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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF ALAMEDA

JEREMY JONG, individually and on behalf of similarly situated individuals, Plaintiff, v. BLUE SHIELD OF CALIFORNIA, Defendant.	Case No. 24CV069627 **CLASS ACTION COMPLAINT** DEMAND FOR JURY TRIAL

CLASS ACTION COMPLAINT

Plaintiff Jeremy Jong ("Plaintiff") brings this Class Action Complaint against Defendant Blue Shield of California ("Defendant" or "Blue Shield") to stop Defendant's unlawful and fraudulent Artificial-Intelligence ("AI") powered prior-authorization and review system of their insureds' insurance claims and to seek redress for all those who have been harmed by Defendant misconduct. Plaintiff alleges as follows based on personal knowledge as to himself and his own acts and experiences and as to all other matters, on information and belief, including an investigation by his attorneys:

NATURE OF THE CASE

1. This action arises from Defendant's illegal scheme of implementing its AI prior-authorization software to systematically, wrongfully, and automatically deny its insureds the thorough, individualized physician review of claims guaranteed to them by law and, ultimately, the payments for necessary medical procedures owed to them under Blue Shield's health insurance policies.

2. Defendant is one of the largest medical insurance companies in the United States, with over 4.8 million members in California. *See* www.blueshieldca.com/content/dam/bsca/en/member/docs/Blue-Shield-of-California-2022-Mission-Report.pdf.

3. Defendant prides itself on being dedicated to "creat[ing] a healthcare system worthy of its family and friends" and providing its members "with access to high-quality care at an affordable price." *Id* at 5.

4. In reality, Defendant systematically deploys AI software, known as the Claims Data Activator, to streamline the prior authorization process of its insureds' claims and enable doctors to automatically deny coverage *en masse* for treatments, medications, and testing that do not match a certain preset criteria, thereby evading the legally-required individual physician review process.

5. Relying on this AI software, Defendant instantly rejects claims on lack of medical necessity grounds, despite a patient's doctor providing documentation as to why such medical treatment is medically necessary, and without ever opening patient files, leaving thousands of patients effectively without coverage and with unexpected bills.

6. The use of such AI technology undoubtably saves Defendant money by allowing it to deny claims it would have been required to pay and by eliminating labor costs associated with paying doctors and other employees for the time needed to conduct individualized review for each insured. *See* https://news.blueshieldca.com/2023/05/09/in-the-news-blue-shield-of-california-

collaborates-with-google-cloud-in-pilot-to-streamline-prior-authorization-for-members-providers.

7. Nearly 1 in 5 insured adults experienced a denied claim in the past year and with 85% of consumers not filing a formal appeal to their denial, Defendant knows that it will not be held accountable for wrongful denials. *See* www.kff.org/affordable-care-act/issue-brief/consumer-survey-highlights-problems-with-denied-health-insurance-claims.

8. Defendant rejected Plaintiff's and Class members' claims using the Claim Data Activator system. Defendant failed to use reasonable standards in evaluating the individual claims of Plaintiff and the Class members.

9. By engaging in this misconduct, Defendant breached its fiduciary duties to its insureds, including its duty of good faith and fair dealing, and also violated California's insurance regulations.

10. Accordingly, Plaintiff brings this class action for legal and equitable remedies to redress and to enjoin Defendant from continuing to perpetuate its fraudulent scheme against its insureds.

JURISDICTION AND VENUE

11. This Court has subject-matter jurisdiction over this action pursuant to Cal. Code Civ. Proc. § 410.10 and Article VI, § 10 of the California Constitution.

12. Plaintiff has standing to bring this action pursuant to the California Unfair Competition Law, California Business and Professions Code § 17200, *et seq*. ("UCL"); and the common law.

13. This Court has personal jurisdiction over Defendant and venue is proper in this Court because Defendant maintains its headquarters in Oakland, California and because a substantial part of the events giving rise to the claims asserted herein occurred in this County.

THE PARTIES

14. Plaintiff Jeremy Jong is a resident within the State of California. At all

relevant times mentioned herein, Plaintiff was covered by a health insurance policy provided by Defendant.

15. Defendant Blue Shield of California is a California corporation with its principal place of business at 601 12th St., Oakland, CA 94607.

COMMON FACTUAL ALLEGATIONS

16. Defendant offered and sold health care coverage to California consumers, including Plaintiff and the Class members.

17. Plaintiff and the Class members enrolled with Defendant to receive health insurance coverage.

18. Defendant provided Plaintiff and the Class members with written terms explaining the plan coverage Defendant offered them.

