Exhibits to the American Kidney Fund's Response to
CMS Request for Information No. CMS-6074-NC

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EXHIBIT 1

2014 WL 8332136
Only the Westlaw citation is currently available.
United States District Court,
M.D. Louisiana.

John EAST, et. al.
v.
BLUE CROSS AND BLUE SHIELD OF LOUISIANA, et. al.

Civil Action No. 3:14–cv–00115–BAJ–RLB.
|
Signed Feb. 24, 2014.

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TEMPORARY RESTRAINING ORDER

BRIAN A. JACKSON, Chief Judge.

***1** Before the Court is putative class representative John East's ("East") **APPLICATION FOR A TEMPORARY RESTRAINING ORDER (Doc. 7) ("Application"),** requesting that the Court enjoin Defendants Blue Cross and Blue Shield of Louisiana ("Blue Cross"), Vantage Health Plan, Inc. ("Vantage"), and Louisiana Health Cooperative, Inc. ("Louisiana Health)" from changing their existing policies as they relate to Ryan White HIV/AIDS Program funds ("Ryan White Funds"), and/or implementing new policies related to Ryan White Funds, *(id.* at p. 4). East's Application is filed in accordance with Fed.R.Civ.P. ("Rule") 65 and this Court's Local Rules, *see* M.D. La. LR65. Defendants Blue Cross and Vantage each oppose East's Application. (Doc. 8; Doc. 17). Defendant Louisiana Health has not filed a notice of appearance, nor given any indication as to its position regarding East's Application.

For reasons explained below, the Court **GRANTS** East's Application as to all Defendants. In accordance with Rule 65, this Temporary Restraining Order shall be effective as of **6:00 p.m., Monday, February 24, 2014** and shall expire 14 days after the time of entry, unless otherwise ordered by this Court. *See* Fed.R.Civ.P. 65(b)(2)-(3). A hearing to determine whether a preliminary injunction shall supplant and/or follow this Order shall proceed at **12:00 p.m., Tuesday, February 25, 2014.**

Rule 65 provides, in relevant part:

> The court may issue a temporary restraining order without written or oral notice to the adverse party or its attorney only if:
>
> (A) specific facts in an affidavit or a verified complaint clearly show that immediate and irreparable injury, loss, or damage **will** result to the movant before the adverse party can be heard in opposition; and
>
> (B) the movant's attorney certifies in writing any efforts made to give notice and the reasons why it should not be required.

Fed.R.Civ.P. 65(b)(1). Additionally,

> Every temporary restraining order issued without notice must state the date and hour it was issued; describe the injury and state why it is irreparable; state why the order was issued without notice; and be promptly filed in the clerk's office and entered in the record.

Id. at 65(b)(2). Further, "[i]f the order is issued without notice, the motion for a preliminary injunction must be set for hearing at the earliest possible time, taking precedence over all other matters except hearings on older matters of the same character ." *Id.* at 65(b)(3). Finally, "[t]he court may issue ... a temporary restraining order only if

the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." *Id.* at 65(c).

Here, the Court is satisfied that East has met the requirements for the temporary relief he seeks. First, East has scrupulously adhered to Rule 65's procedural requirements. His Application is accompanied by an affidavit describing the nature of the "irreparable injury" that will result absent a temporary restraining order ("TRO"), (Doc. 7–2), as well as his attorney's certified description of the efforts that have been made to contact all Defendants in this case, including Defendant Louisiana Health, (Doc. 7–3). *See* Fed.R.Civ.P. 65(b)(1). Further, East's Application adheres to this District's requirements that: (1) the Application "be made in a document separate from the complaint"; and (2) "actual notice of the time of making the application" be included in the Application, (*see* Doc. 7–3 at p. 1). M.D. La. LR65.1.

