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Superior Court of California
County of Los Angeles

OCT 31 2016

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

BC 639205

PAUL SIMON, individually, and on behalf of others similarly situated,

Plaintiff,

vs.

BLUE CROSS OF CALIFORNIA, d/b/a ANTHEM BLUE CROSS; and DOES 1 - 100, inclusive,

Defendants.

Case No.:

CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL

1. VIOLATION OF BUSINESS & PROFESSIONS CODE § 17200, ET SEQ. (UNLAWFUL & UNFAIR)
2. BREACH OF THE DUTY OF GOOD FAITH AND FAIR DEALING
3. BREACH OF CONTRACT
4. DECLARATORY RELIEF

Plaintiff Paul Simon (hereafter "Plaintiff"), by his attorneys, brings this action on behalf of himself and all others similarly situated against Blue Cross of California dba Anthem Blue Cross (hereafter "Anthem"). Plaintiff alleges the following on information and belief, except as to those allegations which pertain to the named Plaintiff:

NATURE OF THE ACTION

1. Anthem is engaged in a "bait and switch" scheme designed to significantly downgrade health coverage to its members while increasing the price. Urgent action by this Court is necessary to protect California consumers as the "Open Enrollment Period" for securing health plan coverage for 2017 begins on November 1, 2016. Consumers who renew their Anthem coverage by the December 15 deadline will be locked into those plans for all of 2017.

2. Anthem's latest marketing ploy is based on its hard-earned experience. The last time Anthem cancelled members' coverage and replaced it with less comprehensive health plans, members revolted and Anthem lost customers. This time around, Anthem is not telling customers that their coverage is being cancelled. Instead, Anthem is representing that though customers' coverage will "change" as of January 1, 2017, "you'll be automatically re-enrolled in similar coverage." This is in reality, a fraud. Customers are being transitioned from coverage that provides comprehensive coverage for doctors and hospitals that are not participating in Anthem's provider network, to coverage that provides no out-of-network care whatsoever. This change leaves customers potentially facing thousands of dollars or more in medical bills that would have been covered under their existing plan. Many consumers likely face loss of access to their physicians altogether, a prospect particularly harmful for those in the midst of treatment, as paying full cost of out-of-network care is untenable for all but the wealthiest. Anthem knows that if consumers were informed that coverage was being withdrawn from the market and replaced with entirely different coverage as the law requires, consumers would take a closer look at their options, including health plans offered by other companies.

3. Plaintiff brings this class action for a violation of Business and Professions Code section 17200, breach of the duty of good faith and fair dealing, breach of contract, and declaratory relief against Anthem for characterizing and marketing its 2017 individual and

family health plan contracts as a "renewal" of its 2016 plans despite changing the plans from "Preferred Provider Organization" or "PPO" plans, which offer out-of-network benefits, into "Exclusive Provider Organization" or "EPO" plans, which provide no out-of-network benefits. Anthem has announced its intent to automatically "renew" its members' 2016 PPO plans for the 2017 plan year, even though the transformation of the plans into EPO plans renders the 2016 PPO plans "discontinued." By characterizing and marketing its new 2017 EPO plans as the same or similar coverage as the 2016 PPO plans, Anthem is breaching its contracts with members in bad faith, and engaging in unfair competition by, *inter alia*, violating Federal and California laws requiring "discontinuation" notices to be sent to members.

THE PARTIES

4. Plaintiff Paul Simon is, and at all relevant times was, a resident and citizen of the state of California. Plaintiff is an enrollee in an individual Anthem Platinum 90 D PPO tiered health plan contract for the plan year 2016.

5. Defendant Anthem is, and at all relevant times was, a corporation duly organized and existing under and by virtue of the laws of the State of California and is authorized to transact and is transacting business as a health plan issuer in this state, with its headquarters located in the County of Los Angeles.

6. The true names or capacities, whether individual, corporate, associate, or otherwise, of Does 1 through 100, inclusive, are unknown to the representative Plaintiff, who therefore sues said defendants by such fictitious names. Representative Plaintiff is informed and believes and thereon alleges that each of the defendants sued herein as a Doe is legally responsible in some manner for the events and happenings referred to herein, and will ask leave of this court to amend his Complaint to insert their true names and capacities in place and instead of the fictional names when the same becomes known to the representative Plaintiff.

