IN THE SUPERIOR COURT OF COBB COUNTY
STATE OF GEORGIA

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| FRANCES KIRBY, AUDREY LOGAN, DIOLI AZOFEIFA, JOHN DAVID MARKS, WANDA SILVA, TONYA BEACH, and DAVID FROHMAN, individually and on behalf of all others similarly situated,<br><br>Plaintiffs,<br><br>v.<br><br>BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD AND AS SUCCESSOR IN INTEREST TO BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.<br><br>Defendant, | Case No.: 19-1-02689-53<br><br>**DEMAND FOR JURY TRIAL** |

# FIRST AMENDED CLASS ACTION COMPLAINT

Plaintiffs, Frances Kirby, Audrey Logan, Dioli Azofeifa, John David Marks, Wanda Silva, Tonya Beach, and David Frohman ("Plaintiffs"), individually and on behalf of the Class defined below, file this First Amended Complaint as a matter of course pursuant to O.C.G.A. § 9-11-15(a) and allege the following against Defendant, Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. d/b/a Anthem Blue Cross and Blue Shield and as successor in interest to Blue Cross Blue Shield of Georgia, Inc. (hereinafter referred to as "Defendant" or "Anthem"), based upon

personal knowledge with respect to themselves and on information and belief derived from, among other things, investigations of counsel and review of public documents as to all other matters.

## SUMMARY OF THE CASE

### A. Procedural History

1. In April 2019, Plaintiffs filed their original class action complaint in this Court, targeting the health insurance marketing scheme perpetrated by Anthem in Georgia that occurred during the Affordable Care Act's 2019 open enrollment period ("Open Enrollment Period") and continued afterward.[1] Plaintiffs alleged, in part, that Anthem falsely inflated the size of its physician and hospital networks available to consumers who purchased Anthem's individual and family Pathway health insurance plan(s).

2. In February 2021, Plaintiffs successfully defeated Anthem's motion to dismiss, which relied in part on the filed-rate doctrine.[2] Anthem successfully petitioned the Georgia Court of Appeals to accept an interlocutory appeal on the issue of whether the filed-rate doctrine barred Plaintiff's claims. On February 7, 2022, the Georgia Court of Appeals held that the filed-rate doctrine did not bar

[1] The 2019 Affordable Care Act Open Enrollment Period extended from November 1, 2018 through December 15, 2018.

[2] *See* Order entered on February 11, 2021, denying Defendant's motion to dismiss.

Plaintiffs' claims.[3] Defendant then filed a Petition for Certiorari before the Supreme Court of Georgia and on November 17, 2022, that Court denied Anthem's petition.

3. Over the last few years, while this case was delayed by COVID and litigated in Georgia's appellate courts, significant developments occurred that warrant the filing of this amended complaint.

4. For example, Plaintiffs' original class complaint alleged that Anthem engaged in a health insurance scheme limited to the 2019 Open Enrollment Period. The following year, however, during the 2020 Open Enrollment Period, the *Atlanta Journal-Constitution* published an article entitled "*Anthem ACA Plans Misinform WellStar patients That They'll Be in Network,*" reporting that during the 2020 Open Enrollment Period Anthem again falsely inflated the size of its physician and hospital networks.[4]

5. Also importantly, in March 2022 the Georgia Office of Commissioner of Insuranc issued a $5 million fine against Anthem that stands as the largest ever levied by that office. The Insurance Commissioner cited Anthem for engaging in a years-long pattern of misconduct that mirrors the allegations in this case. The

[3] *Blue Cross Blue Shield of Ga. v. Kirby*, 362 Ga. App. 516 (Feb. 7, 2022).

[4] https://www.ajc.com/news/state--regional-govt--politics/anthem-aca-plans-misinform-wellstar-patients-that-they-network/fOzfD5iiCpa66paiEuUCKK/

*Atlanta Journal-Constitution* reported the fine in an March 29, 2022, article entitled "Georgia Insurance Commissioner's Office Fines Anthem Blue Cross Blue Shield $5 million":

> The state of Georgia has fined Blue Cross Blue Shield, also known as Anthem, $5 million for a repeated, years-long pattern of violations of policyholder's rights, the largest fine ever levied by the Office of Insurance and Safety Fire Commissioner.
>
> "Since my first day in office we have been inundated with complaints about Anthem from individuals, from doctors, hospitals and others from all corners and across Georgia," Commissioner John King said in a press conference Tuesday morning at the state Capitol.
>
> The central problem, King said, has been the inaccuracy of Anthem's list of health care providers, called its network. Patients often decide which insurer to buy a policy from based on whether their doctor or hospital is "in network" with that insurance company. For that to happen, the insurance company has to have its own contract with that doctor or hospital.[5]

6. Another news outlet reported Commissioner King's statement that his "office has received about 78,000 complaints about Anthem Blue Cross Blue Shield over a period of about five years." In that article, King said "one of the biggest issues is Anthem Blue Cross Blue Shield would provide inaccurate information about what doctors and hospitals were in-network."[6]

[5] https://www.ajc.com/news/coronavirus/georgia-fines-anthemblue-cross-5-million-for-consumer-violations/ETD323PBO5C6JJO4DILDKICOQ4/

[6] https://www.news4jax.com/news/local/2022/03/30/georgia-hits-anthem-blue-cross-blue-shield-with-5m-in-fines-for-consumer-violations/

7. In the Consent Order issued by the Georgia Office of Commissioner of Insurance ("Commissioner") dated March 29, 2022, Anthem consented to the findings by the Commissioner which included, in part, the fact that "in March 2015, [Anthem] implemented an internally developed provider database system that served as a centralized data repository for all Anthem provider demographic data." See ¶ 6, Consent Order attached as Exhibit A. "Following the implementation of the provider database system, provider complaints made to both the Department and Respondent noticeably increased during calendar years 2015-2018." Id. "The most common complained of errors ("processing errors") were from (1) claims from in-network providers processing as out-of-network, and (2) claims rejected for unknown reasons." Id.

8. Based on this new information, it is clear that Anthem did not limit its health insurance scheme to the 2019 Open Enrollment Period — the scheme extended over multiple years, before and after policies were issued. These facts support more than a claim that Anthem may have been negligent. They suggest an intentional scheme and a pattern of intentional or reckless misconduct that involved misrepresenting the size of Anthem's network of health care providers to collect more premiums and gain a larger market share in Georgia.

9. As a result, Plaintiffs file this amended complaint to expand the Class Period and to add a claim for violations of the Georgia RICO Act.

**B. Anthem's Misconduct Puts Its Policyholders' Lives at Risk**

10. Beginning in at least 2015 and continuing through March 2022 when Anthem entered into the $5 million Consent Order, Anthem engaged in a deceptive marketing scheme. Anthem knowingly and intentionally made uniform material misrepresentations and omissions that falsely inflated the size of its networks available to consumers who purchased Anthem's individual and family Pathway health insurance plan(s).

11. Anthem lied to Georgia consumers and to agents who sold Anthem's health insurance plans, as well as to state and federal regulators. Anthem falsely included physicians and health systems in its list of in-network providers knowing that those physicians and health systems did not accept Anthem's Pathway plan(s). These included, for example, Georgia's largest health system, WellStar Health System, Inc. ("WellStar"), Atlanta's largest hospital system, Emory Healthcare ("Emory"), and Piedmont Healthcare ("Piedmont"), which consists of 11 hospitals and nearly 100 physician and specialist offices across greater Atlanta and North Georgia. Anthem also listed as "in-network" other Atlanta-area physicians and health provider groups that were not exclusively in the WellStar, Emory and/or Piedmont health systems. Anthem knew that those physicians and groups did not accept Pathway health plans.

12. Anthem's scheme was designed to generate profits by misleading Georgia consumers purchasing individual and family health insurance policies[7] to believe that Georgia's largest and most popular healthcare systems were covered providers, when Anthem knew that they were not, or were not going to be, in-network.

13. The harm caused by Anthem's scheme cannot be overstated. For example, then-27-year-old Plaintiff Audrey Logan and her husband Kenneth Matthew Logan had a 10-month-old daughter named Peyton. Ms. Logan suffers from post-partum cardiomyopathy and CPVT, a form of tachycardia. Ms. Logan has been under the care of a cardiologist since she was a child, and learned in 2018 that she needed a heart transplant to survive. Prior to enrolling in her Anthem Pathway health care plan, Ms. Logan did her due diligence and confirmed on the Healthcare.gov and Anthem.com websites that her WellStar cardiologists were in-network providers covered under Anthem's insurance. But after the 2019 Open Enrollment period closed, she was shocked to learn that WellStar was not a covered provider under her Pathway insurance policy. In addition, she learned that Emory, which is the only hospital in Georgia that can perform her heart transplant surgery, was not in-network, either, even though Anthem listed Emory as in-

[7] Consumers who are not eligible for group health insurance coverage through an employer may purchase individual and family health insurance.

network. Ms. Logan's fight for Anthem to honor its promises and allow her to receive a heart transplant under the care of her longstanding WellStar cardiologist at Emory was and remains a matter of life and death for her.

14. Plaintiff Dioli Azofeifa suffers from multiple sclerosis ("MS") and is confined to a wheelchair. She requires treatment from multiple specialists including her primary care physician, Dr. Sharon Odell, who is a WellStar physician and thyroid specialist who treats Ms. Azofeifa for thyroid-related issues. Ms. Azofeifa enrolled with Anthem during the 2019 Open Enrollment Period. When signing up for the Anthem insurance, Ms. Azofeifa and her husband made sure that Plaintiff's WellStar primary care physicians, including Dr. Odell, were listed by Anthem as being in-network. After the close of the 2019 Open Enrollment Period, Ms. Azofeifa learned that WellStar was not in-network. As a result, she was denied necessary medical treatment by WellStar and was required to continue to pay premiums until January 1, 2020, for a health plan that did not cover her doctors and local hospitals. Had she known that truth, Ms. Azofeifa would not have enrolled with Anthem.

15. The other named Plaintiffs have serious medical conditions and need treatment by their specialists for their chronic and terminal problems, such as cancer, heart failure and spinal cord disorders. They too were misled by Anthem

into believing that their doctors were in-network providers under Anthem's Pathway health plan.

16. To add insult to injury, after the 2019 Open Enrollment Period closed, Plaintiffs and Class Members received a letter from Anthem that stated in pertinent part:

> **[Name of Member], need to see a specialist?**
>
> You'll have to get a referral.
>
> Your 2019 Member Contract incorrectly said you don't need a referral from your primary care doctor to see a specialist. Your plan **does** require a referral to see a specialist.
>
> That was our mistake, and we/re sorry for any confusion. The good news is that nothing changed with your benefits and you don't need to take any action. We're just making sure you have the right information.

("Anthem Letter") (bold in original). See attached Exhibit B.

17. As explained below, Anthem's Member Contract expressly prohibits Anthem from unilaterally changing any material contractual term, and yet Anthem did it anyway, breaching that contract under Georgia law. As explained below, Anthem's breach created more harm to Plaintiffs and Class Members, delayed their treatment and forced them to incur additional expenses as a result of having to seek a referral from their primary care physician, even though many of them were already under the care of a specialist.

**C. Brief Description of Anthem's Deceptive Marketing Scheme**

18. Consumers purchase health insurance based on whether their health care providers are covered by the insurance. Therefore, it logically follows that Plaintiffs and Class Members enrolled with Anthem because the company represented before and after the issuance of their health insurance policies that the insurance covered Plaintiffs' health care providers. Furthermore, as explained in more detail below, Anthem is the only health insurance provider in 44 mostly rural counties in Georgia. Providing those patients with access to their doctors is critical to choosing a plan.

19. Beginning in at least 2015, Anthem knew that consumers select health insurance based on whether their health care providers are going to be covered by the health insurance.