***2** East has also satisfied Rule 65's substantive requirements. His affidavit (Doc. 7–2) and his Complaint (Doc. 1) each contain "specific facts" indicating that "immediate injury, loss, or damage will result" if a TRO is not issued. In particular, East states: (1) he is "an individual living with HIV," (Doc. 7–2 ¶ 2); he "take[s] two medications [each day] to treat [his] HIV," (*id.* at ¶ 4); his insurance provider, Blue Cross, has heretofore accepted full payment for his insurance premiums from "the Louisiana Health Insurance Program which receives funding from the Ryan White Program," (*id.* at ¶¶ 11–12, 19); East is otherwise unable to pay his monthly insurance premium of $1,306, (*id.* at ¶¶ 19, 24); Blue Cross and the other named Defendants—Vantage and Louisiana Health—recently decided "that they will no longer be accepting Ryan White assistance payments for health insurance premiums," (*id.* at ¶¶ 23, 26); this decision has caused East to miss his most recent payment, which means that he is "now without insurance coverage," (*id.* at ¶ 24); East does not otherwise qualify for health care assistance, (*id.* at ¶¶ 8, 10); and, finally, lacking insurance. East will "run out of ... essential medication," which will, eventually, result in his death, (see *id.* at ¶¶ 6, 30).

It goes without saying that Mr. East's eventual death is an irreparable injury. *See* Fed.R.Civ.P. 65(b)(2) ("Every temporary restraining order issued without notice must ... describe the injury and state why it is irreparable...."). Further, this result is hardly speculative given HIVs pathology, and the known consequences of discontinuity in its treatment. (*See* Doc. 1 at ¶ 56). Given the severe ramifications to Mr. East and other members of his putative class if their insurance coverage is allowed to lapse, the Court is convinced that this Order should be issued, thereby ensuring that the status quo is temporarily maintained, even in the absence of Louisiana Health's notice of appearance, and/or the opportunity for an evidentiary hearing on the issue. *See* Fed.R.Civ.P. 65(b)(2) ("Every temporary restraining order issued without notice must state ... why the order was issued without notice....").[1]

Accordingly,

IT IS ORDERED that East's **APPLICATION FOR A TEMPORARY RESTRAINING ORDER (Doc. 7)** is **GRANTED.** Specifically,

1. Defendants are enjoined from changing their policies of accepting Ryan White HIV/AIDS Program funds ("Ryan White Funds") from current or prospective applicants to, or policy holders of, Defendants' health insurance plans;

2. Defendants are enjoined from implementing or executing their new policies of refusing Ryan White Funds from current or prospective applicants to, or policy holders of, Defendants' health insurance plans;

3. Given the nature of the issues and the parties involved, it is unnecessary for Plaintiffs to post a bond in this matter; and

***3** 4. This Order expires in 14 days or as modified by the Court.

IT IS FURTHER ORDERED that a hearing to determine whether a preliminary injunction shall supplant and/or follow this Order shall proceed at **12:00 p.m., Tuesday, February 25, 2014.**

All Citations

Not Reported in F.Supp.3d, 2014 WL 8332136

Footnotes

1 To the extent that East must satisfy the traditional 4–prong preliminary injunction test before a TRO may issue, see *Garcia v. United States,* 680 F.2d 29, 31 (5th Cir.1982) (indicating that "the requirements justifying a temporary restraining order" are equivalent to those justifying a "preliminary injunction"), the Court also finds that each of these requirements are met. First, East has made a preliminary showing that he is likely to succeed on the merits of his claim because the Affordable Health Care Act contains an express Nondiscrimination provision, requiring that "an individual shall not ... be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance," 42 U.S.C. § 18116; second, as explained, East has demonstrated a substantial threat of irreparable injury—specifically, declining health and eventual death—if his insurance is discontinued; third, this threat to East's well-being far outweighs any injury to Defendants because Defendants are simply required to maintain their existing policies of accepting Ryan White Funds paid on behalf of insureds in East's position; finally, the TRO serves the public interest because it ensures that insureds in East's position maintain their current health care coverage, thereby avoiding, among other things, additional costs resulting from lost health care coverage, such as emergency room treatment in lieu of regularly scheduled doctor appointments and medications. *See Texans for Free Enter. v. Tex. Ethics Comm'n,* 732 F.3d 535, 536–37 (5th Cir.2013) ("A preliminary injunction is an "extraordinary remedy" that should be granted only if the movant establishes (1) a substantial likelihood of success on the merits, (2) a substantial threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that the grant of an injunction will not disserve the public interest.")(quotation marks omitted).