7. At all relevant times, defendants, and each of them, were the agents and employees of each of the remaining defendants, and were at all times acting within the purpose and scope of said agency and employment, and each defendant has ratified and approved said agency and employment, and each defendant has ratified and approved the acts of its agent.

JURISDICTION AND VENUE

8. This Court has jurisdiction of this action under Article VI, section 10 of the California Constitution and section 410.10 of the Code of Civil Procedure.

9. Jurisdiction over Anthem is also proper because Anthem is headquartered in Los Angeles County, has purposely availed itself of the privilege of conducting business activities in California, and because Anthem currently maintains systematic and continuous business contacts with this State, and has many thousands of policyholders who are residents of this State.

10. Venue is proper in this Court because Plaintiff and many Class Members did business with Anthem in this County, Anthem engaged in business in this County, and because Anthem received substantial profits from policyholders who reside in this County.

FACTUAL ALLEGATIONS

11. Under recently enacted federal law, California health care consumers purchasing individual coverage may only renew coverage or enroll in new coverage during designated Open Enrollment Periods. The Open Enrollment Period for health coverage in effect for calendar year 2017 is between November 1, 2016 and January 31, 2017. However, for coverage to be in effect on January 1, 2017, consumers must renew existing coverage or enroll in new coverage by December 15, 2016.

12. At the end of September 2016, Plaintiff received a 24-page "renewal" packet that Anthem sent out to consumers enrolled in its PPO and tiered PPO plans throughout California informing members that their "health insurance coverage [was] still being offered but some details may have changed." According to this notice, plan members would be automatically enrolled in this "similar coverage" if they did not take action by December 15, 2016. A complete copy of Plaintiff's "Notice Packet" is attached as **Exhibit A** and incorporated herein by reference.

13. In the Notice Packet, Anthem disguised the fact that it was actually not offering the same or similar coverage to plan members. Instead, Anthem was attempting to automatically "renew" its plan members into a completely new and different product—switching members from a PPO plan into an EPO plan, which provides significantly less coverage. Meanwhile, in

the same Notice Packet Anthem announced premium rates would increase as of January 1, 2017 even though coverage would be significantly decreased. According to the Notice Packet, Plaintiff's premium will increase by 33%.

14. Under state and federal law, California consumers have a right to renew their existing coverage unless Anthem fulfills specifically defined criteria. Anthem has failed to fulfill those statutory obligations.

15. Under federal law, a health plan issuer ("issuer") like Anthem is required to renew coverage at the option of the individual. (42 U.S.C. § 300gg-2; 45 CFR § 147.106(a).) An issuer is only permitted to make changes to existing coverage if those changes qualify as a "uniform modification of coverage" under 45 CFR § 147.106(c).

16. One of the requirements necessary to qualify as a uniform modification of coverage is that the product must be offered "as the same product network type (for example, health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), point of service, or indemnity.)" (45 CFR § 147.106(e)(3)(ii).) An issuer is not permitted to renew coverage and change the product type from PPO to EPO.

17. If the health plan issuer wants to change the product type—for example, as here, from PPO to EPO—the issuer is required to "discontinue" the coverage and issue a new product. (45 CFR §§ 147.106(b)(4) and (c).) Notice of discontinuation of a health plan must be made at least 90 calendar days before the date the coverage will be discontinued. (45 CFR § 147.106(c)(1).) If the issuer fails to discontinue coverage, it must renew the coverage. (42 U.S.C. § 300gg-2; 45 CFR § 147.106(a).) As explained below, since Anthem failed to provide the required notice of discontinuation at least 90 days prior to January 1, 2017—the discontinuation date—Anthem must renew the coverage.

18. The federal regulations also set forth the form of specific Notice letters that are required to be sent to consumers when coverage is renewed or discontinued. The regulations require that one type of form notice be sent when a plan renews existing coverage, and that that a completely different form notice be sent when a plan discontinues coverage. If an issuer is renewing a health plan, the renewal notice must include the expected monthly premium payment

of the renewing plan. (45 CFR § 156.1255.) The federally required discontinuation notices are attached as **Exhibit B** and incorporated herein by reference.

