfair to consumers and unlawful.

16 4. These inaccurate directories, known as "ghost networks," falsely describe the
17 breadth of an insurer's provider network, promising consumers access to health care that, in
18 reality, is unavailable under the plan. Californians who buy health insurance from plans
19 with ghost networks rely on directories advertising robust and broad provider networks,
20 only realize those networks are illusory when they try to use them. These consumers are left
21 exasperated by fruitless hours spent trying to find an in-network provider taking new
22 patients, and haunted by out-of-network provider charges. Some consumers will delay care
23 or even forgo care entirely because of ghost networks, harming not only those consumers
24 but also the broader public health.

25 5. As one Molina enrollee complained to the Better Business Bureau in March
26 2021:

27 I have called dozens of providers from Molina's website. I even
28 opened it up to "within 50 miles" of my zipcode. Every single
receptionist who has answered says that they DO NOT ACCEPT

1 Molina insurance. The website says it was updated yesterday, but
2 when I ask these providers if they ever took Molina, most of them
3 say they have not taken it for 3 or more years. . . **I may as well have
4 not even bought insurance. (emphasis added)**

5 6. Directory inaccuracies also distort health insurance markets. Insurance
6 companies that invest the resources to maintain accurate provider directories are
7 disadvantaged in marketing their plans to consumers when their competitors like Molina do
8 not invest resources to maintain accuracy and misrepresent their provider networks as
9 broader and deeper than they are.

10 7. In addition, insurers with ghost directories drive higher-needs consumers out
11 of their insurance plans, in what is effectively an end-run around protections of those with
12 pre-existing conditions or greater needs. Consumers with greater health care needs are more
13 likely to seek health care, discover directory errors, and be forced to spend significant time
14 searching for covered, in-network providers; go out-of-network for the needed treatment; or
15 forego care entirely when they are unable to find a doctor taking appointments that is
16 covered under their health insurance plan.

17 8. Molina's grossly inaccurate provider directories harm its own customers'
18 personal health, as well as their wallets, while unlawfully and unfairly enabling the
19 companies to shed more costly enrollees to the detriment of its market competitors.

20 PARTIES

21 9. The People of the State of California, by and through San Diego City Mara W.
22 Elliott, prosecute this action pursuant to the Unfair Competition Law and the False
23 Advertising Law, Business and Professions Code §§ 17204, 17206, 17535, and 17536.

24 10. Defendant Molina Healthcare of California is a California corporation with its
25 principal place of business in Long Beach, California.

26 11. Defendant Molina Healthcare of California is the surviving corporation from a
27 merger with Molina Healthcare and Partner Plan, Inc. on January 31, 2020. Upon
28 information and belief Defendant Molina Healthcare of California assumed the liabilities of

1 Molina Healthcare and Partner Plan, which ceased to exist upon merger. It was a California
2 corporation with its principal place of business in Long Beach, California.

3 12. Molina Health Care of California sells health insurance in the State of
4 California.

5 13. Defendant is a wholly owned subsidiary of Molina Healthcare, Inc., a publicly
6 traded, FORTUNE 500 company, which provides managed health care services under the
7 Medicaid and Medicare programs and through the state insurance marketplaces across the
8 country, including in California.

9 14. Molina Healthcare, Inc. was founded in 1980 in Long Beach, California, and
10 focused on marketing its products to low-income individuals, primarily those with health
11 care through government programs such as Medicare and Medicaid.

12 15. Molina Healthcare, Inc. reports consolidated financial statements for its wholly
13 owned subsidiaries, including Defendant. For fiscal year 2020, Molina Healthcare, Inc.
14 grossed over \$19.4 billion in revenue and over \$1.1 billion in EBITDA (Earnings Before
15 Interest, Taxes, Depreciation, and Amortization).

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

19 17. The true names or capacities of defendants sued as Doe Defendants 1-20 are
20 unknown to the People. The People are informed and believe, and on this basis allege, that
21 each of the Doe Defendants are legally responsible for the conduct alleged herein. The People
22 will seek leave of court to amend this Complaint to allege such names and capacities as soon
23 as they are ascertained.

24 18. The People are informed and believe that all of the acts and omissions
25 described in this Complaint by any Defendant were duly performed by, and attributable
26 to, all Defendants, each acting as agent, employee, alter ego, and/or under the direction
27
28

1 and control of the others, and such acts and omissions were within the scope of such
2 agency, employment, alter ego, direction, and/or control.

3 19. Additionally, or in the alternative, each Defendant has aided and abetted all
4 other Defendants in violating the letter of and the public policy embodied in the laws set
5 forth in this Complaint.