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EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

JOHN EAST, individually and on behalf of all other persons similarly situated, Plaintiffs, v. BLUE CROSS and BLUE SHIELD of LOUISIANA, LOUISIANA HEALTH COOPERATIVE, INC., and VANTAGE HEALTH PLAN, INC., Defendants.	Civil Action No.: 14-115 Section Magistrate **COMPLAINT- CLASS ACTION** **JURY DEMANDED**

Plaintiff JOHN EAST, individually and on behalf of all other persons similarly situated (collectively, "Plaintiffs" or the "Plaintiff Class"), through his undersigned counsel, for his Complaint against Defendants BLUE CROSS AND BLUE SHIELD OF LOUISIANA, LOUISIANA HEALTH COOPERATIVE, INC., and VANTAGE HEALTH PLAN, INC., (collectively, "Defendants"), alleges the following upon knowledge as to his individual conduct and interactions and upon information and belief as to the conduct of others:

PRELIMINARY STATEMENT

1. This action seeks injunctive and declaratory relief to halt Defendants' abrupt and systematic policy of targeted discrimination on the basis of Plaintiffs' disability, *i.e.*, their

infection with the human immunodeficiency virus ("HIV"),[1] in violation of sections 1557(a) and 1311(c) of the Patient Protection and Affordable Care Act (codified at 42 U.S.C. §§ 18116(a) and 18031), and in contravention of Louisiana state law.

2. To ensure equal access to health care under the Affordable Care Act, Congress placed robust antidiscrimination requirements on health insurers that profit from the billions of federal dollars flowing into the health care insurance market and from the vast new market of health insurance consumers made available to insurers through the Affordable Care Act's health insurance exchanges.

3. One such safeguard is section 1557 of the Affordable Care Act, which expressly prohibits health insurers that receive federal funds, as do Defendants, as well as entities established under Title I of the Affordable Care Act, from discriminating against any individual on the basis of a disability for purposes of the individual's participation in or enjoyment of the benefits of health insurance coverage.

4. The "Plaintiff Class" consists of all Louisiana residents living with HIV who are qualified for health insurance premium assistance from the Ryan White HIV/AIDS Program.[2]

5. The Plaintiff Class includes a subclass of persons who have existing or past insured relationships with one or more Defendants ("Insured Plaintiffs").

6. The Plaintiff Class is fully eligible for coverage under Defendants' available plans. Insured Plaintiffs have been paying their premiums in full—some of them for decades—and all Plaintiffs are and remain ready, willing, and able to pay premiums with federal funds designed precisely for that purpose.

[1]HIV, when left untreated, causes AIDS.
[2] The Ryan White HIV/AIDS Program is a federal program that makes grants to states, cities, and non-profit organizations to provide people living with HIV with access to health care, including by assisting in the payment of health insurance premiums.

7. The Plaintiff Class benefits from health insurance premium assistance funded by federal grant money from the Ryan White HIV/AIDS Program, which is available exclusively for people living with HIV in need of financial assistance, and without which none of the Plaintiffs can afford individual health insurance premiums.

8. Defendants have routinely accepted funds from the Ryan White HIV/AIDS Program ("Ryan White Funds") for dozens of their policy-holders' health insurance premiums. Blue Cross and Blue Shield of Louisiana ("BCBS") has accepted Ryan White Funds since at least 2009, and upon information and belief, the other defendants have accepted such funds since each began offering health insurance in Louisiana and Ryan White HIV/AIDS Program premium assistance became available through the Louisiana Health Insurance Program.