20. Beginning in at least 2015, Anthem used uniform misrepresentations on its Anthem.com website, the Healthcare.gov website, its health insurance applications and contracts to mislead prospective consumers into believing that Plaintiffs' and Class Members' health care providers were in-network for Anthem's health insurance plans, when they were not.

21. Anthem was and is required by federal law to provide the U.S. Department of Human Health Services ("DHS") with up-to-date and accurate lists of networks of covered healthcare providers so that consumers can make informed

decisions when selecting health insurance plans under the Affordable Care Act. As explained below, Anthem violated federal regulations by providing false information to DHS and causing inaccurate information to be published on www.healthcare.gov.

22. Once the Open Enrollment Period closed, Plaintiffs and Class Members were locked in to paying Anthem premiums through the following year. Despite the fact that their healthcare providers were not in-network, Anthem continued to falsely list healthcare providers as in-network on the policyholders' patient portals and on Anthem's directories that were available online and in hardcopy. When Plaintiffs and Class Members attempted to use the health insurance, they discovered that their health care providers were not covered by their Pathway health insurance plan. As a result, Plaintiffs and Class Members were required to pay 100% of the health care/medical expenses.

23. Plaintiffs and Class Members have longstanding medical relationships with their doctors, including WellStar, Emory, Piedmont and other specialists, who treat them for long-term, chronic, serious medical problems such as cancer and heart conditions. Furthermore, WellStar, Emory and Piedmont are among the largest health care systems in Georgia, and WellStar is by far the most prominent health care system in northwest Metro Atlanta. According to its website:

> WellStar Health System is a non-profit system founded in 1993 providing comprehensive care in Metro Atlanta, Georgia, United States.
>
> At WellStar Health System, our momentum is sustained by the compassionate care delivered by the more than 20,000 team members at our 11 hospitals, more than 250 medical office locations, and our multiple outpatient facilities. And in 2017, our impact in the communities we serve was truly extraordinary.
>
> https://www.wellstar.org/community/documents/wellstar-community-benefits-report.pdf

24. As a result, Anthem's deceptive business practices of misrepresenting that WellStar, Emory, Piedmont and other health care providers would be in-network providers caused Plaintiffs to enroll with Anthem.

25. Based on the allegations above and below, Plaintiffs and the putative Class Members are seeking to certify a Georgia class to hold Anthem responsible for the damage caused to them by Anthem's deceptive conduct as well as the breaches of its contracts.

## JURISDICTION AND VENUE

26. This Court has subject matter jurisdiction.

27. This Court has personal jurisdiction over Defendant, an insurance company organized as a Georgia corporation.

28. Venue is proper within this Court pursuant to O.C.G.A. § 33-4-1 because Defendant is a Georgia insurer that has agents or a place of doing business in Cobb County, Georgia. In addition, the health insurance contracts for many of

the named Plaintiffs and putative Class Members were entered into in Cobb County, Georgia.

**PARTIES**

29. At all times material, Plaintiff Frances Kirby is a resident and citizen of Cobb County, Georgia.

30. Plaintiff Audrey Logan is a resident and citizen of Cobb County, Georgia.

31. Plaintiff Dioli Azofeifa is a resident and citizen of Cobb County, Georgia.

32. Plaintiff John David Marks is a resident and citizen of Cobb County, Georgia.

33. Plaintiff Wanda Silva is a resident of Cobb County, Georgia

34. Plaintiff Tonya Beach is a resident and citizen of DeKalb County, Georgia.

35. Plaintiff David Frohman is a resident and citizen of Fulton County, Georgia.

36. Defendant Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. is a Georgia corporation and is the issuer of the insurance policies at issue. Anthem Blue Cross and Blue Shield is the trade name of Blue Cross and Blue Shield Heathcare Plan of Georgia, Inc. On or about January 1, 2019, Defendant Blue

Cross Blue Shield Healthcare Plan, Inc. merged with Blue Cross and Blue Shield of Georgia, Inc. Defendant was the surviving entity, and is a successor-in-interest to the non-surviving entity, Blue Cross and Blue Shield of Georgia, Inc.

## STATEMENT OF FACTUAL ALLEGATIONS

### A. Anthem Is the Largest Health Insurance Provider in Georgia

37. Anthem, Inc., Defendant's parent company, is a publicly traded company and according to its most recent Form 10-K, the company touts:

> We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 40 million medical members through our affiliated health plans as of December 31, 2018. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross. (emphasis added).

*See* Anthem, Inc. Form 10-K, Feb. 2019.

38. At all times material, Defendant was the issuer of the health insurance policies at issue in this case.

39. Anthem holds itself out to independent agents, brokers and to its retail partnership partners as the largest and oldest health benefits provider in Georgia, and claims that almost one-third of Georgia's population carries one of Anthem's cards. Below is a chart from 2018 showing how prevalent Anthem's Pathway HMO is in the State:

| County | Only Provider | Plan Type | County | Only Provider | Plan Type |
|---|---|---|---|---|---|
| Morgan | Yes | Pathway HMO | Hall | No | Pathway HMO |
| Oglethorpe | Yes | Pathway HMO | Hart | No | Pathway HMO |
| Bartow | No | Pathway HMO | Lumpkin | No | Pathway HMO |
| Cherokee | No | Guided Access HMO | Rabun | No | Pathway HMO |
| Cobb | No | Guided Access HMO | Stephens | No | Pathway HMO |
| Coweta | No | Pathway HMO | Towns | No | Pathway HMO |
| DeKalb | No | Guided Access HMO | Union | No | Pathway HMO |
| Douglas | No | Guided Access HMO | White | No | Pathway HMO |
| Fayette | No | Guided Access HMO | Atkinson | Yes | Pathway HMO |
| Forsyth | No | Guided Access HMO | Johnson | Yes | Pathway HMO |
| Fulton | No | Guided | Laurens | Yes | Pathway |

| | | | | | |
|---|---|---|---|---|---|
| | | Access HMO | | | HMO |
| Gwinnett | No | Guided Access HMO | Crawford | Yes | Pathway HMO |
| Henry | No | Guided Access HMO | Chattooga | No | Pathway HMO |
| Jasper | Yes | Pathway HMO | Floyd | No | Pathway HMO |
| Lamar | No | Pathway HMO | Gilmer | No | Pathway HMO |
| Pike | No | Pathway HMO | Pickens | No | Pathway HMO |
| Carroll | Yes | Pathway HMO | Polk | No | Pathway HMO |
| Haralson | Yes | Pathway HMO | Berrien | Yes | Pathway HMO |
| Heard | Yes | Pathway HMO | Brooks | Yes | Pathway HMO |
| Burke | Yes | Pathway HMO | Clinch | Yes | Pathway HMO |
| Columbia | Yes | Pathway HMO | Colquitt | Yes | Pathway HMO |
| Emanuel | Yes | Pathway HMO | Cook | Yes | Pathway HMO |
| Glascock | Yes | Pathway HMO | Decatur | Yes | Pathway HMO |
| Jefferson | Yes | Pathway HMO | Early | Yes | Pathway HMO |
| Jenkins | Yes | Pathway HMO | Echols | Yes | Pathway HMO |
| Lincoln | Yes | Pathway HMO | Grady | Yes | Pathway HMO |
| McDuffie | Yes | Pathway HMO | Lanier | Yes | Pathway HMO |
| Richmond | Yes | Guided Access HMO | Lowndes | Yes | Pathway HMO |
| Taliaferro | Yes | Pathway | Seminole | Yes | Pathway |

| | | | | | |
|---|---|---|---|---|---|
| Warren | Yes | HMO Pathway HMO | Thomas | Yes | HMO Pathway HMO |
| Wilkes | Yes | Pathway HMO | Tift | Yes | Pathway HMO |
| Charlton | Yes | Pathway HMO | Turner | Yes | Pathway HMO |
| Ware | Yes | Pathway HMO | Baldwin | Yes | Pathway HMO |
| Upson | Yes | Pathway HMO | Hancock | Yes | Pathway HMO |
| Fannin | No | Pathway HMO | Washington | Yes | Pathway HMO |
| Banks | No | Pathway HMO | Wilkinson | Yes | Pathway HMO |
| Dawson | No | Pathway HMO | | | |
| Franklin | No | Pathway HMO | | | |
| Habersham | No | Pathway HMO | | | |

40. As shown above, approximately 44 counties, many of them rural counties, rely solely on Anthem's Pathway HMO to provide health insurance coverage to its residents. It logically follows that excluding WellStar and Emory and Piedmont, the largest health systems in Georgia and other health care providers from coverage under Anthem's Pathway plan(s), is a material fact to each Plaintiff and all Class Members.

## B. In 2017, Anthem Left the Individual and Family Health Insurance Marketplace in Metro Atlanta

41. According to news reports in August 2017, Anthem pulled out of the Metro Atlanta individual health insurance market citing federal uncertainty about

the future of the Affordable Care Act. After intense negotiations with state regulators, Anthem continued to provide service in South Georgia counties where there was no other health insurance provider. *See Atlanta Journal-Constitution*, "Blue Cross Pulls Back on Georgia Coverage," Aug. 7, 2017. The article goes on to illustrate the frustration that Anthem's retreat from the Metro Atlanta market in 2017 caused residents of northwest Metro Atlanta. For example, Marc Morton, a Cobb County resident whose wife and daughter have pre-existing conditions and got their insurance at the time from Anthem on the exchange, was quoted:

> **"**My wife was in a panic," he said. "I looked at it and I thought, well this is just something that has to be overcome somehow." *Id*.

42. As a result of Anthem's departure from the northwest Metro Atlanta market in 2018, residents of the area who purchased individual health insurance policies had to switch during the 2018 Open Enrollment Period (November 1 through December 15, 2018) from Anthem to either Kaiser Permanente or Ambetter.

43. Both Kaiser and Ambetter had a much smaller network of physicians and medical facilities statewide than Anthem. For example, Ambetter, a health insurance company that previously only insured Medicaid patients, expanded into the individual coverage market in 2018, and while WellStar was a covered service provider, patients who may have needed specialized care, such as those with severe spinal injuries, were precluded from using nationally renowned health care

facilities such as The Shepherd Center in Atlanta. Anthem, on the other hand, provided coverage for treatment facilities such as The Shepherd Center.

44. It is therefore understandable that when Anthem announced that it was reentering the Metro Atlanta healthcare market during the 2019 Open Enrollment Period, patients in need of individual health insurance looked at Anthem, with its more expansive network, as a preferred choice to alternatives like Ambetter and Kaiser.

### C. Anthem Reintroduced Itself as a Health Insurance Provider to Metro Atlanta During the 2019 Open Enrollment Period

45. Prior to the 2019 Open Enrollment Period that began in November 2018, Anthem made the business decision to renter the Metro Atlanta health insurance market. As explained in the January 2, 2019 *Atlanta Journal-Constitution* article entitled "Sometimes, Georgia Health Care Costs Are a Simple Matter of Location," insurance companies such as Anthem reentered the market by narrowing their networks and striking better deals, but with fewer hospitals and doctors.[8] The article states: "Consumers may wind up paying more money, having fewer choices or sometimes both. . . . Experts study all those powerful forces, and they don't know how the consumer can get out of the middle." The article goes on the state:

[8] https://www.ajc.com/news/state--regional-govt--politics/sometimes-georgia-health-care-costs-are-simple-matter-location/y3SeqD68Kf9TewVE1IpbpL/

> In 2017, Blue Cross Blue Shield of Georgia made a dramatic decision to pull out of metro-Atlanta. In 2018, it decided to come back, but not all the way: it returned to the entire metro region except for Clayton and Rockdale. It also stayed out of dozens of rural Georgia counties it initially proposed to enter after seeing competitors' proposals to do business there. *Id*.