19. Similarly, under California law, an individual health benefit plan "shall be renewable at the option of the enrollee." (Health and Safety Code § 1399.853(a).) An issuer may only "withdraw" (equivalent to "discontinue" under federal law) a health benefit plan from the market if it complies with Health and Safety section 1365(a)(6)(A) and California Code of Regulation, title 28, section 1300.65(c)(6), which requires the health plan issuer to notify the member at least 90 days prior to the discontinuation, among other requirements. The notice must state: (1) the reason for the nonrenewal, (2) an explanation of the right to submit a Request for Review the nonrenewal, and (3) the required Language for Notice of Cancelation or Nonrenewal specifically set forth by 28 CCR § 1300.65(c)(6). This language is mandated to be included in every notice for a discontinuation of coverage.

20. Indeed, this requirement is memorialized in Anthem's health plan contracts, or Evidences of Coverage, with its members:

> **Guaranteed Renewable**
> Coverage under this Agreement is guaranteed renewable except as permitted to be terminated, canceled, rescinded, or not renewed under applicable State and federal law. The Member may renew this Agreement by payment of the renewal Premium by the end of the Grace Period of the Premium due date, provided the following requirements are satisfied:
>
> 1. Eligibility criteria continues to be met;
> 2. There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage, and;
> 3. Membership has not been terminated by Anthem under the terms of this Agreement.

A true and correct copy of Plaintiff's Evidence of Coverage is attached as **Exhibit C** and incorporated herein by reference.

21. Because Anthem attempted to change the network type from a PPO to an EPO, it cannot qualify as a uniform modification of coverage under 45 CFR § 147.106(e). In order for Anthem to lawfully take away plan members' out-of-network benefits, it was required to follow

both (1) federal law for discontinuing a particular product (45 CFR § 147.106(c)) *and* (2) California law for discontinuing a health plan (Health & Saf. Code § 1365(a)(6)(A)). Anthem failed to comply with either law.

22. Anthem sent the notices for plan renewals, rather than the proper notice required for a product discontinuation. Anthem did not include the required language in its notice.

23. Anthem's Notice Packet is littered with deceptive and misleading statements. Under the guise of "renewal," Anthem is misleading current 2016 PPO members into thinking they will be enrolled in the same plan with the same coverage in 2017 as long as they just continue paying their new (increased) premium like usual.

24. For instance, the packet interchangeably refers to both the existing PPO and the new EPO as "your plan" throughout the material. It also untruthfully states that "Bottom line: if you like your current plan, you can keep it."

25. The packet also contains various sections referencing plan changes, yet in most places it completely fails to disclose that plan members will be losing their out-of-network benefits. In only two places within the 24-page packet does Anthem even discuss out-of-network benefits—an obvious attempt to carefully conceal these coverage limitations from consumers.

26. In fact, the packet contains a nine-page insert entitled "Notice of changes to your Individual plan." The first line of the Notice states "[t]his Notice of Changes to your Individual Plan (Notice) gives a summary of changes for your plan." Yet unbelievably, the nine-page insert does not even make one mention of the fact that the new plan will be an EPO or that the new plan will not offer any out-of-network benefits.

27. The Notice Packet also includes a cover letter with a section entitled "Changes you'll see to your plan in 2017." Again this section does not even make one reference to the fact that the new plan (or to use Anthem's terminology, the "existing plan") will be an EPO and will not contain any out-of-network benefits. In fact, the entire cover letter of the Notice Packet makes *zero* mention of an EPO or of out-of-network benefits.

28. Plan members would be forced to read to the very end of a benefit comparison chart hidden within the packet to discover that the plan no longer includes any out-of-network

benefits. But this text is not prominently displayed, is not italicized, bolded, or placed in larger text than the surrounding text. The difference between PPO plans and EPO plans then appears in only one other place in the Notice Packet but is buried within numerous inconsistent statements about the "same plan" being "renewed," and again is not italicized, bolded, or placed in larger text. These carefully hidden "disclosures" fail to comply with Health and Safety Code section 1389.25 requirements that changes in plan design must be italicized and that the reason for the change to plan design must be bolded.