9. In or around January 2014, however, BCBS took the position that it would no longer accept Ryan White Funds for premium payments and advised the Louisiana Health Insurance Program of this change to its longstanding policy of accepting these payments.

10. BCBS's new policy excludes Plaintiff class members from access to BCBS coverage, which Plaintiffs can afford only with Ryan White Funds, as surely as if BCBS had posted a sign saying "low-income people with HIV need not apply."

11. BCBS's abrupt policy change coincides with the open enrollment period of the Affordable Care Act's insurance exchange marketplace. BCBS's initial explanation for its dubiously timed policy change was guidance issued by the Centers for Medicare & Medicaid Services ("CMS," a lead federal agency administering the Affordable Care Act) on November 4, 2013 (the "November 2013 Regulatory Guidance"). This guidance discouraged insurers from accepting third-party premium payments from *hospitals, health care providers, and other commercial entities* that might fraudulently seek to attract health care consumers with promises

to make their premium payments, or to defray the costs of otherwise uncompensated care by paying the premiums of those whose coverage would soon lapse.

12. That guidance, however, did ***not*** discourage insurers from accepting payments from other sources, such as federal programs designed specifically to provide premium support. In fact, in a more recent statement, CMS expressly stated that its earlier guidance regarding third-party premium payments "does not apply to payments for premiums and cost sharing made on behalf of QHP [Qualfied Health Plan] enrollees by . . . state and federal government programs or grantees (such as the Ryan White HIV/AIDS Program)."

13. Even after CMS repudiated BCBS's sole justification for refusing these payments, BCBS did not acknowledge its misinterpretation—or mischaracterization—of the earlier guidance and did not resume its longstanding policy to accept Ryan White HIV/AIDS Program payments.

14. Instead, BCBS disregarded CMS' clarification and doubled-down on its discriminatory actions, thereby attempting to skew the Louisiana health insurance market in its favor. BCBS issued a statement on February 13, 2014 making clear that it was going ahead with its discriminatory policy, which would have the effect of keeping low-income individuals living with HIV from enrolling in a BCBS individual insurance plan.

15. In turn, the other state-wide insurers in Louisiana have followed BCBS's lead. Around the time that CMS issued its clarifying guidance, Defendant Louisiana Health Cooperative, Inc. ("Louisiana Health Cooperative") began informing enrollees that it too would no longer accept Ryan White HIV/AIDS Program third-party premium payments. Shortly thereafter, Vantage Health Plan, Inc. ("Vantage") announced that while it would continue to

accept such payments for the time-being, it would reconsider its policy if BCBS and the Louisiana Health Cooperative continued to refuse Ryan White Funds.

16. To avoid the costs associated with more people living with HIV on their insurance rolls, Defendants are intentionally discriminating against Ryan White Funds recipients.

17. Indeed, in an email that was recently made public, a Congressional staffer in Senator Mary Landrieu's office wrote that

> ***BCBS LA told me their decision was not due to the CMS [Centers for Medicare & Medicaid Services] guidance or any confusion (as we thought before) but was in fact due to adverse selection concerns.***

18. The National Association of Insurance Commissions defines adverse selection to include "insurance purchasing decisions based on [consumers'] own knowledge of their insurability . . . [including when] the applicant might have information about the risk that is not known to the insurer, or the insurer might have access to the information but be unable to incorporate it fully into the price of coverage, due to factors such as antidiscrimination laws." *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act*, Nat'l Ass'n of Ins. Comm'rs (2011), *available at* http://www.naic.org/store/free/ASE-OP.pdf.

19. Against the backdrop of the Affordable Care Act prohibiting health insurers from incorporating applicants' pre-existing conditions into the price of coverage, BCBS candidly admitted that it was excluding a large group of expensive-to-insure individuals—Plaintiffs—for no other reason than to avoid adverse selection.