46. Upon information and belief, Anthem engaged in the same type of sharp business practices described above in its dealings with WellStar when negotiating WellStar's inclusion as an Anthem in-network provider in its Pathway health plan. Presumably, after initially deciding to enter the Metro Atlanta market, and after seeing competitors' proposals to do business with WellStar, Anthem terminated negotiations with WellStar and decided it was not going to include WellStar as an in-network provider during the pertinent coverage period in 2019. After the Open Enrollment Period closed, WellStar disclosed that this in a document that it published on its website, entitled "Update on Anthem/Blue Cross Blue Shield's Affordable Health Care Exchange Plan," which stated in pertinent part:

> In August 2018, Anthem/Blue Cross Blue Shield notified us that they were terminating WellStar as a participating provider in their Pathway product available through the Affordable Health Care Exchange. We immediately disputed this action, and are pursuing all contractual rights we have to resolve this issue. But it appears unlikely that WellStar will be participating past Feb. 4, 2019.
>
> We understand how difficult this is for patients who chose WellStar hospitals and physicians.
>
> And while WellStar normally notifies affected patients about a cancelled contract to permit them to make informed decisions about

> their healthcare needs, we were not able to notify Anthem/Blue Cross Blue Shield members of this change, as we do not have a listing of individuals who signed up for its Anthem plan. That is because Anthem/Blue Cross Blue Shield pulled out of the ACA health insurance exchange in metro Atlanta at the end of 2017. So WellStar had no metro Atlanta Pathway patients in 2018.

*See* attached Exhibit C.

47. Despite the fact that Anthem informed WellStar in August 2018 that it would not be including WellStar as an in-network provider for its individual health plans during the 2019 coverage period, Anthem never informed consumers of this fact and engaged in a deceptive marketing scheme to continue to list WellStar providers as in-network during the open enrollment period.

**D. Anthem's Scheme to Falsely Inflate the Size of Its In-Network Providers Is Not Limited to Wellstar, But Also Includes Emory Healthcare, Piedmont Healthcare and Other Physician Groups**

48. Anthem's scheme to mislead and fraudulently induce enrollees to pay premiums to use its provider network is not limited to WellStar, but also includes Emory Healthcare and other physician groups.

49. For example, Plaintiff Tonya Beach is a resident of Atlanta, and in or around early December 2018 she began researching whether to stay with her current provider, Kaiser Permanente, or change to Anthem. Ms. Beach called Anthem and spoke to a representative who recommended that she enroll in Anthem's Bronze Pathway health plan. On or about the same date, the representative emailed her a list of providers, many of whom were Emory primary

care physicians and OBGYN doctors. Because Ms. Beach had previously used Emory physicians, she enrolled in Anthem's Bronze Pathway health plan.

50. In January 2019, Ms. Beach began calling the Emory physicians on the list that Anthem provided her and she learned from those doctors offices that they did not accept her Anthem Pathway health plan.

51. Based upon investigation by Plaintiffs' counsel, Emory physicians and hospitals did not accept Anthem Pathways the prior year, either, and yet Anthem falsely listed Emory physicians and hospitals as being in-network on its website and on the Healthcare.gov website during the 2019 Open Enrollment Period, despite knowing that they were not in-network.

52. In addition, Plaintiff David Frohman began researching health insurance plans during the 2019 Open Enrollment Period. Mr. Frohman was in need of spinal surgery and visited the Healthcare.gov website, which stated that Mr. Frohman's long-time spinal surgeon, Dr. Max Steuer at Polaris Spine and Neurosurgery, was in-network under Anthem's Pathway health plan. During the Open Enrollment Period, Mr. Frohman also contacted and spoke with an Anthem representative to confirm this fact prior to enrolling in the Anthem Pathway health plan. Relying on this information, Mr. Frohman enrolled in Anthem's Pathway health plan only to learn after the Open Enrollment Period closed that Dr. Steuer and Polaris had not accepted Anthem's Pathway health plan. Mr. Frohman was

also told by Polaris that the medical group had previously complained to Anthem to take their names off the Anthem website.

### E. Even Though Anthem Knew That Healthcare Providers Such as Wellstar, Emory and Piedmont Were Not or Would Not Be In-Network Providers for Its Pathway Health Insurance Plan, Anthem Continued to Falsely Represent in Its Directories (Before and After the Policies Were Issued) They Were In-Network Providers for Anthem's Pathway Health Insurance Plan

53. As alleged above, Anthem, Inc. states in its most recent Form 10-K that "we market our products through direct marketing activities [including on its website] and an extensive network of independents agents, brokers and retail partnerships for Individual and Medicare customers. *See* Anthem's Form 10-K, Dec. 2017.

54. Upon information and belief, prior to and during the open enrollment period beginning on November 1, 2018 and continuing throughout the Class Period, Anthem disseminated uniform deceptive marketing materials to its independent agents that falsely represented that healthcare providers such as WellStar, Emory, and Piedmont were in-network in its Pathway health insurance plan when they were not.

55. In addition, for Plaintiffs and Class Members who enrolled in Anthem's Pathway plan through Anthem's website, Anthem furthered its scheme by requiring new policyholders to select a primary care physician. Plaintiffs and Class Members were therefore allowed by Anthem to select WellStar, Emory and

other physicians as their primary care physicians, not telling them that those physicians were not in-network providers or would not be beyond February 4, 2019. Anthem went so far as to list those WellStar, Emory and other primary care physicians by name on some or all the Plaintiffs' health insurance cards, which not only furthered the deceptive marketing scheme, but also incorporated those out-of-network primary care physicians as part of the contract with Anthem.

56. Anthem also breached its Member Contract by failing to provide Plaintiffs and Class Members with an up-to-date, accurate and complete provider directory of in-network providers after the policies were purchased.

**F. Anthem Violated Applicable Federal Regulations**

57. The Affordable Care Act and the federal regulations governing the health insurance exchange market provide rules designed to protect consumers from misleading marketing. These regulations include provisions that promote consumer transparency, provide adequate provider networks that are designed to protect consumers and ensure that all services within a network have sufficient providers in number and type that provide necessary health treatments to patients without unreasonable delay.

58. Pursuant to the Affordable Care Act and its underlying regulations, Anthem falls within the definition of a "QHP issuer." As such, Anthem is required to comply with the statutory requirements of the Affordable Care Act, as well as

the underlying federal regulations, including but not limited to 45 CFR § 156.230 (Network Adequacy Standards).

59. Subsection (a)(2) of 45 CFR § 156.230 states in pertinent part:

> (a) *General requirement.* Each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards—
>
> […]
>
> (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
>
> […]
>
> (b) *Access to provider directory.* (1) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

60. As alleged above and below, Anthem violated the above regulation because the true size of its network is not sufficient in number and type of providers to assure that all services will be accessible without unreasonable delay.

61. Subsection (b)(2) of 45 CFR § 156.230 states in pertinent part:

> (2) For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees,

> prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when— (emphasis added)
>
> […]
>
> (ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

62. Anthem violated 45 CFR § 156.230 (b)(2) because it failed to publish an up-to-date, accurate and complete provider directory, including information on which providers were accepting new patients in manner that is easily accessible to plan enrollees, i.e., Plaintiffs and Class Members, prospective enrollees, the State of Georgia, the Exchange, HHS and OPM. In addition, Anthem offered multiple provider networks but did not provide a directory was easy to discern or accessible to consumers.

63. Subsection (c) of 45 CFR § 156.230 states in pertinent part:

> (c) *Increasing consumer transparency.* A QHP issuer in a Federally-facilitated Exchange must make available the information described in paragraph (b) of this section on its Web site in an HHS specified format and also submit this information to HHS, in a format and manner and at times determined by HHS.

64. Anthem violated subsection (c) of 45 CFR § 156.230 because it failed to publish on its Anthem.com website an up-to-date, accurate and complete provider directory, including information on which providers were accepting new

patients in manner easily accessible to plan enrollees, i.e., Plaintiffs, Class Members and prospective enrollees.

65. Subsection (d) of 45 CFR § 156.230 states in pertinent part:

> (d) *Provider transitions.* A QHP issuer in a Federally-facilitated Exchange must—
>
> (1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal[.]

66. Anthem violated 45 CFR § 156.230(d)(1) because it failed to make a good-faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients who are seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, regardless of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

67. Anthem also violated 45 CFR § 156.250, which states:

> A QHP issuer must provide all information that is critical for obtaining health insurance coverage or access to healthcare services through the QHP, including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in §155.205(c) of this subchapter. Information is deemed critical for

> obtaining health insurance coverage or access to health care services if the issuer is required by law or regulation to provide the document to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.

**F. Anthem Has Engaged In Similar Deceptive Conduct In Other Parts of the United States.**

68. Several years ago, the State of California conducted an audit of Anthem/Blue Cross Blue Shield's networks and, according to an article published by *Consumer Watchdog*, the audits confirmed that Blue Shield and Blue Cross in California dramatically misrepresented the number of doctors available to consumers under new Obama health care plans.[9] According to the article, the audits found that at least 25% of physicians listed by Anthem/Blue Cross and Blue Shield of California were not taking patients enrolled in Obamacare plans or are no longer at the location listed by the companies. *Id*. A victim of this scheme is quoted describing their experience as follows:

> When my wife and I enrolled in our new Blue Shield health plan it was important to us that our long-time physicians were included in our plan's network. . . . Before enrolling we confirmed through Blue Shield's website that our doctors were 'in-network' and we even called our doctors to double-check. It was only after we visited our doctors for routine check-ups that the bills started rolling in informing us for the first time that our doctors were in fact out of network and Blue Shield was only covering a fraction of the cost. Adding insult to injury, when we called Blue Shield to complain we experienced hold times of two to four hours each time we called. I feel Blue Shield is

[9] https://www.consumerwatchdog.org/newsrelease/state-audits-confirm-blue-shield-and-blue-cross-misled-consumers-about-doctors-available

> trying to get away with a blatant 'bait and switch' and I won't stand for it! *Id*.

69. Upon and information and belief, the class action lawsuits filed in California based on a similar deceptive scheme as here settled for approximately $23 million, and Anthem agreed to make business changes going forward to prevent future problems in California.

**G. Anthem Breached Its Contract With Plaintiffs and Class Members**

70. Anthem's contract with each of the Plaintiffs and Class Members is captioned as the *Individual Member Contract* and is contained within a booklet captioned *An Owner's Manual for Your Health Benefits [-] What's Covered, How It Works, How Much It Costs*, which was provided to Plaintiffs and Class Members (the "Member Contract").

71. As alleged above, Anthem breached the Member Contract by failing to provide Plaintiffs and Class Members with an up-to-date, accurate and complete provider directory of in-network providers after the policies were purchased.

72. Anthem also breached the Master Contract by listing doctors and health systems that were not in-network as though they were on Appellees and Class Members' health insurance cards. The Member Contract includes I.D. cards in the definition of "Contract."

The Member Contract provides in pertinent part:

> **How to Find a Provider in the Network**

> […]
>
> You do not need a Referral to see a Specialty Care Physician. You can visit any Network Specialist including a behavioral health Provider without a referral from a Primary Care Physician.
>
> […]
>
> **Entire Contract and Changes**
>
> Your Application for Coverage, this document, any later applications, and any future attachments, additions, deletions, or other amendments will be the entire Contract. No change in this Contract is valid unless it is signed by the President of Anthem. No agent or employee of Anthem may change this Contract or declare any part of it invalid.
>
> Anthem has the right to amend this Contract at any time by giving You written notice of the amendment at least ninety days before the amendment takes effect. You must agree to the change in writing. However, this requirement of notice shall not apply to amendments which provide coverage mandated by the laws of the United States.

Member Contract, p. 92 (emphasis added).

73. In violation of its Member Contract, Anthem sent letters to Plaintiffs and Class Members dated February 21, 2019 (and perhaps other dates), which stated in pertinent part:

> # [Name of Member], need to see a specialist?
>
> You'll have to get a referral.
>
> Your 2019 Member Contract incorrectly said you don't need a referral from your primary care doctor to see a specialist. Your plan **does** require a referral to see a specialist.