29. Since Anthem is required to give at least 90-day notice prior to discontinuing a health plan, it can no longer comply with the Notice requirements for a plan discontinuation currently scheduled for January 1, 2017. Therefore, because Anthem has not provided adequate notice of the plan termination under either Federal or California law, it is required to renew its tiered PPO product in all regions where it unlawfully attempted to automatically renew plan members into a new EPO plan for 2017.

30. On or around October 15, 2016, Anthem sent a one-page "correction" notice to its members ("October 15 Notice"). The October 15 Notice states "[w]e're writing to tell you about a correction to the 2017 benefits that were included in the Open Enrollment materials you recently received." Acknowledging that the original Notice Packet failed to include material information, the October 15 Notice then states: "The [Notice Packet] did not call out the following changes to your benefits:

> **PPO to EPO plan change**
> The health plans we offer in your area will change beginning in 2017. Your current PPO plan will be changed to an EPO plan effective January 1, 2017. Your EPO plan network means you have the freedom to choose an in-network doctor without needing a referral, however, **utilizing out of network providers is no longer covered** – except for emergency or urgent care.

A true and correct copy of the October 15 Notice is attached as **Exhibit D** and incorporated herein by reference. Unlike the Notice Packet, which arrived in an oversized white and blue envelope with an eye-catching arrow graphic containing the words in large print—"Open Enrollment is November 1, 2016-January 31, 2017"—the October 15 Notice arrived in a nondescript plain white envelope with no indication whatsoever of the it information contained.

This disparate treatment in notice was intended to further disguise the true nature of the 2017 health plans.

31. Not only is this "correction" notice untimely (sent after the 90-day notice deadline) but it also fails to comply with any of the federal and state regulations for terminating coverage: (1) in violation of 47 CFR § 147.106 it does not inform plan members that their coverage is being discontinued—still unlawfully characterizing the plan termination and automatic renewal as a "plan change"; (2) in violation of 47 CFR § 147.106(a), (b)(4), and (c)(1), it fails to follow the federally mandated notice requirements for terminating coverage in the form and manner set forth by the Secretary; (3) in violation of Health and Safety Code section 1399.853(a) and Health and Safety Code section 1365(a)(6)(A), and California Code of Regulation, title 28, sections 1300.65(c)(1)-(6), it fails to correctly notify plan members that Anthem is terminating their coverage and it also fails to provide a reason for the nonrenewal, an explanation of the right to submit a Request for Review of the nonrenewal, and does not include any of the required language set forth by 28 CCR § 1300.65(c)(6); (4) in violation of Health and Safety Code section 1360 it untruthfully characterizes the plan termination as a "plan change"; and (5) in violation of Health & Safety Code section 1389.25 it fails to italicize the changes to plan design and bold the reason for the change to the plan design.

32. According to the actuarial memo supporting Anthem's 2017 rate filing with Department of Managed Health Care, Anthem also mischaracterizes the EPO plans offered in the 15 pricing regions at issue here as "renewing" rather than "new."

CLASS ALLEGATIONS

33. This action is brought on behalf of the Plaintiff individually and on behalf of all others similarly situated pursuant to Code of Civil Procedure section 382. Plaintiff seeks to represent the following class:

> All California residents who are currently enrolled in an Anthem individual PPO health plan for the plan year 2016 that Anthem intends to convert to an EPO plan effective January 1, 2017 and for which notice of discontinuation was not provided as required by law.

34. The proposed Class is composed of tens of thousands, and possibly hundreds of thousands, of persons dispersed throughout the State of California and joinder is impracticable. The precise number and identity of Class members are unknown to Plaintiff but can be obtained from Anthem's records.

35. There are questions of law and fact common to the members of the Class which predominate over questions affecting only individual Class members.

36. Plaintiff is a member of the Class and Plaintiff's claims are typical of the claims of the Class.

37. Plaintiff is willing and prepared to serve the Court and the proposed Class in a representative capacity. Plaintiff will fairly and adequately protect the interests of the Class and has no interests adverse to or which conflict with the interests of the other members of the Class.

38. The self-interest of Plaintiff is co-extensive with and not antagonistic to those of absent Class members. Plaintiff will undertake to represent and protect the interests of absent Class members.