19. According to these terms, Defendant must provide benefits for covered health services and pay all reasonable and medically necessary expenses incurred by a covered member.

20. During the relevant time period, thousands of Defendant's insureds, through their healthcare providers, submitted pre authorization claims of treatment for reasonable and medically necessary treatment covered by their plan terms.

21. Under California law, Defendant was required to conduct and diligently pursue a "thorough, fair, and objective" review to determine whether a submitted claim is medically necessary. Cal. Code. Regs. Tit. 10, § 2695.7(d).

22. Defendant has deliberately failed to fulfill its obligation to review individual claims in a thorough, fair, and objective manner because it utilized its AI software to automatically deny claims submitted for prior authorization of treatment.

23. Once Defendant's AI software determines that such tests and procedures are not medically accepted or necessary, Defendant's doctors sign off on the denials without reviewing the insureds' files or the documentation provided by the insureds' healthcare provider.

24. Defendant misled its insureds into believing their health plan would

individually assess their claims and pay for medically necessary procedures.

25. Had Plaintiff and the Class members known Defendant would evade its legally required process for reviewing patients' prior authorization claims and delegate that process to its AI software, they would not have enrolled with Defendant to provide healthcare coverage.

26. Defendant's prior authorization and review system of their insureds' claims undermines the principles of fairness and meaningful claim review, which insureds undeniably expected from their insurer.

FACTS SPECIFIC TO PLAINTIFF

27. Plaintiff Jeremy Jong has been enrolled with Blue Shield since 2021.

28. On or about January 10, 2024 Plaintiff's doctor submitted a prior authorization to Defendant for a magnetic resonance imaging ("MRI") scan of Plaintiff's abdomen and pelvis area after Plaintiff had been suffering from gastrointestinal issues for several months ("MRI Request").

29. Plaintiff's doctor indicated that this was medically necessary for his gastrointestinal condition and to determine the effective course of treatment.

30. After submitting the MRI Request, On January 13, 2024, a Saturday, Defendant sent a response letter stating that it needed more information from Plaintiff's doctor to make a decision on whether it would authorize coverage of the MRI.

31. Plaintiff's doctor quickly responded and provided all requested and necessary documentation to show that the MRI was medically necessary, including his most recent clinic notes from his recent visits and previous ultrasound reports of Plaintiff's abdomen.

32. Shortly thereafter, on January 24, 2024, Defendant provided a letter stating that it would dene coverage for his MRI scan and stating that "i[]n order for us to cover this request, we need your doctor to send us notes that say results of other recent testing that was done first (such as other x-ray, imaging or scope testing upper

or lower gastrointestinal series, ultrasound and/or colonoscopy/endoscopy) […and] why your doctor now wants this test done."

33. As stated above, Plaintiff's doctor *had* in fact already provided all of the information that was requested in the denial letter.

34. Indeed, following the denial, Plaintiff requested his doctor's office to let him know if the requested documentation had been submitted to Blue Shield, which they responded in the affirmative confirming that they had sent over all documentation that was requested in Blue Shield's letter.

35. Upon information and believe, Defendant used its AI software to "review" and deny Plaintiff's claim for prior authorization of his MRI.

36. Upon information and belief, Defendant failed to have any doctor conduct a thorough, fair, and objective investigation into Plaintiff's claim and instead denied it based on its automated AI software.

CLASS ALLEGATIONS

37. Plaintiff brings this action on his own behalf and on behalf of a class (the "Class") defined as follows: All persons who had purchased health insurance from Blue Shield of California in California during the relevant limitations period and for whom a claim was denied after Defendant utilized an AI claim review software as shown by Defendant's records.

38. Upon information and belief, there are millions of members of the Class, making the members of the Class so numerous that joinder of all members is impracticable. Although the exact number of members of the Class is currently unknown to Plaintiff, the members can be easily identified through Defendant's records.