> That was our mistake, and we/re sorry for any confusion. The good news is that nothing changed with your benefits and you don't need to take any action. We're just making sure you have the right information.

("Anthem Letter") (bold in original).

74. The Anthem Letter was not signed by the President of Anthem.

75. Each of the Plaintiffs and, upon information and belief, each of the Class Members, received letter that was substantially the same as the Anthem Letter attached as Exhibit B.

76. The Anthem Letter was not approved in writing by any of the Plaintiffs or Class Members.

77. Anthem breached the Member Contract, and, in particular, Anthem breached the above-quoted provisions of the Anthem Contract, by sending the Anthem Letter to the Plaintiffs and Class Members.

78. The Anthem Letter itself evidences a breach of the Member Contract by Anthem.

79. In addition to constituting a breach of the Member Contract, the Anthem Letter is false and misleading in stating: "The good news is that nothing changed with your benefits."

80. Anthem knew that the above-quoted statement was false when it made the statement, and Anthem intended to mislead the Plaintiffs and Class Members and induce forbearance by making the false statement.

## PLAINTIFFS' EXPERIENCE

### A. Plaintiff Audrey Logan Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan

81. Plaintiff Audrey Logan suffers from post-partum cardiomyopathy and CPVT, a form of tachycardia. She was diagnosed with CPVT in May 2008 and cardiomyopathy in July 2018 after the birth of her daughter. Ms. Logan has been under the care of a cardiologist since May 2008. Since 2013, when she aged out of her pediatric cardiologist's practice, Ms. Logan has been under the care of her current cardiologist, Dr. Cesar Egoavil, a WellStar cardiologist. Ms. Logan is also under the care of a cardiologist that specializes in heart failure, Dr. David Snipelisky, who is also a WellStar cardiologist.

82. In July 2018, Plaintiff Logan learned from her cardiologists that she will need a heart transplant should the medication she was on prove not to be effective. By the fall of 2018, it became clear that the medicine used to treat her heart failure disorder was not working and that a heart transplant was going to be necessary.

83. In and around November 2018, in preparation for and during the Affordable Care Act Open Enrollment Period, Plaintiff began researching health insurance plans. Ms. Logan researched available plans on healthcare.gov and anthem.com to see what plan best fit her critical medical needs.

84. At the time of the Open Enrollment Period, Plaintiff had group health insurance with Cigna through her husband's employer. However, even though it covered her treatment for heart failure, the Cigna policy was expensive and as a result, Plaintiff researched whether a family plan through the Exchange would be a better fit.

85. Plaintiff reviewed the various health plans offered through the Exchange and believed that the Anthem Silver Pathways Guided Access HMO 2000 met her and her daughter's needs.

86. Based on the information provided to her on Healthcare.gov and Anthem's website, Plaintiff Logan enrolled in the Anthem Silver Pathway Guided Access HMO, which began on January 1, 2019 and ends on December 31, 2019.

87. In or around early February 2019, after the Open Enrollment Period was closed, Ms. Logan learned that WellStar was not an in-network provider under Plaintiff's Anthem Silver Pathway plan. She learned this important fact while she was trying to get imaging tests performed by WellStar Imaging for her heart transplant surgery.

88. Ms. Logan subsequently learned from her cardiologist that her insurance would not cover her continued treatment, which put her life at risk.

89. In addition, in February 2019, Ms. Logan's cardiologist referred her to Emory Healthcare for the first appointment in connection with her anticipated heart

transplant surgery. At that time, upon information and belief, Emory Healthcare was the only health provider in the State of Georgia that performed heart transplants. During the scheduling of that appointment with Emory Healthcare, Plaintiff Logan learned that Emory did not accept her Pathway health insurance even though Anthem's website represented that Emory is in-network.

90. Ms. Logan was locked in with Anthem's Pathway X Guided Access HMO plan until the end of 2019. She was not allowed to switch mid-contract to another health insurance provider. Therefore, in order to maintain health insurance, she had to remain with Anthem and continue to pay her monthly premiums despite the fact that she would be unable to receive treatment from the providers Anthem misrepresented were in-network.

91. Needless to say, Ms. Logan would not have switched from Cigna to Anthem had Anthem not misrepresented that her health providers were in-network providers.

92. In addition to being fraudulently induced into enrolling with Anthem, Ms. Logan received a letter addressed to her from Anthem. The letter memorializes that Anthem substantially violated several material provisions of its Contract with her, which breached her contract with Anthem.

**B. Plaintiff Dioli Azofeifa Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan**

93. Plaintiff Dilio Azofeifa is married to her husband Shahram Vakili. She suffers from multiple sclerosis ("MS") and is confined to a wheelchair. Plaintiff requires treatment from multiple specialists including her primary care physician, Dr. Sharon Odell who is a WellStar physician.

94. Ms. Azofeifa enrolled with Anthem during the Open Enrollment Period that spanned from November 1 through December 15, 2018. When signing up for the Anthem insurance, Ms. Azofeifa and her husband made sure on Anthem's website and the Healthcare.gov website that Plaintiff's WellStar primary care physician was listed by Anthem as being in-network. Anthem listed WellStar's physicians, including Dr. Odell, its hospitals and medical facilities on its anthem.com website and on the healthcare.gov website as being in-network, even though it knew that it was not.

95. After the close of the Open Enrollment Period, Ms. Azofeifa learned that WellStar was not in-network. She was denied necessary medical treatment by WellStar and was stuck in a policy until January 1, 2020 in which her doctors and local hospitals were not covered by her health insurance plan. Had she known that truth, Ms. Azofeifa would not have enrolled with Anthem.

96. The number of physicians and specialists who are Anthem in-network providers is significantly less from the providers Anthem represented as in-network when Ms. Azofeifa was researching health insurance plans. In addition,

the closest hospital was Northside-Atlanta, which is very far from her home. In contrast, WellStar's Kennestone Hospital is less than 10 miles from her home.

97. Ms. Azofeifa also believed that even after being seen by these new providers, like any new patient, she would endure medical testing and examinations she had already undergone, so that the new provider could get up to speed as to her medical conditions and formulate a treatment plan.

98. Ms. Azofeifa incurred additional medical expenses as a result of the additional medical visits and testing as a result of the switch to new providers.

99. Ms. Azofeifa was locked in with Anthem's Pathway X Guided Access HMO plan until the end of 2019. She was not allowed to switch mid-contract to another health insurance provider. Therefore, in order to maintain health insurance, she had to remain with Anthem and continue to pay her monthly premiums despite the fact that she was unable to receive treatment from the providers Anthem misrepresented were in-network.

100. Ms. Azofeifa would not have purchased the Anthem plan had Anthem not misrepresented that WellStar was not going to be an in-network provider through the duration of her contract.

101. In addition, Ms. Azofeifa received a letter addressed to her from Anthem which is substantively identical to one described above . The letter

memorializes that Anthem substantially violated several material provisions of its Contract with her, which breached her contract with Anthem.

### C. Plaintiff Frances Kirby Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan

102. In and around November 2018, in preparation for and during the Affordable Care Act Open Enrollment Period, Frances Kirby began researching health insurance plans. She researched plans available in her area and learned that there were three companies, including Anthem, offering plans in Cobb County, Georgia. Ambetter, her health insurer for 2018, was also offering health insurance.

103. Ms. Kirby has had the same primary care physician, Dr. James Elsbree, a WellStar physician, for over 20 years and saw him regularly for routine physicals and various health issues not requiring a specialist. In addition, Ms. Kirby has several significant health issues, which required nine different specialists. The majority of these specialists were WellStar physicians. The primary factor in determining which health insurance plan Ms. Kirby would choose was whether her primary care physician and other specialists were in-network providers.

104. Prior to enrolling in any plan, Ms. Kirby visited Anthem's website and used the provider search tool to determine whether Dr. Elsbree and her other specialists were in-network. Like her 2018 coverage with Ambetter, Ms. Kirby's primary care and specialists were deemed in-network providers. Ms. Kirby then

compared the overall general network of providers of Anthem with Ambetter. Anthem's representations made it appear as though the Anthem's network of providers was more expansive than Ambetter's.

105. Based upon Anthem's representations that her primary care physician and specialists were in-network and Anthem's representations that their in-network far surpassed Ambetter's in-network coverage, Ms. Kirby made the decision to switch from Ambetter to Anthem and enroll in Anthem's Gold Pathway X Guided Access HMO plan.

106. Ms. Kirby's Anthem plan did not provide coverage for out-of-network providers. However, Ms. Kirby was not concerned with this fact given her primary care provider and specialists were listed as in-network by Anthem.

107. As required by Anthem's application process, Ms. Kirby designated Dr. James Elsbree, a Wellstar Health Systems physician, as her primary care physician and Anthem approved this selection and placed Dr. Elsbree on her Anthem insurance card.

108. Ms. Kirby's Gold Pathway X Guided Access HMO plan began on January 1, 2019 and the contract ended on December 31, 2019.

109. On or about January 10, 2019, Ms. Kirby, while in Dr. Elsbree's office, was notified by Dr. Elsbree's staff that Anthem had terminated their relationship with WellStar and that Dr. Elsbree would not be considered an in-

network provider as of February 4, 2019. It was at this point that Ms. Kirby also realized that if this information were true that the majority of her medical specialists would also not be considered in-network providers given that they too were WellStar providers.

110. Ms. Kirby did not receive any notice from Anthem regarding their termination of WellStar and/or its providers as an in-network provider despite the fact that her primary care physician listed on her Anthem insurance card was a WellStar physician and many of the specialists that provide her with treatment were WellStar physicians as well.

111. Upon receiving the information from Dr. Elsbree's office, Ms. Kirby again used the provider search tool on Anthem's website and Dr. Elsbree was listed as an in-network provider. She contacted Anthem with her confusion and frustration and was advised that Anthem's internal computer information differed from the information that Anthem provided consumers through its website and provider search tool.

112. While Anthem failed to adequately notify Ms. Kirby that Wellstar Health System would no longer be considered in-network, Ms. Kirby was able to confirm her fears through a press release from WellStar attached as Exhibit C, which explained that Anthem had terminated Wellstar Health System as a

participating in-network provider for the Pathway product available through the Affordable Health Care Exchange.

113. Because Ms. Kirby's primary care physician and several of her specialists were WellStar providers, Ms. Kirby had to search for a new primary care physician and several new medical specialists. This caused a lapse in Ms. Kirby's medical treatment while she conducted a search for in-network providers that she was comfortable with and who were taking new patients.

114. The number of specialists who were Anthem in-network providers are significantly less from the providers Anthem represented as in-network when Ms. Kirby was researching health insurance plans. In addition, the majority of specialists in Ms. Kirby's area were WellStar Health System physicians. This made finding a specialist in Ms. Kirby's area more difficult. Given Ms. Kirby's health, traveling will put an additional strain on her health.

115. Further, all of this caused an undue delay in medical treatment for Ms. Kirby and her various medical issues.

116. In addition, Anthem's alleged misconduct, caused unnecessary repetitive testing and additional delay in medical treatment.

117. Ms. Kirby incurred additional medical expenses as a result of the medical visits and testing she did as a result of the switch to new providers.

118. Ms. Kirby also had to endure hospitalizations for her medical conditions. WellStar was the only hospital in Cobb County, Georgia. With WellStar terminated as an in-network provider, Ms. Kirby had to travel outside her area to another county for future hospitalizations.

119. Ms. Kirby was locked in with Anthem's Gold Pathway X Guided Access HMO plan until the end of 2019. She was not allowed to switch mid-contract to another health insurance provider. Therefore, in order to maintain health insurance, she had to remain with Anthem and continue to pay her monthly premiums despite the fact that she was unable to receive treatment from the providers Anthem misrepresented were in-network.