39. Plaintiff has engaged the services of counsel indicated below who are experienced in complex class litigation, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent the Plaintiff and absent Class members.

40. The prosecution of separate actions by individual members of the Class would create a risk of inconsistency and varying adjudications, establishing incompatible standards of conduct for Anthem.

41. Anthem has announced its intention to act on grounds generally applicable to the Class, thereby making relief with respect to the Members of the Class as a whole appropriate.

42. A class action is superior to other available means for the fair and efficient adjudication of this controversy. Prosecution of the complaint as a class action will provide redress for individual claims too small to support the expense of complex litigation and reduce the possibility of repetitious litigation.

43. Plaintiff anticipates no unusual management problems with the pursuit of this Complaint as a class action.

SUMMARY OF ILLEGAL ACTS

44. Through its conduct of characterizing and marketing its 2017 EPO plans as the "same coverage" and a "renewal" of its 2016 PPO plans, Anthem:

a. Is breaching its duty of good faith and fair dealing owed to Plaintiff and Class Members;

b. Is breaching its health plan contracts with Plaintiff and Class Members;

c. Is violating 42 U.S.C. § 300gg-2 and 45 CFR § 147.106 by attempting to automatically renew plan members out of their existing PPO plan into an EPO plan as of January 1, 2017 apparently under a "uniform modification of coverage" exception, rather than correctly disclosing to consumers that Anthem is discontinuing their 2016 coverage;

d. Is violating 45 CFR § 147.106(a), (b)(4), and (c)(1), which prohibits a health plan issuer from discontinuing a particular product if it does not provide notice in a form and manner specified by the Secretary of the Department of Health and Human Services, by failing to provide the federally mandated notice of the termination to consumers;

e. Is violating California Health and Safety Code section 1399.853(a), Health and Safety Code section 1365(a)(6)(A), and California Code of Regulation, title 28, sections 1300.65(c)(1)-(6) by failing to provide (1) the reason for the nonrenewal, (2) an explanation of the right to submit a Request for Review the nonrenewal, and (3) the required Language for Notice of Cancelation or Nonrenewal specifically set forth by 28 CCR § 1300.65(c)(6);

f. Is violating Health and Safety Code section 1360, which prohibits untrue and misleading statements in advertising, by disseminating deceptive and misleading statements to consumers in its Notice Packet;

g. Is violating Health and Safety Code section 1389.25 by failing to disclose in the notices changes in the reduction in out-of-network benefits in italicized in bold-faced font; and

h. Is violating California's longstanding requirement[1] that reductions in coverage on renewal policies must be conspicuous and clear.

FIRST CAUSE OF ACTION

(Violation of Business & Professions Code § 17200, et seq. (Unlawful & Unfair))

45. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

46. Business and Professions Code section 17200, et seq. prohibits acts of "unfair

[1] *Davis v. United Services Auto. Ass'n* (1990) 223 Cal.App.3d 1322, 1332.

competition" which is defined by Business and Professions Code section 17200 as including "any unlawful, unfair or fraudulent business act or practice . . . ."

47. Anthem and Does 1 through 100 have violated and continue to violate Business and Professions Code section 17200's prohibition against engaging in "unlawful" business acts or practices, by, inter alia, violating provisions of federal law, the California Health and Safety Code, California Code of Regulations, and Code of Federal Regulations as described herein.

48. Anthem's and Does 1 through 100's conduct, as described above, and each of them, also constitute "unfair" business acts and practices under Business and Professions Code section 17200.

49. Anthem's and Does 1 through 100's conduct does not benefit consumers or competition. Indeed the injury to consumers and competition is substantial.

50. Plaintiff and Class Members could not have reasonably avoided the injury each of them suffered.

51. Plaintiff and Class Members have suffered injury in fact and lost money and/or property as a result of Anthem's and Does 1 though 100's unlawful and unfair business acts and practices.

52. The gravity of the consequences of Anthem's and Does 1 through 100's conduct as described above outweighs any justification, motive or reason therefore and is immoral, unethical, oppressive, unscrupulous, and offends established public policy set forth in federal and state law, and state and federal regulatory provisions as well as their underlying purposes.