6 **JURISDICTION & VENUE**

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

9 21. The Superior Court has personal jurisdiction over Defendants because:

- 10 a. Defendant Molina Healthcare of California is a domestic corporation
11 headquartered in Long Beach, California;
- 12 b. Defendants conduct business across the State of California; and
- 13 c. Defendants otherwise have sufficient minimum contacts with and
14 purposely avail themselves of the markets of the State.

15 22. Venue is proper under California Code of Civil Procedure section 393(a)
16 because thousands of the illegal and unfair acts pled in this Complaint occurred in the City
17 and County of San Diego. Defendants conduct a significant portion of their business in San
18 Diego County, where they provide health insurance to over 240,000 enrollees.

19 **FACTUAL BACKGROUND**

20 **The Role of Provider Directories in the Health Insurance Market**

21 23. Provider directories are a prime advertising and recruitment mechanism for
22 health care insurance providers to enroll new members and increase market share. At their
23 core, provider directories represent to consumers what they are purchasing when they
24 choose a particular health insurance plan. It is important to consumers that they be able to
25 easily seek—and easily find—in-network coverage and that they be able to accurately
26 determine whether their preferred primary care physician, specialists, psychiatrists, and
27 pediatricians will be covered by the plan they purchase.

1 24. Both state and federal law recognize the importance of these directories by
2 requiring companies selling health insurance to make accurate provider directories available
3 to the public and enrollees/consumers, both in hard copy (upon request) and online,
4 regardless of whether they have purchased an insurance plan.

5 25. Consumers therefore review provider directories to see whether their doctors
6 will be in-network under a particular plan offering, as well as to determine how many in-
7 network primary care physicians, mental health care providers, specialists, and hospitals
8 will be available within their geographic area. Consumers compare the costs of the plan
9 offerings and the in-network provider coverage knowing that having to obtain health care
10 out-of-network will vastly increase their health care costs.

11 26. Industry, government, and academic studies demonstrate that plan cost and
12 provider network are top considerations for consumers when choosing a health plan, and,
13 further, that consumers rely on provider directories to choose their plans. A 2016 Rand
14 Corporation research report evaluating how consumers choose health plans found that
15 consumers highly value having their doctor in their network when picking a health plan.
16 Further illustrating the importance of accurate directories, a 2020 study concerning patient
17 preferences for provider choice found that consumers are willing to pay substantially higher
18 monthly premiums for both having their doctor in network and for broader access to doctors
19 in their area.¹

20 27. The California Department of Health Care Services, (“DHCS”), which runs
21 Medi-Cal, notes that some consumers rely “exclusively” on provider directories to choose a
22 plan.²

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

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

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

5 29. Consumers’ reliance on provider directories is in keeping with state agencies’
6 own advice. Covered California, the agency that runs the California ACA marketplace,
7 strongly urges consumers to use provider directories and networks when choosing a health
8 plan. Covered California includes provider networks among the “five key points to
9 consider” when picking a health plan, explaining, “[t]he larger the provider network, the
10 more choices you’ll have.”⁴ Additionally, its shop and compare tool has a required question
11 allowing consumers to filter out plans that do not include their doctors and links directly to
12 plans’ directories. DHCS also urges Medi-Cal consumers to “look at . . . provider directories”
13 when choosing a plan, and its plan comparison tool—like Covered California’s—links
14 directly to plans’ directories.⁵

15 California Law Requires Health Insurers to Provide Accurate Directories

16 30. California law requires that insurers provide up-to-date, accurate, and
17 complete provider directories including the following information: the providers’ (a)
18 location, (b) contact information, (c) specialty, (d) medical group, (e) any institutional
19 affiliation; and (f) which providers are accepting new patients. (Cal. Health & Safety Code §
20 1367.27.)

21 31. Additionally, inclusion of this information in a provider directory is a
22 representation by the health plan to enrollees and potential enrollees that the provider is in-
23 network. Accurate provider directories inform consumers which providers participate in

24 _____
25 ³ *Id.* at 38.

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

27 ⁵ 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 which plans and provider networks. California law explicitly prohibits a provider directory
2 from listing or including information on a provider that is not currently under contract with
3 the plan. (*Id.* § 1367.27(e)(2).)

4 32. Because of the importance of providing this information in an up-to-date,
5 accurate, and complete manner, the State of California has set forth explicit statutory
6 requirements for provider directory updates. A health insurance plan must update its
7 printed provider directories at least quarterly. (*Id.* § 1367.27 (d)(2).) It also must update its
8 online provider directories at least weekly, when informed of any inaccuracies in
9 information about a provider included in the provider directory. (*Id.* § 1367.27(e).) It must
10 prominently include contact information for providers and members of the public to report
11 inaccuracies in the provider directory. (*Id.* § 1367.27 (f).) Additionally, it must allow provider
12 searches by provider name, practice address, city, ZIP Code, provider language or
13 languages, provider group, hospital name, facility name, or clinic name, among other search
14 terms. (*Id.* § 1367.27(c)(2).)