39. There are many questions of law and fact common to the claims of Plaintiff and the other Class Members, and those questions predominate over any questions that may affect individual members of the Class. Common questions for the Class include, but are not limited to, the following:

(a) Whether Defendant automatically denied coverage for prior authorization claims submitted by insureds and/or healthcare providers without having a medical doctor examine patient records, review coverage policies, and use their expertise to decide whether to approve or deny those claims based on a medical necessity analysis;

(b) Whether Defendant's denial of claims are based on the use of its AI software, Claims Data Activator;

(c) Whether Defendant failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies;

(d) Whether Defendant has a practice of relying on AI software to review and deny its insureds' claims instead having a review and denial process conducted by medical personnel;

(e) Whether Defendant's delegation of reviewing its insureds' claims to its AI software for prior authorization resulted in its failure to diligently conduct a thorough, fair, and objective investigation into determinations of claims for medical coverage claims submitted by insureds and/or healthcare providers as required by law.

40. Plaintiff's claims are typical of the claims of the Class and arise from the same common practice and scheme used by Defendant to deny the claims of the members of the Class and have resulted in similar injuries to Plaintiff and to the Class. As alleged herein, Defendant has used its AI software to review, process, and deny its insureds' claims without individualized evaluation.

41. Plaintiff will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has retained counsel with substantial experience in prosecuting complex litigation and class actions. Plaintiff and Plaintiff's counsel are committed to vigorously prosecuting this action on behalf of the other members

of the Class and have the financial resources to do so. Neither Plaintiff nor Plaintiff's counsel have any interest adverse to those of the other members of the Class.

42. Absent a class action, most members of the Class would find the cost of litigating their claims to be prohibitively expensive and would thus have no effective remedy. The class treatment is superior to multiple individual actions in that it conserves the resources of the courts and the litigants and promotes consistency of adjudication.

43. Defendant has acted and failed to act on grounds generally applicable to Plaintiff and the other members of the Class, requiring the Court's imposition of uniform relief.

COUNT ONE
Breach of Implied Covenant of Good Faith and Fair Dealing
(On behalf of Plaintiff and the Class)

44. Plaintiff hereby incorporates the above allegations by reference as though fully set forth herein.

45. Plaintiff and the Class entered into written contracts with Defendant for which Defendant was required to pay for Plaintiff's and the Class members' medically necessary services rendered by healthcare providers.

46. Pursuant to the contracts it entered into with Plaintiff and the other Class members, and in exchange for Plaintiff's and the Class members' monthly premium payments, Defendant implied and covenanted that it would act in good faith and follow the law with respect to the prompt and fair payment of Plaintiff's and Class members' claims.

47. Defendant has breached its duty of good faith and fair dealing by, among other things: (i) improperly delegating its claim review process to its AI software which used an automated process to improperly deny claims; and (ii) failing to have its medical personnel conduct a thorough, fair, and objective investigation of each submitted claim to decide whether to approve or deny claims.

48. As a direct and proximate result of Defendant's breaches, Plaintiff and the Class members have suffered and will continue to suffer in the future economic losses, including the out-of-pocket healthcare expenses that they paid for and which should have been paid for by Defendant, the insurance premiums paid to Defendant, the interruption of Plaintiff's and the Class members' businesses, and other general, incidental, and consequential damages, in amounts according to proof at trial. Plaintiff and the Class members also seek statutory and pre- and post-judgment interest against Defendant as well as reasonable attorney's fees and litigation expenses.

COUNT TWO
Violation of California's Unfair Competition Law
Cal. Bus. & Prof. Code § 17200 et seq.
(On behalf of Plaintiff and the Class)

49. Plaintiff realleges and incorporates by reference all preceding allegations as though fully set forth herein.

50. Plaintiff brings this claim against Defendant pursuant to California's Unfair Competition Law, Cal. Bus. & Prof. Code § 17200 *et seq.* ("UCL"), on behalf of the Class.

51. The UCL prohibits "any unlawful, unfair or fraudulent business act or practice." Cal. Bus. & Prof. Code § 17200.

52. Under California Insurance Code section 790.03(h), the following are classified as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance when they are knowingly committed or performed with such frequency as to indicate a general business practice:

i. "Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies." Cal. Ins. Code § 790.03(h)(3).

ii. "Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." Id. § 790.03(h)(5).

53. Furthermore, under section 2695.7(d) of Title 10 of the California Code of Regulations, "[e]very insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute."

54. In addition, California Health and Safety Code section 1367.01(e) requires that only a "licensed physician or a license health care professional . . . may deny or modify requests for authorization of health care services[.]"