53. As a result of Anthem's and Does 1 though 100's violations of the Business and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Anthem to renew the PPO health plans subject to this action for the 2017 calendar year.

SECOND CAUSE OF ACTION

(Breach of the Duty of Good Faith and Fair Dealing)

54. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

55. Defendant Anthem and Does 1 through 100 have breached their duty of good

faith and fair dealing owed to Plaintiff and members of the Class by unreasonably characterizing and marketing its 2017 EPO plans as the "same coverage" and a "renewal" of its 2016 PPO plans, when the two plan products are different types of coverage.

56. Plaintiff is informed and believes and thereon alleges that defendants, and each of them, have breached their duty of good faith and fair dealing owed to Plaintiff and members of the Class by other acts or omissions of which Plaintiff is presently unaware and which will be shown according to proof at the time of trial.

57. As a proximate result of the aforementioned unreasonable and bad faith conduct of defendants, Plaintiff and members of the Class have suffered, and will continue to suffer in the future, damages under the health plans, plus interest, and other economic and consequential damages, in an amount to be proven at trial.

58. As a further proximate result of the unreasonable and bad faith conduct of defendants, Plaintiff and members of the Class were compelled to retain legal counsel and to institute litigation to obtain the benefits due under the contracts. Therefore, defendants are liable for those attorneys' fees, witness fees and litigation costs reasonably incurred in order to obtain their benefits under the health plan contracts.

59. Defendants' conduct described herein was intended by the defendants to cause injury to members of the Class and/or was despicable conduct carried on by the defendants with a willful and conscious disregard of the rights of members of the Class, subjected members of the Class to cruel and unjust hardship in conscious disregard of their rights, and was an intentional misrepresentation, deceit, or concealment of material facts known to the defendants with the intention to deprive members of the Class property, legal rights or to otherwise cause injury, such as to constitute malice, oppression or fraud under California Civil Code section 3294, thereby entitling Plaintiff and members of the Class to punitive damages in an amount appropriate to punish or set an example of defendants

60. Defendants' conduct described herein was undertaken by Anthem and Does 1 through 100 officers or managing agents who were responsible for claims supervision and operations decisions. The previously described conduct of said managing agents and individuals

was therefore undertaken on behalf of Anthem. Anthem further had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents whose precise identities are unknown to Plaintiff at this time and are therefore identified and designated herein as Does 1 through 100.

THIRD CAUSE OF ACTION

(Breach of Contract)

61. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

62. Anthem and Does 1 through 100 owe duties and obligations to Plaintiff and members of the Class under health plan contracts at issue.

63. Specifically, Anthem promises in its plan contracts entered into between Anthem and Class Members:

> **Guaranteed Renewable**
> Coverage under this Agreement is guaranteed renewable except as permitted to be terminated, canceled, rescinded,
> or not renewed under applicable State and federal law. The Member may renew this Agreement by payment of the
> renewal Premium by the end of the Grace Period of the Premium due date, provided the following requirements are
> satisfied:
>
> 1. Eligibility criteria continues to be met;
> 2. There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage, and;
> 3. Membership has not been terminated by Anthem under the terms of this Agreement.

(Exhibit C, p. 41.)

64. Plaintiff continues to meet the eligibility criteria; Plaintiff has not made fraudulent or intentional misrepresentations on the application or under the terms of this coverage; and Anthem has not terminated membership under the terms of the health care contract.

65. Anthem and Does 1 through 100 have made a clear, positive, and unequivocal declaration, without justification, of their intent to breach its obligations under the health plan

contracts between the Class Members and Anthem and Does 1 through 100 by characterizing and marketing its 2017 EPO plans as the "same coverage" and a "renewal" of its 2016 PPO plans, when the two plan products are different types of coverage and do not qualify as a "uniform modification of coverage" under 45 CFR § 147.106(e).

66. By carrying out the declared acts, Anthem and Does 1 through 100 have breached the terms and provisions of the health plan contracts by failing and refusing to pay benefits under the contracts.

67. As a direct and proximate result of Anthem's and Does 1 through 100 conduct and breach of contractual obligations, Plaintiff and members of the Class will suffer damages under the health plan contracts in an amount to be determined according to proof at the time of trial.