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

20 34. Regulation of health insurance in California is split amount three agencies, the
21 California Department of Managed Health Care (“DMHC”), the DHCS, and the Department
22 of Insurance (“DOI”).

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

26 36. DMHC also licenses plans under Medi-Cal, the state Medicaid program that
27 insures 30 percent of Californians. Medi-Cal plans are also overseen by DHCS.

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

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

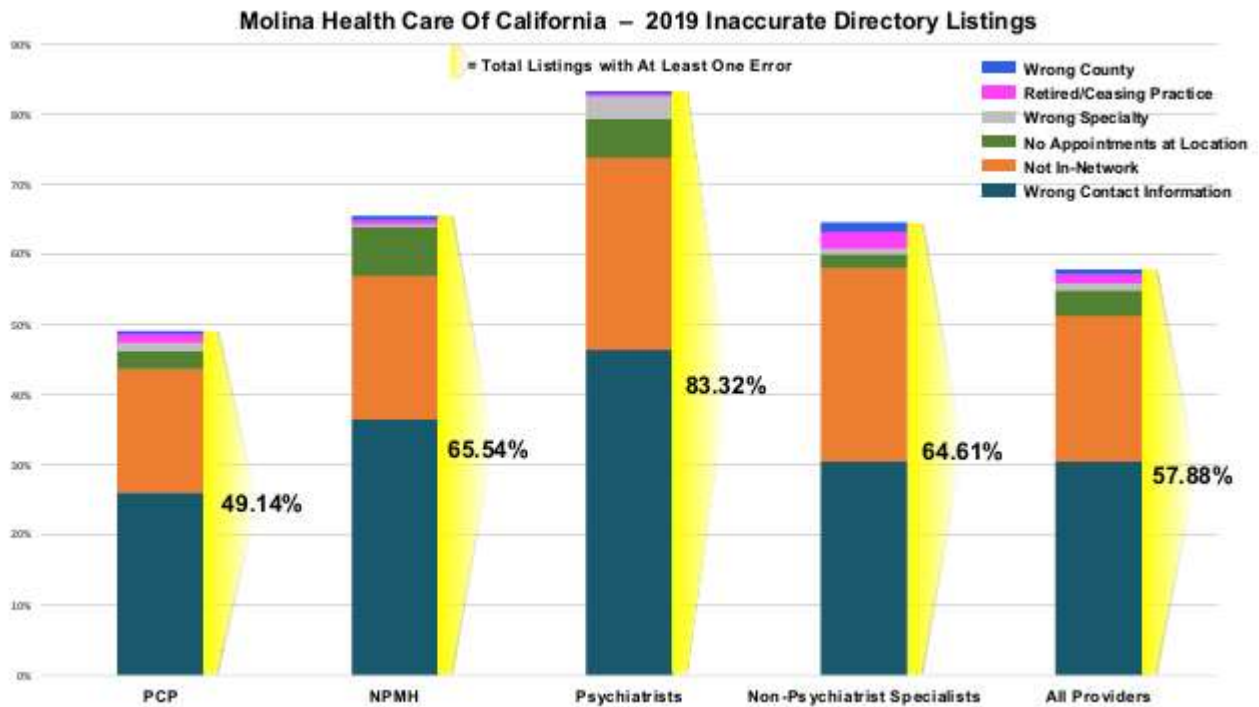
6 39. The TAS is a survey in which providers report on the maximum wait times for
7 enrollees to obtain an appointment with a specific provider in certain categories: primary
8 care practitioners, certain specialists, psychiatrists, and non-physician mental health care
9 providers (“NMHPs”).

10 40. In conducting the TAS, DMHC plans must generate a provider contact list from
11 their December provider directory in the year preceding the survey. During the period April
12 1st through December 31st of the survey year, the plans must survey either the entirety of
13 the provider contact list, or a random statistically significant sample which has been
14 generated according to specifications in DMHC’s guidance document, “Provider
15 Appointment Availability Survey Methodology.” For example, for its 2021 TAS, a health care
16 plan would survey its providers using a contact list generated from its December 2020
17 provider directory.