20. Due to the eligibility requirements of the Ryan White HIV/AIDS Program, which is designated to be a payor of last resort, Plaintiffs by definition do not have employer-provided insurance, are ineligible for Medicare, Medicaid, or other federal health care programs, and cannot afford private insurance on their own. Without Ryan White HIV/AIDS Program

assistance, Plaintiffs cannot obtain health insurance, without which Plaintiffs cannot maintain the continuous access to care and prescription medications that literally keep them alive.

21. Defendants' plans are Plaintiffs' only viable health insurance options.[3] Defendants' discriminatory policy of refusing to accept Ryan White Funds puts Plaintiffs in a situation that class representative John East describes as "a matter of life and death."

22. As a result of Defendants' unlawful discrimination in violation of sections 1557 and 1311 of the Affordable Care Act, hundreds—if not thousands—of low-income Louisianans with HIV face being dropped immediately from their health care coverage, and those who are currently uninsured will have no health care coverage option to which they can turn.[4]

23. As a result of Defendants' unlawful discrimination and refusal to accept Insured Plaintiffs' premium payments via the Ryan White HIV/AIDS Program, Defendants have violated their contractual obligations to Insured Plaintiffs, their duty of good faith and fair dealing, as well as other duties under state law.

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[3] The residents of Jefferson Parish who are currently eligible for assistance through the Louisiana Health Insurance Program may be able to pay for a health insurance plan offered by Humana Medical Plan, Inc., using Ryan White Funds, though it is unclear whether that plan will adequately meet the health care needs of all of these individuals, cover the specific medications currently being prescribed to these individuals, or allow these individuals to remain with the physician currently providing them with care and treatment. Furthermore, unless the other insurers doing business in Jefferson Parish are prevented from discriminating against low-income people living with HIV and kicking them off their insurance rolls, Humana may have difficulty maintaining its position as the only insurer in Louisiana complying with the nondiscrimination mandates of the Affordable Care Act and providing these individuals with coverage.

[4] Through nondiscrimination provisions, and regulations promulgated thereunder, the ACA prohibits precisely the tactic Defendants are employing to rid their insurance rolls of people living with HIV. In addition to section 1557, section 1311 requires that participating health insurance plans not employ benefits designs or marketing practices that discourage people with significant health needs from enrolling, and regulations promulgated under section 1311 further elucidate these standards. *See, e.g.*, Section 1311(c)(1)(A) of the ACA provides that "to be certified, a plan shall, at a minimum (A) . . . not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs. . . ." *See* 42 U.S.C. § 18031. *See also, e.g.*, 45 C.F.R. § 147.104(e) (prohibiting insurers from "employ[ing] marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's . . . present or predicted disability . . . or other health conditions"); 45 C.F.R. § 156.125(a) ("[a]n issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's . . . present or predicted disability . . . or other health conditions"); 45 C.F.R. § 156.225(b) (prohibiting insurers from "employ[ing] marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs").

24. As a result of Defendants' longstanding practice of accepting and benefiting from Ryan White Funds, which induced Plaintiffs' reliance that Defendants would continue to do so, Defendants must also be estopped from taking their new position leaving Plaintiffs with no viable health insurance option.

JURISDICTION AND VENUE

25. This Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343(a)(4) where this action arises under, *inter alia*, sections 1557 and 1331 of the Affordable Care Act and 29 U.S.C. § 794. The Court has jurisdiction over Plaintiffs' state law claims, which arise from a common nucleus of operative facts as Plaintiffs' federal claims, pursuant to 28 U.S.C. § 1367(a).

26. Venue is proper in this district pursuant to 28 U.S.C. § 1391 because, upon information and belief, Defendant BCBS resides in the Middle District of Louisiana and all Defendants are residents of Louisiana, and because all or a substantial part of the events giving rise to the claims in this action occurred and are occurring in the Middle District of Louisiana.

27. Declaratory relief is authorized pursuant to 28 U.S.C. § 2201 and 28 U.S.C. § 2202. A declaration of the law is necessary and appropriate to determine the respective rights and duties of the parties to this action.