FOURTH CAUSE OF ACTION

(Declaratory Relief)

68. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

69. California Code of Civil Procedure section 1060 provides that any person "interested under … a contract … may, in cases of actual controversy relating to the legal rights and duties of respective parties" bring an action in Superior Court for a declaration of his or her rights and the "the court may make a binding declaration of these rights or duties, whether or not further relief is or could be claimed at the time."

70. An actual controversy has arisen between Plaintiff and the members of the Class he represents, on the one hand, and Anthem and Does 1 through 100 on the other hand, as to their respective rights and obligations under the health plan contracts between them.

71. Additionally, Plaintiff and the Class contend that Anthem is in violation of the following federal regulations and state laws:

a. Is breaching its health plan contracts with Plaintiff and Class Members;

b. Is violating 42 U.S.C. § 300gg-2 and 45 CFR § 147.106 by attempting to automatically renew plan members out of their existing PPO plan into an EPO plan as of January 1,

2017 under a "uniform modification of coverage" exception, rather than correctly disclosing to consumers that Anthem is discontinuing their 2016 coverage;

c. Is violating 45 CFR § 147.106(a), (b)(4), and (c)(1), which prohibits a health plan issuer from discontinuing a particular product if it does not provide notice in a form and manner specified by the Secretary of the Department of Health and Human Services, by failing to provide the federally mandated notice of the termination to consumers;

d. Is violating California Health and Safety Code section 1399.853(a), Health and Safety Code section 1365(a)(6)(A), and California Code of Regulation, title 28, sections 1300.65(c)(1)-(6) by failing to provide (1) the reason for the nonrenewal, (2) an explanation of the right to submit a Request for Review the nonrenewal, and (3) the required Language for Notice of Cancelation or Nonrenewal specifically set forth by 28 CCR § 1300.65(c)(6);

e. Is violating Health and Safety Code section 1360, which prohibits untrue and misleading statements in advertising, by disseminating deceptive and misleading statements to consumers in its Notice Packet;

f. Is violating Health and Safety Code section 1389.25 by failing to disclose in the notices changes in the reduction in out-of-network benefits in italicized in bold-faced font; and

g. Is violating California's longstanding requirement that reductions in coverage on renewal policies must be conspicuous and clear.

72. Anthem contends that its conduct was proper.

73. Plaintiff seeks a declaration as to the respective rights and obligations of the parties.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, on his own behalf and on behalf of the Class, pray for relief as follows:

AS TO THE FIRST CAUSE OF ACTION FOR VIOLATIONS OF THE BUSINESS AND PROFESSIONS CODE SECTION 17200

1. An order of this Court enjoining Anthem to renew the PPO health plans subject to this action for the 2017 calendar year.

2. For attorneys' fees, witness fees and costs of litigation incurred herein;

AS TO THE SECOND CAUSE OF ACTION FOR BREACH OF THE DUTY OF GOOD FAITH AND FAIR DEALING

3. Damages for failure to provide benefits under the contracts, plus interest, including prejudgment interest, and other economic and consequential damages, in a sum to be determined at the time of trial;

4. For attorneys' fees, witness fees and costs of litigation incurred to obtain the contract benefits in an amount to be determined at trial;

5. Punitive and exemplary damages in an amount appropriate to punish or set an example of defendants;

6. For costs of suit incurred herein; and

7. For such other and further relief as the Court deems just and proper.

AS TO THE THIRD CAUSE OF ACTION FOR BREACH OF CONTRACT

8. Damages under the contracts, plus interest, in an amount to be determined according to proof at the time of trial;

9. For attorneys' fees, witness fees and costs of litigation incurred herein; and

10. For such other and further relief as the Court deems just and proper.

AS TO THE FOURTH CAUSE OF ACTION FOR DECLARATORY RELIEF

11. For a declaratory judgment on the rights and obligations of the parties;

12. For attorneys' fees, witness fees and costs of suit incurred herein; and

13. For such other and further relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Plaintiff demands a trial by jury on all issues triable.

Date: October 31, 2016

SHERNOFF BIDART ECHEVERRIA LLP

By _____
MICHAEL J. BIDART
TRAVIS M. CORBY
Attorneys for Plaintiff

CONSUMER WATCHDOG

By _____
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