120. Ms. Kirby would not have switched from Ambetter to Anthem had Anthem not misrepresented that her health providers and the only hospital in her area were Anthem in-network providers.

121. In addition, Ms. Kirby recently received a letter addressed to her from Anthem which is substantively identical to one described above. The letter memorializes that Anthem substantially violated several material provisions of its Contract with her, which breached her contract with Anthem.

### D. Plaintiff John David Marks Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan

122. In and around November 2018, after receiving a renewal letter from his existing Ambetter health insurance provider, Plaintiff Marks began researching

health insurance plans on the Affordable Care Act website, www.healthcare.gov. Plaintiff Marks researched plans available in his area and learned that there were three companies, including Anthem, offering health service plans in Cobb County, Georgia. Ambetter, his health insurer for 2018, was also offering health service plans.

123. Plaintiff Marks was diagnosed with prostate cancer in October 2016. Since that time, he has received medical treatment by WellStar specialists for his cancer. In addition, Mr. Marks has long-term cardiac problems including having had a heart attack and being diagnosed with atrial fibrillation in 2004, and has been under cardiac care with WellStar specialists since then. A primary reason that Plaintiff chose to enroll with Anthem was that his specialists were in-network providers, and the premiums advertised by Anthem were approximately $200 per month less expensive than his Ambetter policy.

124. Prior to enrolling in any plan, in November 2018 Mr. Marks visited Anthem's website and used the provider search tool to determine whether his primary care physician and his specialists and hospitals were in-network. Mr. Marks confirmed on Anthem's website that his primary care physician and specialists were included as in-network providers.

125. Based upon Anthem's representations that his primary care physician and specialists were in-network, Mr. Marks made the decision to switch from

Ambetter to Anthem and enroll in Anthem's Bronze Pathway X Guided Access HMO plan.

126. Mr. Marks' Anthem plan does not provide coverage for out-of-network providers. However, he was not concerned with this fact given his primary care provider and specialists were listed as in-network by Anthem.

127. Mr. Mark's Bronze Pathway X Guided Access HMO plan began on January 1, 2019, and the contract ended on December 31, 2019.

128. On February 5, 2019, Mr. Marks had a scheduled visit with his WellStar urologist in connection with monitoring his prostate cancer. During the last week of January 2019, however, Mr. Marks spoke with his urologist's office to confirm that they were in-network with Anthem. When Mr. Marks told them that he had just switched to Anthem Pathway, the office informed him that Anthem terminated their relationship with WellStar and that the urologist's office would not accept Anthem's insurance after February 4, 2019. As a result, Mr. Marks was forced to cancel his appointment. It was at this point that Mr. Marks also realized that if this information were true, the majority of his other medical specialists would not be considered in-network providers given that they also were WellStar providers.

129. Because Mr. Marks specialists are WellStar providers, Mr. Marks had to search for new medical specialists. This caused a lapse in Mr. Marks' medical

treatment while he conducted a search for in-network providers that he would be comfortable with and who were taking new patients.

130. The number of specialists who were Anthem in-network providers was significantly less than the number of providers Anthem represented as in-network when Mr. Marks was researching health insurance plans. In addition, the vast majority of specialists in Mr. Marks' area were WellStar physicians. Mr. Marks has determined that the closest hospital that he has access to was in mid-town Atlanta, over 25 miles from his home, which was extremely concerning given that he has heart problems and required a closer hospital like WellStar's that is only five miles from his home.

131. Anthem's alleged misconduct caused an undue delay in medical treatment.

132. Mr. Marks also endured medical testing and examinations, that he had already undergone, so that his new provider could get up to speed as to his medical conditions and formulate a treatment plan. This caused unnecessary repetitive testing and additional delay in medical treatment.

133. Mr. Marks also incurred additional medical expenses as a result of the additional medical visits and testing he anticipates as a result of the switch to new providers.

134. Mr. Marks was locked in with Anthem's Bronze Pathway X Guided Access HMO plan until the end of 2019. He was not allowed to switch mid-contract to another health insurance provider. Therefore, in order to maintain health insurance, he had to remain with Anthem and continue to pay his monthly premiums despite the fact that he was unable to receive treatment from the providers Anthem misrepresented were in-network.

135. Mr. Marks would not have switched from Ambetter to Anthem had Anthem not misrepresented that his health providers and the only hospital in his area were Anthem in-network providers.

136. In addition, Mr. Marks recently received a letter addressed to her from Anthem which is substantively identical to one described above . The letter memorializes that Anthem substantially violated several material provisions of its Contract with her, which breached his contract with Anthem.

**E. Plaintiff Wanda Silva Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan**

137. In and around November 2018, in preparation for and during the Affordable Care Act Open Enrollment Period, Wanda Silva began researching individual health insurance plans and used a health insurance consultant to research and recommend the best health insurance plan to meet her needs. At the time of the Open Enrollment Period, Plaintiff Wanda Silva had health insurance through Ambetter but was interested in changing to Anthem because it purported to have a

larger network of healthcare providers, specifically WellStar physicians and hospitals.

138. Plaintiff Silva has several health problems that require treatment from specialists. At the time of the Open Enrollment Period, Ms. Silva had and continues to have longstanding patient relationships with her primary care physician and multiple WellStar specialists including but not limited to her OB/GYN and urologist. A primary reason that Plaintiff chose to enroll with Anthem was that her primary care doctor and specialists were in-network WellStar providers.

139. During the Open Enrollment Period, Ms. Silva's health insurance consultant provided Plaintiff with written documentation from Anthem representing that Ms. Silva's WellStar physicians were in-network.

140. Based on the materials that were provided to her as well as other similar information on Anthem's website and her conversations with the health insurance consultant, Plaintiff Silva enrolled in the Anthem Silver Pathway Guided Access HMO 3000 plan, which began on January 1, 2019 and would end on December 31, 2019.

141. In or around February 2019, after the Open Enrollment Period was closed, Ms. Silva learned that WellStar was not an in-network provider under Plaintiff's Anthem Silver Pathway plan.

142. Because Ms. Silva's specialists were WellStar providers, she had to search for new medical specialists, which caused a lapse in her medical treatment while she conducted a search for in-network providers that she was comfortable with and who were taking new patients.

143. The number of specialists who were Anthem in-network providers are significantly less from the providers Anthem represented as in-network when Ms. Silva was researching health insurance plans. In addition, the closest hospital that she had access to was very far from her home, which was extremely concerning given that she has health problems that required a closer hospital like WellStar's that is less than five miles from her home.

144. Further, Ms. Silva anticipated that once she selected new providers, she would experience a significant delay in being able to be seen by these providers given she was a new patient. Also, because of Anthem's scheme, Ms. Silva would be forced to spend time away from running her business causing additional damage.

145. Ms. Silva also believed that even after being seen by these new providers, like any new patient, she would likely endure medical testing and examinations that she had already undergone, in order that the new provider could get up to speed as to her medical conditions and formulate a treatment plan. This caused unnecessary repetitive testing and additional delay in medical treatment.

146. Ms. Silva incurred additional medical expenses as a result of the additional medical visits and testing she anticipated as a result of the switch to new providers.

147. Ms. Silva was locked in with Anthem's Silver Pathway X Guided Access HMO plan until the end of 2019. She was not allowed to switch mid-contract to another health insurance provider. Therefore, in order to maintain health insurance, she had to remain with Anthem and continue to pay her monthly premiums despite the fact that she was unable to receive treatment from the providers Anthem misrepresented were in-network.

148. Ms. Silva would not have switched from Ambetter to Anthem had Anthem not misrepresented that her health providers and the only hospital in her area were Anthem in-network providers.

149. In addition to being fraudulently induced into enrolling with Anthem, Ms. Silva received a letter addressed to her from Anthem which is substantively the same as the letter described above. The letter memorializes that Anthem substantially violated several material provisions of its Contract with her, which breached her contract with Anthem.

## F. Plaintiff Tonya Beach Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan

150. In and around early December 2018, in preparation for and during the Affordable Care Act Open Enrollment Period, Tonya Beach began researching

health insurance plans. At the time of the Open Enrollment Period, Plaintiff Tonya Beach had health insurance through Kaiser Permanente but was interested in changing to Anthem because it purported to include physicians and hospitals in the Emory Healthcare system.

151. On or about December 11, 2018, Ms. Beach called Anthem and spoke to a representative to find out which Pathway plan was best for her, e.g. Gold, Silver or Bronze. During that call, the Anthem representative convinced Ms. Beach that the Pathway X Bronze plan was the best fit for her needs. That same day, the Anthem representative emailed Ms. Beach two lists consisting of primary care physicians and Obstetrician-gynecologist (OB/GYN) physicians that were affiliated with Emory Healthcare and all of them were identified as in-network.

152. Based on the materials that were provided to her as well as other similar information on Anthem's website and her conversation with the Anthem representative, Plaintiff Tonya Beach enrolled in the Anthem Bronze Pathway X plan, which began on January 1, 2019 and ended on December 31, 2019.

153. In or around mid-January 2019, after the Open Enrollment Period was closed, Plaintiff Tonya Beach began contacting the physicians on the lists provided to her to select her new primary care physician and OB-GYN and learned from their respective offices that none of the physicians affiliated with Emory Healthcare accepted her health insurance.

154. Anthem knew at the time that they sent the lists of physicians to Ms. Beach that Emory did not accept her health insurance plan, but failed to disclose this material fact to her. Instead, Anthem sent the lists of physicians to her knowing that it contained material misrepresentations about the scope of its in-network healthcare providers.

155. Ms. Beach would not have switched from Kaiser Permanente to Anthem had Anthem not misrepresented that physicians and hospitals affiliated with Emory Healthcare were in-network providers.

156. In addition to being fraudulently induced into enrolling with Anthem, Plaintiff Tonya Beach received a letter addressed to her from Anthem which is substantively identical to one attached as Ex. A. The letter memorializes that Anthem substantially violated several material provisions of its Contract with her, which breached her contract with Anthem.

**G. Plaintiff David Frohman Was Fraudulently Induced Into Purchasing an Anthem Pathway Health Insurance Plan.**

157. In and around December 1, 2018, Plaintiff Frohman began researching health insurance plans for the coming year. At that time, Mr. Frohman had health insurance with Kaiser Permanente.

158. In or around 2006, Plaintiff Frohman became symptomatic from and was then diagnosed with multi-level cervical spine disease. In subsequent years his cervical spine deteriorated and, by the end of 2018, Plaintiff Frohman believed

that a follow-up consultation with his long-time spinal neurosurgeon was warranted. Plaintiff Frohman has been a long-time patient of neurosurgeon Dr. Max Steuer, who is currently a neurosurgeon with Polaris Spine and Neurosurgery ("Polaris").

159. On or about December 1, 2018, Mr. Frohman visited the Healthcare.gov exchange website to carefully research his health insurance plan options for the coming year, and then select his 2019 health insurance plan.

160. Relying on representations made within the Anthem Blue Cross listed plan options on the Healthcare.gov website, which stated that Dr. Max Steuer and Polaris were specifically listed as in-network providers under the Anthem Blue Cross plan, Mr Frohman selected it. Mr. Frohman already had Dr. Max Steuer and Polaris as part of his Kaiser HMO in-network medical plan during 2018 and would not have left Kaiser if he had known that Dr. Max Steuer and Polaris were not part of the Anthem Blue Cross HMO plan as represented by them at the time of Mr. Frohman's selection and purchase.

161. Mr. Frohman's Anthem plan does not provide coverage for out-of-network providers.

162. Mr. Frohman's Anthem Silver Pathway X Guided Access HMO plan began on January 1, 2019, and ended on December 31, 2019.