18 41. Providers are only eligible for the TAS survey if they are in-network, are
19 currently practicing their listed specialty in their listed county, are taking appointments with
20 enrollees, and have correct contact information. While DMHC only uses this data to compile
21 reports concerning insurers’ compliance with California timely access standards, the TAS
22 also functions as a provider directory accuracy survey. In addition to the final TAS results,
23 insurers must submit to DMHC the raw survey data. The raw data lists all the providers that
24 were “ineligible” for the survey as well as the reason for their ineligibility: their county was
25 incorrect, their contact information was incorrect, their specialty was incorrect, they do not
26 take appointments at that location or at all, they are not actually in-network, or they are no
27 longer practicing.

Molina’s Own Data Reports Prove its Provider Listings Are Inaccurate
and that it Fails to Correct Known Errors

42. Molina’s provider directories for its California plans are grossly inaccurate. For 2019, according to the raw TAS data submitted to DMHC, Molina Health Care of California’s December 2018 directory had an error rate of 57.88 percent and a staggering 83.32 percent error rate for psychiatrists listed in its directories.⁶ The following chart presents Molina Health Care of California’s inaccuracy rates in 2019⁷:



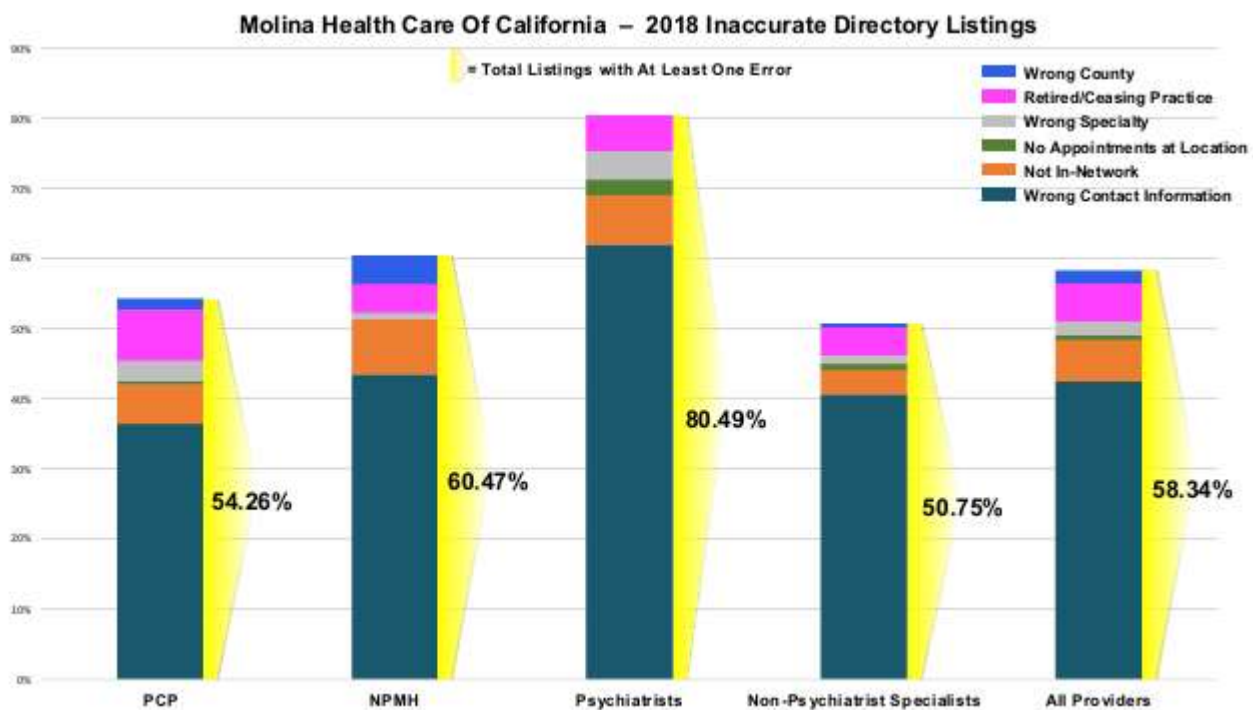
43. This data shows that, in 2019, a Molina enrollee looking for a psychiatrist would have a less than a two in ten chance of finding an accurate directory listing. Further,