55. Defendant's conduct violates the unlawful prong of the UCL because it has violated California's express statutory and regulatory requirements regarding insurance claims handling pursuant to California Insurance Code section 790.03, section 2695.7 of Title 10 of the California Code of Regulations, and California Health and Safety Code section 1367.01. Defendant violated the unlawful prong of the UCL when it:

i. did not attempt in good faith to effectuate prompt, fair, and equitable settlements of claims for Plaintiff and the Class members as required by California Insurance Code section 790.03(h) and failed to comply with sections 790.03(h)(3) and (5).

ii. failed to implement reasonable standards for the thorough, fair, and objective investigation and processing of claims arising under their policies for Plaintiff and the Class members as required by section 2695.7(d) of Title 10 of the California Code of Regulations; and

iii. allowed its AI software to review and deny Plaintiff's and the Class members' claims instead of having a licensed physician or licensed health care professional as required by California Health and Safety Code section 1367.01(e).

56. Defendant's actions also violated the unfair prong of the UCL because the acts and practices set forth above, including Defendant's use of the AI software

system to review and deny claims without a thorough, fair, and objective investigation, offend established public policy and cause harm to consumers that greatly outweighs any benefit associated with those practices.

57. Defendant's actions also violate the unfair prong of the UCL because they constitute a systematic breach of consumer contracts.

58. Plaintiff and the Class members would not have enrolled with Defendant had they known Defendant failed to diligently pursue a thorough, fair, and objective investigation into each submitted claim.

59. As a direct and proximate result of Defendant's violation of the UCL, Plaintiff and the Class members have suffered injuries including economic losses for the out-of-pocket healthcare expenses that they paid for and which should have been paid for by Defendant and the insurance premiums paid to Defendant for insurance services that were not provided in accordance with the law.

60. To date, Defendant continues to violate the UCL by utilizing its AI software.

61. Pursuant to California Business and Professions Code § 17203, Plaintiff and the Class seek an order enjoining Defendant from continuing to engage in its unlawful, unfair, and fraudulent conduct alleged herein. Without such an order, there is a continuing threat to Plaintiff and the Class that Defendant will continue to systematically deny benefits to its insureds through its use of its AI software system for claim review.

62. Pursuant to §17203, Plaintiff and the Class seek an order awarding restitution of the money Defendant wrongfully acquired through its violations of the UCL and/or disgorgement of Defendant's ill-gotten revenues and/or profits obtained in violation of the UCL, in an amount to be determined at trial.

COUNT FOUR
Unjust Enrichment
(On behalf of Plaintiff and the Class)

63. Plaintiff realleges and incorporates by reference all preceding allegations as though fully set forth herein.

64. Plaintiff brings this claim for unjust enrichment against Defendant on behalf of the Class.

65. By delegating the prior authorization claims review process to its automated AI software system, Defendant knowingly charged Plaintiff and the Class members insurance premiums for services that Defendant failed to deliver.

66. Defendant knowingly received and retained wrongful benefits and funds from Plaintiff and the Class members.

67. As a result of Defendant's wrongful conduct as alleged herein, Defendant has been unjustly enriched at the expense of, and to the detriment of, Plaintiff and the Class members.

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

69. It is inequitable for Defendant to be permitted to retain the benefits it received from denying its insureds' medical payments owed to them under its insurance policies in an unfair and unconscionable. Defendant's retention of such funds under such circumstances makes it inequitable for Defendant to retain the funds and constitutes unjust enrichment.

70. The financial benefits derived by Defendant rightfully belong to Plaintiff and the Class members. Defendant should be compelled to return in a common fund for the benefit of Plaintiff and the Class members all wrongful or inequitable proceeds received by Defendant.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, individually and on behalf the Class, respectfully requests the Court to enter an Order:

A. certifying the proposed Class pursuant to Federal Rule Civil Procedure 23(a)- (b)(3), as set forth above;

B. awarding monetary damages, including but not limited to any compensatory, incidental, or consequential damages in an amount the Court of jury will determine, in accordance with applicable law;

C. any and all equitable monetary relief the Court deems appropriate;

D. enjoining Defendant from continuing to engage in the unlawful conduct and practices described herein;

E. awarding Plaintiff his reasonable attorney's fees and costs; and

F. providing such further relief as the Court deems reasonable and just.

JURY DEMAND

Plaintiff requests trial by jury of all claims that can be so tried.

DATED: March 27, 2024

Respectfully submitted,

JEREMY JONG, individually and on behalf of similarly situated individuals

By: /s/ *Eugene Y. Turin*
One of Plaintiff's Attorneys

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