163. On Monday, January 14, 2019, and approximately two weeks after Mr. Frohman had enrolled and purchased the Anthem Silver Pathway X Guided Access HMO plan through Healthcare.gov, Mr. Frohman specifically made a point of calling Anthem. He did this to conduct extra due diligence on his part, and independently confirm that Dr. Max Steuer and Polaris were indeed in-network within his Anthem plan, before scheduling any appointments with them. Mr. Frohman then received confirmation from the Anthem representative during the phone call that Dr. Max Steuer and Polaris were indeed in-network with Anthem, independently confirming what Anthem had represented at the time of Mr. Frohman's selection and purchase.

164. In or around January 25, 2019, Mr. Frohman scheduled a consultation with neurosurgeon Dr. Max Steuer at Polaris for evaluation of his spinal problems described above. During Mr. Frohman's consultation with Dr. Steuer of February 26, 2019, Dr. Steuer urgently recommended that Plaintiff have an immediate cervical spine operation because he was at serious risk of having his spinal cord compromised should his neck region suffer any trauma (as from a car accident, for example), and becoming permanently paralyzed as a result.

165. During that same appointment, Plaintiff Frohman learned that Dr. Steuer and Polaris were not in-network under Plaintiff's Anthem policy, despite the fact that as of the date that Mr. Frohman purchased his Anthem policy,

both Dr. Steuer and Polaris Spine and Neurosurgery were represented by Anthem as being in-network with them.

166. Mr. Frohman would now have to pay for an initial surgery of approximately $25,000.00 completely out of his own pocket. Dr. Steuer also concluded that additional spinal surgeries may be required, which Mr. Frohman would likewise have to pay for out-of-pocket health care expenses. Mr. Frohman therefore faced unwarranted and additional out-of-pocket expenses that were clearly Anthem's responsibility under Mr. Frohman's policy with them.

167. As having to pay for spinal surgeries out of pocket is not an option for Mr. Frohman, he had to search for new medical specialists. This caused a lapse in his medical treatment and inability to obtain affordable and potentially life-saving surgery, while he conducted a search for a legitimate in-network Anthem provider that he was comfortable with and, most critically, who would even accept new patients.

168. The number of specialists who are Anthem in-network providers are significantly less than the providers Anthem represented as in-network when Mr. Frohman carefully researched health insurance plans during the 2019 Open Enrollment Period.

169. Further, Mr. Frohman anticipated that once he selected a new neurosurgeon, he would experience a significant delay in being able to be seen by

them as a new patient. In his experience, new patients may not be seen by a specialist for an initial visit for a number of months or more. This would cause an undue delay in medical treatment for Mr. Frohman and his potentially life-threatening medical issues.

170. Mr. Frohman also believes that both as a new patient, and due to the complexity of his case, he would likely have to endure extensive medical testing and examinations previously completed, in order that the new provider could educate themselves as to his medical conditions and formulate a treatment plan.

171. Mr. Frohman would thus have to incur additional medical expenses, as a result of said additional medical visits and testing he anticipates as a result of the switch to a new provider.

172. Mr. Frohman was locked-in with Anthem's Silver Pathway X Guided Access HMO plan until the end of 2019. He was not allowed to switch mid-contract to another health insurance provider. Therefore, in order to maintain health insurance, he had to remain with Anthem and continue to pay his monthly premium, despite the fact that he was unable to receive treatment from providers Anthem misrepresented were in-network at Mr. Frohman's time of purchase.

173. Mr. Frohman would not have switched from Kaiser Permanente to Anthem had Anthem not misrepresented that Dr. Max Steuer and Polaris were in-

network Anthem providers for 2019, as they still remained a part of his former Kaiser network that he could have thus chosen instead of Anthem for 2019.

174. In addition to being fraudulently induced into enrolling with Anthem, Mr. Frohman received a letter addressed to him from Anthem which is substantively identical to one described above. The letter memorializes that Anthem substantially violated several material provisions of its Contract with Plaintiff, which constitutes a breach of contract by Anthem.

## CLASS ACTION ALLEGATIONS

175. Plaintiffs bring this action on behalf of themselves and all others similarly situated as members of a proposed class ("Class") initially defined as:

> Class
>
> All Georgia residents who purchased an individual or family Pathway health insurance plan(s) from Defendant from November 1, 2015 to the present, paid premiums, and whose claims for payment were rejected as "out of network" even though the providers who provided the healthcare services were listed by Anthem as in-network in its directories.
>
> Sub-Class:
>
> All Georgia residents who purchased an individual or family Pathway health insurance plans(s) during the 2019 Open Enrollment Period, and whose claims for payment were rejected by Defendant because they did not obtain a referral from a primary care physician prior to receiving medical care from a specialist.

176. Excluded from the Class are Plaintiffs' counsel and family members, Defendant's employees, officers, directors; Defendant's legal representatives,

successors, and assigns; any entity in which Defendant has a controlling interest; any Judge to whom the litigation is assigned and all of members of the Judge's immediate family; and all persons who timely and validly request exclusion from the Class.

177. This action had been brought as a class action, and may properly be maintained, pursuant to the provisions of O.C.G.A. § 9-11-23 of the Georgia Civil Practices Act and case law thereunder.

**A. Plaintiffs Meet the Prerequisites of O.C.G.A. §9-11 23(b)(3)**

**1. Numerosity of the Class**

178. The Class is so numerous that individual joinder of class members is impracticable. As explained above, recent news reports by reputable media outlets such as the *Marietta Daily Journal* and the *Atlanta Journal-Constitution* demonstrate that thousands of Georgia residents as a result of Anthem's deceptive scheme. The precise number of class members and their identities and addresses are unknown to Plaintiffs at this time, but such number, identity and address of each class member, can be readily ascertained from Defendants' records. In addition, according to the news outlets' reporting as described above, the Georgia Insurance Commissioner's Office received approximately 78,000 complaints from Class Members and those complaints can be obtained in discovery. Class members

may be notified of the pendency of this action by mail, supplemented (if deemed necessary of appropriate by the Court) by published notice.

**2. Existence and Predominance of Common Questions of Fact and Law**

179. There is a well-defined community of interest in common questions of law and fact that exists as to all members of the Class. These questions predominate over the questions affecting only individual Class members. These common legal and factual questions include:

a. Whether Anthem's provider list for its covered plans were inaccurate;

b. Whether inaccuracies in Anthem's provider lists misled Plaintiffs and Class Members;

c. Whether Anthem engaged in uniform deceptive marketing practices, including but not limited to direct marketing online to consumers and marketing to independent agents/brokers;

d. Whether Anthem breached its contract and the implied covenant of good faith and fair dealing with Plaintiffs and Class Members by providing prospective and current members with inaccurate provider lists;

e. Whether Anthem breached its contract with Plaintiffs and Class Members by unilaterally changing material term(s) to require

Plaintiffs and Class Members to seek a referral from a primary care physician to a specialist;

f. Whether Anthem breached its contract with Plaintiffs and Class Members by sending the letter attached as Exhibit B to Plaintiffs and Class Members;

g. Whether Anthem's wrongful conduct damaged Plaintiffs and class members; and

h. Whether Plaintiffs and class members are entitled to damages, injunctive relief and equitable relief.

**3. Typicality of Claims**

180. Plaintiffs' claims are typical of the Class. Plaintiffs, like other class members, were told by Anthem's website and the information on Heathcare.gov that their providers would be covered in-network, when in fact their providers were out of network. Plaintiffs' and other class members' claims therefore arise from a common course of conduct by Defendants and are based on the same legal theories.

181. In addition, Plaintiffs' breach of contract claim is typical of the Class. Plaintiffs and Class Members all had a Member Contract with Anthem that expressly stated that they did not have to seek a referral from a primary care physician to seek treatment from a specialist. Plaintiffs and Class Members

received the same letter from Anthem informing them that Anthem unilaterally violated material terms of the Member Contract by changing the term and requiring Plaintiffs and Class Members to obtain a referral, which breaches multiple sections of the Member Agreement.

**4. Adequacy of Representation**

182. Plaintiffs are adequate representatives of the Class because their interests do not conflict with the interest of the Class, and they have retained counsel competent and experienced in complex class action litigation. The interests of the Class will be fairly and adequately protected by Plaintiffs and their counsel.

**5. Superiority of the Class Action**

183. A class action is superior to other available means for the fair and efficient adjudication of this dispute. The damages suffered by class members are likely to exceed millions of dollars. However, while the damages suffered by each individual class member are significant, they are small in comparison to the burden and expense of individual prosecution. Without the class action device, it would be virtually impossible for class members individually to obtain effective redress for the wrongs done to them.

184. Furthermore, even if the class members themselves could afford such individual litigation of class members' claims, the court system could not.

Individualized litigation presents a potential for inconsistent and contradictory judgments. Individualized litigation would involve thousands of separate actions, increasing the delay and expense to all parties and to the court system. By contrast, the class action device presents fewer management difficulties, requiring only a single adjudication of the complex legal and factual issues in this dispute, thereby providing the benefits of economy of scale, and comprehensive supervision by a single court.

185. Plaintiffs and their counsel know of no difficulties which will be encountered in the management of this case which would preclude it being maintained as a class action.

## CAUSES OF ACTION

### COUNT I
### BREACH OF CONTRACT

186. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

187. Defendant has a contractual relationship with Plaintiffs and Class members, which is embodied in its Member Contract.

188. An essential term of Defendant's Member Contracts with Plaintiffs and Class Members is that Defendant provide an accurate and up-to-date directory of healthcare providers that are in-network.

189. Anthem breached its Member Contract with Plaintiffs.

190. Plaintiffs and Class Members have been and will be damaged by Defendant's conduct.

191. In addition, Defendant Anthem breached the Member Contract by sending Plaintiffs and Class Members the Anthem Letter, which purported to require them to get a referral in order to see a specialist, when the Member Contract provided that no such referral was needed.

192. Further, Anthem breached the Member Contract by purporting to make changes therein without obtaining the prior written approval of the Plaintiffs and Class Members and without having the changes signed by the President of Anthem, when the Member Contract provided that no changes could be made without such prior written approval and without the signature of the President of Anthem.

## COUNT II
## BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING

193. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

194. In the event that Defendant somehow did not breach its express Member Contract with Plaintiffs and the proposed Class Members, it breached its implied contract with those same proposed Class Members.

195. A covenant of good faith and fair dealing is implied in every contract, including Defendant's Member Contracts with Plaintiffs and Class Members.

196. Where a contract vests one party with discretion, the duty of good faith and fair dealing applies, and the party exercising the discretion must do so in a manner that satisfies the objectively reasonable expectations of the other party. A party may not perform an agreement in a manner that would frustrate the basic purpose of the agreement or deprive the other party of its rights and benefits under the agreement.

197. It was objectively reasonable under the circumstances for Plaintiffs and Class Members to expect that the doctors and facilities represented to them by Anthem as being in-network would in fact be in-network. Otherwise, it would make no sense to use the Anthem Pathway plan.

198. It was objectively reasonable under the circumstances for Plaintiff and Class Members to expect that Anthem would not, without prior notice, terminate its relationship with providers that it represented to Plaintiffs and Class members were in-network and refuse to cover charges for services provided by such providers to the Plaintiffs and Class members.

199. Anthem's conduct alleged herein is inconsistent with the reasonable expectations of Plaintiffs and Class Members and is inconsistent with what an objectively reasonably consumer would have expected under the circumstances.

200. Anthem has acted in a manner that frustrates the basic purpose of its contracts with the Plaintiff and Class Members and has deprived Plaintiffs and Class Members of the benefits and rights to which they are entitled under their contracts with Anthem.

201. As a result of Defendant's misconduct, Plaintiffs and Class Members have been damaged in an amount to be determined at trial.

## COUNT III
## FRAUD

202. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

203. Anthem made material representations and/or material omissions to Plaintiffs and Class Members in connection with the sale of its health insurance policies.

204. Anthem knew its misrepresentations and omissions made to Plaintiffs and Class Members were false and/or it was reckless with respect to the same.