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

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

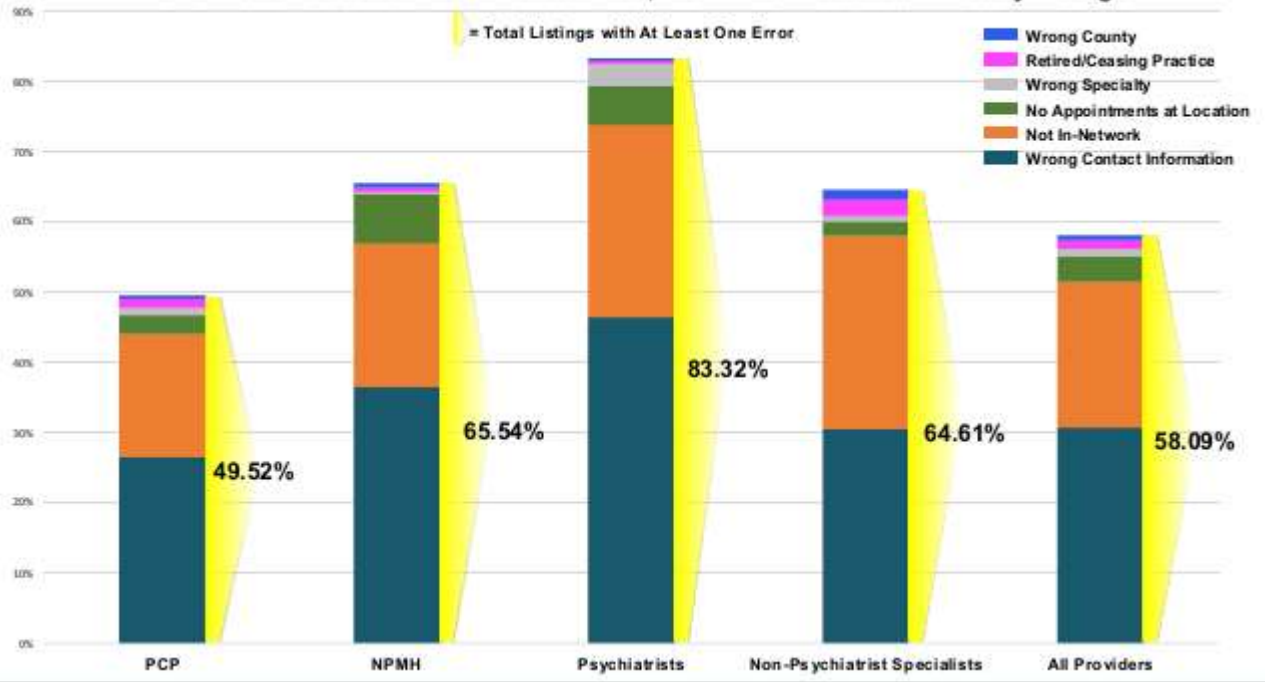
Molina’s provider directories were rife with entries for providers who were not actually in-network: More than a quarter of the listings for psychiatrists in Molina’s directories were for psychiatrists who were not actually in Molina’s network at all and more than 20 percent of all providers surveyed were listed in Molina’s provider directories, but were out of network. Other common errors included failing to remove retired physicians from directories, wrong phone numbers, and wrong addresses.

44. Molina Health Care of California’s 2018 error rates were no better. The overall directory error rate was 58.34 percent, with an 80.49 percent error rate for psychiatrists. The following chart presents Molina Health Care of California’s reported reasons why each erroneous listing was inaccurate:



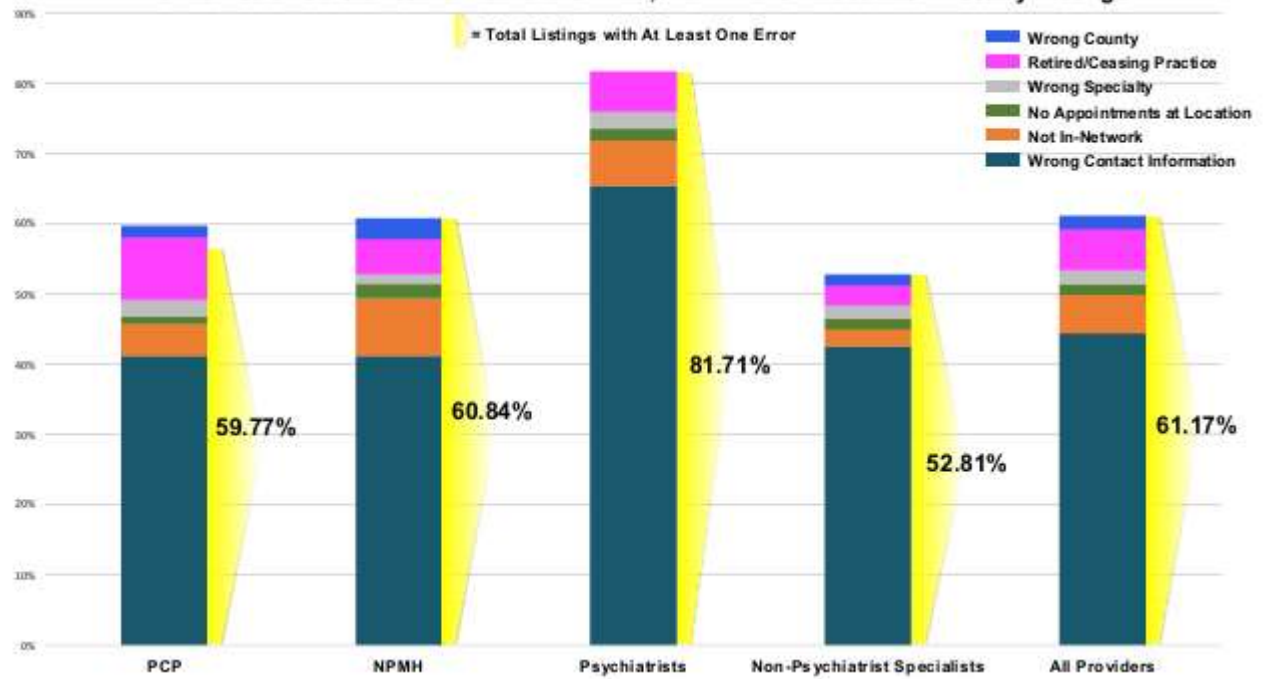
45. Defendant Molina Healthcare of California Partner Plan, Inc.’s (“Molina PP”) submissions also reveal outrageously high error rates. For 2019, Molina PP reported an overall error rate of 58.09 percent, with an astonishing 83.32 error rate for psychiatrists. The following chart presents Molina PP’s reported reasons why each erroneous listing was inaccurate:

Molina Health Care of California Partner Plan, Inc. – 2019 Inaccurate Directory Listings



46. Molina PP’s 2018 accuracy rates were also abysmal. The overall error rate was 61.17 percent, and 81.71 percent of psychiatrist listings were inaccurate. The following chart presents Molina PP’s reported reasons why each erroneous listing was inaccurate:

Molina Health Care of California Partner Plan, Inc. – 2018 Inaccurate Directory Listings



1 47. Indeed, the DMHC data shows that Molina repeatedly and consistently failed
2 to correct inaccurate directory data after learning of its inaccuracy through TAS surveying.
3 For example, of the 443⁸ primary care physicians with unique National Provider Identifiers
4 (“NPIs”) that recorded at least one inaccurate directory listing in the 2018 TAS (because
5 either their contact or specialty information was wrong or the provider was not in-network
6 or was retiring) that were surveyed again in 2019, **nearly three-quarters** (specifically 325
7 physicians, or 73.3 percent of the total) remained in Molina’s provider directory with
8 incorrect information for Molina’s 2019 TAS. Meaning that even though Molina learned in
9 its 2018 survey that these 325 provider listings were erroneous, Molina continued to list them
10 as available to provide care to Molina’s enrollees and potential enrollees in the succeeding
11 year.

12 48. Likewise, of the 285 non-physician mental health providers Molina surveyed
13 and deemed ineligible in the 2018 TAS and who surveyed again in Molina’s 2019 TAS, **more**
14 **than four in five** (specifically 229) remained ineligible the next year. For the 251 psychiatrist
15 specialists surveyed and deemed ineligible in connection with the 2018 TAS who were again
16 surveyed in 2019, **more than 80 percent** (specifically 204 psychiatrists) remained ineligible.
17 Finally, for specialists in all categories, Molina surveyed 538 providers and deemed them
18 ineligible in the 2018 TAS, a similar 80 percent (specifically 435 specialists) remained
19 ineligible.

20 49. Molina does not correct its directories using its own data, and it also fails to
21 prominently include contact information so that consumers and providers can report
22 directory inaccuracies. When conducting searches by computer, a consumer would have to
23 enter a small box at the bottom of the screen where a multitude of disclaimers are visible if
24 one scrolls through them. Only by scrolling through to the end of these disclaimers does one
25 find contact information for reporting directory errors. Molina’s mobile search similarly

26
27 ⁸ 124 primary care physicians who had ineligible entries in 2018 TAS results were not
28 surveyed in connection with the 2019 TAS, so these numbers may understate year-over-year
inaccuracies.

1 requires a consumer to enter and then scroll to the bottom of a tiny disclaimer box at the
2 bottom of their screen. The mobile search tool also does not allow consumers to search
3 providers by practice name, practice address, or NPI.

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

6 Molina’s Unlawful, Unfair, and Fraudulent Conduct Harms Consumers.

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

20 52. 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 foregoing or paying out-of-pocket for care

25 ⁹ 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 ¹⁰ *Id.* at 6.

28 ¹¹ *Id.* at 7.