205. Anthem intended for Plaintiffs and Class members to rely on its misrepresentations and/or omissions.

206. Plaintiffs and Class Members were unaware of the inaccuracies in Anthem's misrepresentations at the time they signed up for Anthem's Pathway plan and selected their providers from Anthem's provider lists.

207. Anthem, moreover, engaged in a "bait and switch" with regard to its inaccurate provider lists—representing that WellStar, Emory, Piedmont and other providers were in-network when it knew that that they were not in-network.

208. Plaintiffs and Class Members justifiably relied on Anthem's misrepresentations and omissions and had they known the truth, they would not have enrolled in Anthem's Pathway plan.

209. As a direct and proximate result of Anthem's misconduct, Plaintiffs and Class Members have been damaged in an amount to be proven at trial.

## COUNT IV
## FRAUDULENT CONCEALMENT

210. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

211. Anthem knowingly failed to disclose to Plaintiffs and Class Members material facts (and affirmatively concealed those facts), namely that Anthem's provider lists were inaccurate.

212. Anthem was under a duty to disclose all material facts in connection with selling its health insurance to consumers. Anthem had a duty to disclose, among other things, that it had terminated its relationship with WellStar, Emory, Piedmont and other providers prior to the open enrollment period beginning on November 1, 2018.

213. Anthem's omissions were material to Plaintiffs' and Class Members' decision in selecting Anthem as a health insurance provider that included WellStar, Emory and others as in-network providers.

214. Plaintiffs and Class Members justifiably relied on Anthem's omission of material facts. Had Plaintiffs and Class Members known the truth they would not have purchased health insurance from Anthem.

215. As a direct and proximate result of Anthem's misconduct, Plaintiffs and Class Members have been damaged in an amount to be proven at trial.

## COUNT V
## NEGLIGENCE PER SE

216. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

217. Defendant had a duty to comply with the Network Adequacy Standards contained in 45 CFR § 156.230 as well as the requirements set forth in 45 CFR § 156.250.

218. Defendant violated 45 CFR § 156.230 and § 156.250.

219. The purpose of 45 CFR § 156.230 and § 156.250 is to protect consumers like the Plaintiffs and Class Members by providing that each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meet certain

standards, including but not limited to requiring QHP issuers to publish an up-to-date, accurate, and complete provider directory.

220. Plaintiffs and Class members were harmed as a result of Defendant's violation of 45 CFR § 156.230 and § 156.250.

221. Plaintiffs and Class members fall within the class of persons that 45 CFR §156.230 and § 156.250 was intended to protect.

222. The harm or injury suffered by the Plaintiffs and Class Members as a result of Defendant's violation of 45 CFR § 156.230 and § 156.250 was the same harm that 45 CFR § 156.230 and § 156.250 was intended to guard against.

223. Defendant's violations of 45 CFR § 156.230 and § 156.250 are capable of having a causal connection between it and the damage or injury inflicted.

## COUNT VI
## NEGLIGENCE

224. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

225. At all times material, Defendant had a duty, or obligation, recognized by law, requiring the them to conform to a certain standard of conduct, for the protection of others against unreasonable risks including, among other things articulated above, the legal duty to conform to the common law standard of care to ensure that the provider network consisting of in-network providers, as available to

all enrollees, meet certain standards, including but not limited to requiring QHP issuers to publish an up-to-date, accurate, and complete provider directory.

226. Defendant thereby owed a legal duty to the Plaintiffs and Class Members.

227. Defendant failed to conform to the standard required and thereby breached the applicable standard of care.

228. There is a reasonable close causal connection between Defendant's conduct and the resulting injury to Plaintiffs and Class Members.

229. Plaintiffs and Class Members suffered actual loss or damage.

## COUNT VII
## UNJUST ENRICHMENT

230. Plaintiffs restate and reallege Paragraphs 1 through 185 as if fully set forth herein.

231. Plaintiffs and Class Members have an interest, both equitable and legal, in the health insurance coverage provided by Anthem that they purchased. Plaintiffs and Class Members conferred payments to Anthem for their health insurance coverage.

232. Anthem benefitted from Plaintiffs and Class Members.

233. As a result of Anthem's wrongful conduct as alleged in this Complaint, Anthem has been unjustly enriched at the expense of, and to the detriment of, Plaintiffs and Class Members.

234. Anthem's unjust enrichment is traceable to and resulted directly and proximately from the conduct alleged herein.

235. Under the common law doctrine of unjust enrichment, it is inequitable for Anthem to be permitted to retain the benefits it received, and is still receiving without justification, from Plaintiffs and Class Members in an unfair and unconscionable manner. Anthem's retention of such benefits under circumstances making it inequitable to do so constitutes unjust enrichment.

236. The benefit conferred upon, received, and enjoyed by Anthem was not conferred officiously or gratuitously, and it would be equitable and unjust for Anthem the retain the benefit.

237. Anthem is therefore liable to Plaintiffs and Class Members for restitution in the amount of the benefit conferred on Anthem as a result of its wrongful conduct.

## COUNT VIII

## VIOLATIONS OF O.C.G.A. § 16-14-4 (GEORGIA'S RICO STATUTE)

238. Plaintiff restates and realleges Paragraphs 1 through 185 as if fully set forth herein.

239. Defendant violated O.C.G.A. § 16-14-4(a) by acquiring or maintaining, directly or indirectly, an interest in or control of Plaintiffs' personal property or proceeds therefrom through a pattern of racketeering activity.

240. Defendant violated O.C.G.A. § 16-14-4(b) by being employed by or associated with any enterprise to conduct, participate in, directly or indirectly, such enterprise through a pattern of racketeering activity.

241. Defendant violated O.C.G.A. § 16-14-4(c) by conspiring or endeavoring to violate § 16-14-4(a) and (b) with its officers and/or it parent company and unnamed entities affiliated with Defendant.

242. Defendant engaged in an enterprise as defined by O.C.G.A. § 16-14-3(3).

243. Defendant engaged in a pattern of racketing activity as defined by O.C.G.A. § 16-14-3(4) and engaged in at least two acts of racketeering activity in furtherance of one or more incidents, schemes, or transactions that have the same or similar intents, results, accomplices, victims, or methods of commission or otherwise interrelated by distinguishing characteristics and are not isolated incidents that occurred after July 1, 1980 and the last such acts occurred within four years, after the commission of a prior racketeering activity.

244. Defendant engaged in a pattern of racketeering activity as defined by O.C.G.A. § 16-14-3(5) that includes but is not limited to the following:

a. Pursuant to O.C.G.A. § 16-14-3(5)(C), Defendant violated 18 USC Section 1961, 18 USC §§ 1341 (mail fraud) and/or 1343 (wire fraud)

by intentionally participating in a scheme to defraud Plaintiffs and Class Members out of money (premiums), which used the mails and/or wires in furtherance of the scheme.

245. For example, as alleged above in greater detail, in a scheme to defraud Plaintiffs and Class Members into purchasing health insurance from Defendant and pay premiums, Defendant disseminated material misrepresentations and omissions about the scope of its network of healthcare providers before and after it issued Member Contracts. Defendant disseminated this false information through Anthem's network of websites, which includes but is not limited to https://www.anthem.com/. Defendant also provided the same type of false information to the federal government so that material misrepresentations and omissions about the scope of Defendant's network of healthcare providers would be disseminated to the public via the federal government's www.healthcare.gov website.

246. Every correspondence mailed or emailed by Defendant or false directory made available online and every directory of healthcare providers that Defendant disseminated to the public or caused to be disseminated to the public through its parent company, Anthem, Inc. or its affiliate, Anthem Life Insurance Companies, Inc. containing material misrepresentations and omissions designed to defraud Plaintiffs and Class Members to obtain or keep their money constitutes a

separate violation of 18 USC Section 1961, 18 USC §§ 1341 (mail fraud) and/or 1343 (wire fraud).

247. Defendant used interstate mail and wire communications to perpetrate its fraudulent scheme.

248. These offenses were not committed as an occasional practice but were a part of a systematic and ongoing pattern over a number of years concealed by a scheme of deception and concealment.

249. Defendant criminally operated the enterprise using fraud and misrepresentation in an interrelated pattern of criminal activity the motive and/or effect of which was and is to derive pecuniary gain.

250. Defendant violated or conspired to violate the RICO statute as a direct and proximate result of which Plaintiffs and Class Members have suffered injury.

251. Plaintiffs' and Class Members' injuries flowed directly from at least one of the predicate acts.

252. There is a *direct nexus* between at least one of the alleged predicate acts and the injuries Plaintiffs sustained.

253. The alleged predicate acts were aimed at Plaintiffs and were not aimed primarily at a third party.

## COUNT IX
## ATTORNEY'S FEES AND EXPENSES

254. Plaintiffs restate and incorporate as if fully set forth herein the allegations contained in Paragraphs 1-185.

255. Pursuant to O.C.G.A. § 13-6-11 and other provisions of Georgia law, Plaintiffs are entitled to recover reasonable attorney's fees and expenses of litigation by reasons of Defendants' bad faith and stubborn litigiousness which has caused Plaintiffs to incur unnecessary trouble and expense.

## COUNT X
## PUNITIVE DAMAGES

256. Plaintiffs restate and incorporates as if fully set forth herein the statements contained in Paragraphs 1- 185.

257. Pursuant to O.C.G.A. § 51-12-5.1, Plaintiffs are entitled to recover punitive damages from Defendant on the basis that Defendant’s actions showed willful misconduct, malice, fraud, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to consequences.

## PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that the court grant Plaintiffs and all Class Members the following relief against Defendant:

A. An order certifying the proposed plaintiff class herein pursuant to Rule 23 of the Federal Rules of Civil Procedure, and appointing Plaintiffs and their counsel of record to represent the Class;

B. An award of damages to Plaintiffs and Class members resulting from Defendants' wrongful or unlawful conduct, including but not limited to any consequential or incidental damages and costs suffered by Plaintiffs and Class members;

C. Treble damages and punitive damages pursuant to O.C.G.A. § 16-14-6(c).

D. Injunctive relief pursuant to O.C.G.A. § 16-14-6(b).

E. Prejudgment interest;

F. Attorney's fees, costs of suit, including expert witness fees; and

G. Such other and further legal and equitable relief, including exemplary damages, as his Court may deem proper.

**DEMAND FOR JURY TRIAL**

Plaintiff hereby requests a jury on all matters so triable.

Dated: June 6, 2023

By: */s/ Jason R. Doss*

Jason R. Doss
Georgia Bar No. 227117
THE DOSS FIRM, LLC
1827 Powers Ferry Road SE
Building 23, Suite 100
Atlanta, Georgia 30339
Telephone: (770) 578-1314
jasondoss@dossfirm.com

Jason Kellogg
Florida Bar No. 0578401
Marcelo Diaz-Cortes
Florida Bar No. 118166
LEVINE KELLOGG LEHMAN
SCHNEIDER + GROSSMAN LLP
100 Southeast Second Street
36th Floor
Miami, Florida 33131
Telephone: (305) 310-4039
jk@lklsg.com

*Attorneys for Plaintiffs and the Proposed Class*

**CERTIFICATE OF SERVICE**

This is to certify that the undersigned served a true and accurate copy of this response and this certificate by STATUTORY ELECTRONIC SERVICE and via email to the attorneys of record.

This 6th day of June 2023.

/s/ *Jason R. Doss*

# EXHIBIT A

**OFFICE OF COMMISSIONER OF INSURANCE**
**STATE OF GEORGIA**

| | | |
|---|---|---|
| **IN THE MATTER OF:** | ) | |
| | ) | **Case Number: 11029362** |
| **BLUE CROSS BLUE SHIELD** | ) | |
| **HEALTHCARE PLAN OF GA., INC.** | ) | |

## CONSENT ORDER

**WHEREAS**, the Commissioner of Insurance of the State of Georgia ("Commissioner") has the duty to uphold the provisions of the Georgia Insurance Code, codified at O.C.G.A. § 33-1-1 *et seq.*; and

**WHEREAS**, the Commissioner has caused an examination to be made into the acts, practices, transactions, and course of business engaged in by Blue Cross and Blue Shield of Georgia, Inc., and Blue Cross Blue Shield Healthcare Plan of Georgia., Inc. pursuant to O.C.G.A. § 33-2-11; and

**WHEREAS**, effective January 1, 2019, Blue Cross and Blue Shield of Georgia, Inc. merged with and into Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., with Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. as the surviving entity (as a result of the merger Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. are hereinafter referred to as the "Respondent"). The Respondent's stated purpose of merging the two companies was to eliminate duplicative administrative costs. The transaction was approved by the Department on October 9, 2018 (Case Number 11022585).

**WHEREAS**, based on the information and documentation received by the Georgia Department of Insurance ("Department") through the course of this examination, the

Commissioner has determined that Respondent has failed to comply with certain provisions of the Georgia Insurance Code; and

**WHEREAS,** Respondent, after being fully advised of all rights and procedures guaranteed to it under the Georgia Insurance Code, including the right to a hearing as provided by O.C.G.A. §§ 33-2-17 and 33-2-24, now desires to enter into this Consent Order, including the Corrective Action Plan attached hereto as Appendix A and incorporated herein by reference for the purpose of resolving all issues described herein, without the necessity of a hearing, and therefore desires to waive any and all such rights and consents to the terms of this Consent Order and the entry thereof; and

**WHEREAS,** Respondent enters into this Consent Order without admitting or denying violations of Georgia law in regard to the issues described herein.

**NOW THEREFORE,** the Commissioner finds the following:

1.

Prior to the merger with Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Blue Cross and Blue Shield of Georgia, Inc. held a Certificate of Authority Number 2000667 to act as a healthcare corporation in the State of Georgia and maintained a business location at 3350 Peachtree Road Northeast, Atlanta, Georgia 30326.

2.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. holds Certificate of Authority Number 200036, to act as a health maintenance organization in the State of Georgia and maintains a business location at 740 W Peachtree St., Atlanta, Georgia 30308.

3.

The Respondent is ultimately owned and controlled by Anthem, Inc. ("Anthem").

4.

A targeted market conduct examination of Respondent was conducted by representatives of the Department with a scope period January 1, 2015, to September 30, 2021.

5.

The examination included, but was not limited to, a review of the Respondent's internal controls related to the implementation of a provider database system during calendar year 2015, implementation of a replacement provider database system during calendar year 2021 and reporting of claims payment data to the Department pursuant to the Department's Directives 99-EXAM-1 and 13-EXAM-2.

6.

During the course of the examination, the Commissioner found that:

a) In March 2015, Respondent implemented an internally developed provider database system designed to consolidate provider data and to serve as a centralized data repository for all Anthem provider demographic data.

b) Following the implementation of the provider database system, provider complaints made to both the Department and Respondent noticeably increased during calendar years 2015-2018.

c) The most common complained of errors ("processing errors") were from: (1) claims from in-network providers processing as out-of-network, and (2) claims rejecting for unknown reasons.

d) As a result of the noted processing errors, a significant number of claims were impacted by issues involving the Respondent's implementation of the provider database system.

e) Respondent implemented a four-phase remediation plan to address provider complaints and claims processing errors and various corrective measures were deployed between 2015-2020, leading to the implementation of a replacement provider database system.

f) During Respondent's implementation of the replacement provider database system (released in April 2021), Respondent performed significant project, implementation, and testing plans of the new system to ensure that adequate safeguards were taken to avert challenges previously experienced with the old provider database system.

g) During this delay, Respondent continued to experience processing errors that resulted from the implementation of the old provider database system. Respondent failed "to adopt and implement procedures for the prompt investigation and settlement of claims arising under their policies," as required under O.C.G.A. § 33-6-34(3).

h) A test of Respondent's submission of claims data pursuant to Directives 99-EXAM-1 and 13-EXAM-2 determined coding and data errors within Respondent's systems caused incomplete and inaccurate claims data submissions to the Department as noted in claims submitted to the Department for claims timeliness testing. Upon the detection of the errors, Respondent revised its internal process for extracting claims timeliness testing data and submitted corrected reports to the Department in 2019.

i) A test of Respondent's compliance with the claims timeliness requirements of O.C.G.A. § 33-24-59.5(b)(1) and/or (c) determined Respondent was out of compliance for several quarters during the period from 2018 to 2021.

**ORDER**

**NOW THEREFORE, IT IS HEREBY ORDERED BY THE COMMISSIONER** and agreed to and consented to by Respondent that:

1.

Pursuant to O.C.G.A. § 33-2-24(g), Respondent shall pay a monetary penalty in the amount of Five Million Dollars ($5,000,000.00) to the Georgia Department of Insurance and as applicable, additional monetary penalty as outlined in Appendix B: Performance Milestones.

2.

Respondent shall adhere to the terms of the Corrective Action Plan attached to this Consent Order as Appendix A. Beginning May 1, 2022, Respondent shall submit a monthly report containing all relevant information demonstrating compliance with the Corrective Action Plan until such time as the Commissioner has rescinded this order or March 31, 2023, whichever is sooner (the "Departmental Supervision Period"). Each report shall be signed by an officer of the Respondent and submitted to the Department within ten (10) business days of the last day of each month.

3.

Respondent shall submit to periodic examinations by a qualified individual or firm of the Department's choosing to examine Respondent's compliance with this agreement, as allowed under O.C.G.A. § 33-2-11(a).

4.

The Single Point of Contact, as described in Appendix A, shall be familiar with the Georgia Insurance Code, the Rules and Regulations of the Georgia Department of Insurance, and the laws of the State of Georgia in order to monitor the day-to-day business practices of the Respondent and to ensure compliance with this Order. Specifically, the Single Point of Contact shall be dedicated to assisting Georgia healthcare providers and facilitating the prompt resolution of any conflicts or disagreements between such providers and Respondent.

5.

Responses and action should be made within fifteen (15) business days of the initial complaints, requests or inquiries filed with the Department.

6.

Respondent will adhere to all Prompt Pay Reporting requirements.

7.

Respondent shall implement strict project management controls including extensive testing for any new functional deployments on provider database systems. All testing should be done considering the size and complexity of its Georgia business. Pursuant to Ga. Comp. R. & Regs. 120-2-80-.04, prior to implementing, deploying, or otherwise subjecting Georgia providers to the use of any new functions or systems, Respondent shall give the Department one hundred and twenty (120) days' advance notice during which time the Department may examine Respondent's implementation plans and related controls. Finally, the Respondent will establish and maintain pre and post command centers to oversee the implementation and resolve any issues discovered with a warranty period of not less than one hundred twenty (120) days for any new functions or systems affecting providers implemented for the Georgia business. Respondent shall maintain all records of any new

functions or systems in accordance with the Company's record retention policy, but not less than two (2) years, and for as long as the new system is maintained.

8.

The complaint system process should be filed with the Department by April 30, 2022.

9.

The Respondent shall not pay any ordinary dividend above One Hundred Million Dollars ($100,000,000) or any other dividends during the Departmental Supervision Period without first obtaining Commissioner approval.

10.

This Consent Order resolves all administrative penalties and sanctions of any kind related to the violations discovered within the scope of the examination for the period from January 1, 2015, through September 30, 2021. If Respondent materially violates any of the terms and conditions specified herein or within the accompanying attachments Appendix A and Appendix B, Respondent shall receive notice of such violation(s) and have a fifteen (15) day period, or other cure period as mutually agreed upon in writing by the Department and Respondent, to cure or mitigate such violation(s). Should the Commissioner then find that such material violation(s) and failure to cure or mitigate such violations(s) have occurred, such violation(s) and failure(s) will be considered a violation of this Consent Order and will subject Respondent to further penalties and sanctions. If a hearing on an order issuing administrative penalties and sanctions is requested by Respondent, the burden of proof shall be on Respondent to show cause as to why the action is not justified.

11.

In consenting to the terms and entry of this Consent Order, Respondent has not waived its rights or defenses to any subsequent claims or proceedings before the Department.

**SO ORDERED** this 29 of March, 2022.

JOHN F. KING
COMMISSIONER OF INSURANCE
STATE OF GEORGIA

CONSENTED TO BY:

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GA, INC.

By: Robert H Burk

Title: President - Anthem BCBS GA

Sworn to and subscribed before me this

24th day of March, 2022.

Notary Public

My Commission Expires: 9/17/2023

[Seal] KATHY SHIVER NOTARY PUBLIC COWETA COUNTY, GEORGIA MY COMMISSION EXPIRES SEPTEMBER 17, 2023

# EXHIBIT B

Anthem

Anthem Blue Cross and Blue Shield
PO BOX 659806
San Antonio, TX 78265-9106

P-3 153 ******AUTO**5-DIGIT 30127 UN0024377

John Marks

[redacted]

February 21, 2019

# John, need to see a specialist?

## You'll have to get a referral.

Plan Details

**Member ID**

[redacted]

Your 2019 Member Contract incorrectly said you don't need a referral from your primary care doctor to see a specialist. Your plan **does** require a referral to see a specialist.

That was our mistake, and we're sorry for any confusion. The good news is that nothing changed with your benefits and you don't need to take any action. We're just making sure you have the right information.

Your updated 2019 Member Contract with the correct language is on **anthem.com**.

**Need help?** Call the Member Services number on your ID card.

- Your Anthem service team

# EXHIBIT C

WELLSTAR.

# UPDATE ON ANTHEM/BLUE CROSS BLUE SHIELD'S AFFORDABLE HEALTH CARE EXCHANGE PLAN

Anthem.

WellStar has been terminated as a provider by Anthem/Blue Cross Blue Shield in their Pathways healthcare exchange plan. This does not affect patients who have employer provided or individual Medicare Advantage healthcare through Anthem/Blue Cross Blue Shield

You may have seen reports that WellStar is no longer covered by Anthem/Blue Cross Blue Shield's Pathways plan, available through the Affordable Health Care Exchange. We would like to provide some facts around this matter.

In August 2018, Anthem/Blue Cross Blue Shield notified us that they were terminating WellStar as a participating provider in their Pathways product available through the Affordable Health Care Exchange. We immediately disputed this action, and are pursuing all contractual rights we have to resolve this issue. But it appears unlikely that WellStar will be participating past Feb. 4, 2019.

We understand how difficult this is for patients who choose WellStar hospitals and physicians.

And while WellStar normally notifies affected patients about a cancelled contract to permit them to make informed decisions about their healthcare needs, we were not able to notify Anthem/Blue Cross Blue Shield members of this change, as we do not have a listing of individuals who signed up for this Anthem plan. That is because Anthem/Blue Cross Blue Shield pulled out of the ACA health insurance exchange in metro Atlanta at the end of 2017. So WellStar had no metro Atlanta Pathways patients in 2018.

Please note that this in no way affects patients who have employer-provided or individual Medicare Advantage healthcare through Anthem/Blue Cross Blue Shield. WellStar's overall contract with Anthem/Blue Cross Blue Shield remains intact. All WellStar patients covered under Anthem/Blue Cross Blue Shield products, other than Pathways, will continue to have access to the entire WellStar Health System.

If you have questions about your Affordable Health Care Exchange coverage through Anthem/Blue Cross Blue Shield, you can call the customer service number on the back of your ID card.

Additionally, patients can contact the following agencies to express network concerns with Healthcare Exchange Products:

- Healthcare.gov's Customer Service at (800) 318-2596; and or
- The Georgia State Insurance Commissioner Consumer Services at (404) 656-2070
- Consumer Complaint Process or OCI Contact Us.

WellStar continues to participate in the Ambetter HIE product.