1 for that entire period. Consumers report paying out-of-pocket both because they cannot find
2 in-network care, or because they relied on directories stating that care they sought was in-
3 network, only to be hit with big bills for out-of-network care.

4 Molina’s Ghost Networks Disproportionately Harm Vulnerable Populations

5 53. For low-income consumers, receiving an unexpected medical bill or having to
6 pay out-of-pocket to see a provider because they cannot find one that accepts their insurance
7 can be catastrophic. Alarming, forty percent of Americans would be unable to pay an
8 unexpected \$400 bill without going into debt¹² Some report forgoing food and necessary
9 health care and medications to afford health care bills.¹³

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

19 55. The financial dangers of Molina’s inaccurate directories are particularly acute
20 for people of color in the United States, especially Black and Hispanic families, who on
21

22 ¹² Division of Consumer and Community Affairs, *Economic Well-Being of U.S. Households in*
23 *2020* 88 (May 2020), <https://www.federalreserve.gov/publications/files/2020-report-economic-well-being-us-households-202105.pdf>.

24 ¹³ L. Hamel et al., *Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored*
25 *Insurance*, 2 KAISER FAMILY FOUNDATION (May 2019), <https://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance>.

26 ¹⁴ Press Release, California’s Efforts to Build on the Affordable Care Act Lead to a Record-
27 Low Rate Change for the Second Consecutive Year, Aug. 4, 2020, *at*
28 <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.¹⁵ 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.¹⁶ 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).¹⁷

7 56. 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.¹⁸ 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.¹⁹ Adults with disabilities are also more likely to experience poor health
12 and use health care at higher rates.²⁰

13 57. 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

17
18 ¹⁵ 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.,
20 [https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-](https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm)
21 [and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm](https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm).

22 ¹⁶ Signe-Mary McKernan et al., *Past-Due Medical Debt a Problem, Especially for Black Americans*,
23 URBAN INSTITUTE (Mar. 27, 2017), [https://www.urban.org/urban-wire/past-due-medical-](https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans)
24 [debt-problem-especially-black-americans](https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans).

25 ¹⁷ Jennifer Benz et al., *Americans' Views of Healthcare Costs, Coverage, and Policy*, NORC AT THE
26 UNIVERSITY OF CHICAGO 6 (2018), [https://www.norc.org/PDFs/WHI%20Healthcare%20Costs](https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf)
27 [%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Pol-](https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf)
28 [icy%20Issue%20Brief.pdf](https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf).

¹⁸ Nanette Goodman et al., *Financial Capability of Adults with Disabilities* (National Disability
Institute 2017), [https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/01/](https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/01/ndi-finra-report-2017.pdf)
[ndi-finra-report-2017.pdf](https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/01/ndi-finra-report-2017.pdf).

¹⁹ 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/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/)
[PMC4355692/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/).

²⁰ Mary Lou Breslin & Silvia Yee, *The Current State of Health Care for People with Disabilities*.
(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.²¹

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

10 Molina Benefits Financially from its Inaccurate Directories

11 59. Molina financially benefits from its provider directory inaccuracies in at least
12 three ways.

13 60. *First*, because a significant portion of Molina’s directory listings are erroneous,
14 Molina’s provider networks appear to be broader and more attractive to potential enrollees
15 than they are. Molina 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 Molina with an unjust windfall.

18 61. *Second*, Molina 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 Molina’s provider directory inaccuracies, obtaining care as a Molina 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

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26 ²¹ 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 accessible that has available appointments, saving Molina the costs associated with coverage.
2 Enrollees with significant health care needs may elect to abandon Molina at the next
3 opportunity and purchase better, more accurate insurance coverage. In this way, Molina
4 benefits financially by forcing out enrollees who are more expensive to insure and by forcing
5 enrollees to obtain out-of-network care while they are insured by Molina plans because they
6 are unable to find suitable providers in network.

7 62. *Third*, Molina saves on the labor costs associated with auditing and updating
8 its directories.

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

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

26 65. Molina knows its provider directory are inaccurate. Indeed, in 2019, the State
27 of Washington imposed a consent decree and a \$600,000 fine on that state's Molina affiliate,
28

1 Molina Health Care of Washington, Inc., in part because of Molina’s failure to maintain an
2 accurate provider directory. Nevertheless, its inaccuracies in California persist with
3 alarming frequency.

4 * * *

5 66. Molina’s failure to provide an accurate provider network is unlawful under
6 state and federal law and has harmed, and is continuing to harm, consumers in San Diego
7 and throughout the State of California.

8 67. Molina’s advertisement of services it fails to provide and publication of false
9 and misleading statements about its provider networks constitute unlawful, unfair, and
10 fraudulent business practices under the UCL, as well as false advertising under the FAL.

11 68. The People seek restitution for those who have paid for Molina health
12 insurance plans, but have not received that for which they paid; injunctive relief ordering
13 Defendants to cease the misrepresentations made to consumers and promulgate accurate
14 provider directories; and civil penalties as a result of each and every violation of the UCL
15 and FAL by Molina’s unfair and unlawful practices.

16 69. These violations include, but are not limited to, those impacting each and every
17 Molina enrollee in connection with each and every enrollment in Molina health insurance
18 plans, their monthly payment of insurance premiums for services, access to care, and other
19 benefits Molina has advertised and failed to provide, and each and every publication of
20 inaccurate provider directories over the statutory period.

21 **CAUSE OF ACTION ONE**
22 **Violation of Unfair Competition Law**
(Cal. Bus. & Prof. Code § 17200, et seq.)

23 70. All preceding factual statements and allegations are incorporated by reference.

24 71. Defendants have engaged in unlawful, unfair, and fraudulent business
25 practices by violating the letter and policy embodied in numerous provisions of California
26 and federal law, as well as by employing business practices likely to deceive the public.
27

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

- 3 a. Affordable Care Act guarantees of access to "an up-to-date, accurate,
4 and complete provider directory." (45 C.F.R. § 156.230(b)(2).)
- 5 b. The Federal Mental Health Parity and Addiction Equity Act, which
6 requires that non-quantitative treatment limits on mental health care
7 be the result of practices that are comparable to and no more stringent
8 than those used for medical and surgical benefits (45 C.F.R. §
9 146.136(c)(4)(i).)
- 10 c. California statutory requirements that ACA plan provider directories
11 be accurate. (Cal. Health & Safety Code § 1367.27.)
- 12 d. California statutory requirements related to the reporting of data
13 related to directory accuracy. (Cal. Health & Safety Code § 1367.27.)
- 14 e. California statutory requirements related to providing prominent on-
15 line contact information for consumers to report directory errors. (Cal.
16 Health & Safety Code § 1367.27.)
- 17 f. California statutory requirements related to the searchability of
18 network providers on-line. (Cal. Health & Safety Code § 1367.27.)
- 19 g. California statutory requirements and regulations related to the
20 reporting of timely access and physician data. (Cal. Health & Safety
21 Code §§ 1367.03, 1367.035.)
- 22 h. Federal regulations requiring Medicaid provider directories be
23 accurate and regularly updated. (42 C.F.R. § 438.10(h).)
- 24 i. False Advertising of products and services. (Cal. Bus. & Prof. Code §
25 17500.)
- 26 j. Molina's conduct is also unlawful because it constitutes a tort of
27 fraudulent inducement to contract.

1 82. The statements are misleading in that they are likely to deceive a reasonable
2 consumer into believing that the health care provider networks being offered were accurate,
3 and that purchase of the advertised plan would provide ready in-network access both to the
4 specific practitioners listed, and to a larger number of practitioners than were actually
5 provided.

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

8 84. The People therefore seek an appropriate civil penalty under the Business and
9 Professions Code section 17536(a) for up to \$2500 per violation of the FAL to hold Defendants
10 accountable for their false and misleading advertising and to deter further violations of the
11 FAL.

12 85. The People seek entry of provisional and final remedies against Defendants
13 including, without limitation, an injunction ordering Defendants to discontinue their false
14 and misleading advertising.

15 86. The People seek an award of restitution in an amount to be determined
16 according to proof.

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

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1 **PRAYER FOR RELIEF**

2 In light of the above, the People request the following remedies:

3 1. That, pursuant to Business & Professions Code § 17206, the Court assess a civil
4 penalty in an amount up to two thousand, five hundred dollars for each violation of § 17200
5 by each Defendant and all of them;

6 2. That, pursuant to Business & Professions Code § 17206.1(a)(1), the Court assess
7 an additional civil penalty in an amount up to two thousand, five hundred dollars for each
8 violation of § 17200 perpetrated against a senior citizen or disabled person, by each
9 Defendant and all of them;

10 3. That, pursuant to Business & Professions Code § 17536, the Court assess a civil
11 penalty in an amount up to two thousand, five hundred dollars for each violation of § 17500
12 by each Defendant and all of them;

13 4. That the Court award provisional and final remedies against Defendants
14 including, without limitation, an injunction prohibiting Defendants from continuing their
15 unlawful, unfair, and fraudulent activities, and discontinue their false and misleading
16 advertising;


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

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

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6 Dated: June 24, 2021

Mara W. Elliott, City Attorney

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