NAMED PARTIES

PLAINTIFF

28. Plaintiff John East, a resident of Louisiana, has purchased insurance coverage from BCBS continuously since 1985. Mr. East is living with HIV. Despite working two jobs, in 2009 Mr. East's escalating health insurance premium costs became unaffordable, and he realized he soon would be unable to make his payment on his own. Because he is a low-income person

living with HIV, Mr. East qualified for and obtained Ryan White HIV/AIDS Program health insurance premium assistance.

29. Mr. East, whose coverage with BCBS began in 1985, never missed a premium payment and his coverage never lapsed. Since he became qualified for premium assistance in approximately 2009, BCBS has been accepting Ryan White Funds premium payments for Mr. East.

30. At the beginning of this year, however, BCBS advised that it would no longer accept Ryan White Funds, leaving Mr. East with no means to make his premium payments. After BCBS's announcement, Mr. East's next payment was due on February 15, 2014, and he now faces the loss of health insurance for the first time in 29 years. Mr. East has since learned that Defendant Louisiana Health Cooperative will no longer accept Ryan White HIV/AIDS Program premium payments. He has also learned that Vantage, his only other potential option for health insurance coverage paid for with Ryan White funds, will likely follow BCBS and Louisiana Health Cooperative and stop accepting Ryan White Funds in March 2014.

DEFENDANTS

31. Defendant BCBS is a Louisiana corporation, with headquarters in Baton Rouge, Louisiana. BCBS offers insurance policies to residents of every Parish in Louisiana through the federal healthcare exchange. Defendant BCBS is the administrator for the Federal Employees Health Benefit Plan in Louisiana. It also offers Health Maintenance Organization and Preferred Provider Organization insurance plans through the federal healthcare exchange, in connection with which it receives federal premium tax credits and cost-sharing subsidy payments directly from the federal government. Finally, Defendant BCBS has received federal money via the very program at issue here—the Ryan White HIV/AIDS Program.

32. Defendant Louisiana Health Cooperative is a non-profit health care company, with headquarters in Metairie, Louisiana. Defendant Louisiana Health Cooperative received a loan for $65,040,660 in 2012 from the Department of Health and Human Services Consumer Oriented and Operated Plan Loan Program to assist with establishing its health insurance business. Defendant Louisiana Health Cooperative is a "Consumer Operated and Oriented Plan" established under title I of the Affordable Care Act. It offers Health Maintenance Organization and Point of Sale insurance plans through the federal healthcare exchange, in connection with which it receives federal premium tax credits and cost-sharing subsidy payments directly from the federal government. Finally, Defendant Louisiana Health Cooperative has received federal money via the very program at issue here—the Ryan White HIV/AIDS Program.

33. Defendant Vantage is a Louisiana corporation, with headquarters in Monroe, Louisiana. It offers Point of Sale insurance plans through the federal healthcare exchange, in connection with which it receives federal premium tax credits and cost-sharing subsidy payments directly from the federal government. Vantage also receives federal funds to administer its Medicare Advantage health insurance plans. Finally, Defendant has received federal money via the very program at issue here—the Ryan White HIV/AIDS Program.

CLASS ACTION ALLEGATIONS

34. The named individual Plaintiff brings this action individually and on behalf of the Plaintiff Class pursuant to Federal Rule of Civil Procedure 23(a) and (b)(2). The class consists of all Louisiana residents living with HIV who are qualified for health insurance premium assistance from the Ryan White HIV/AIDS Program. The class includes a subclass of Plaintiffs who have existing or past insured relationships with one or more Defendants (defined above as "Insured Plaintiffs") who, by virtue of those relationships, are entitled to additional relief under state law.

35. Numerosity. The size of the class is indefinite, and includes at least 1400 individuals who are eligible to apply for and enroll in a health insurance policy offered by one of the Defendants—including a subset of individuals who have existing or past insured relationships with one or more Defendants—but whose premium payments will now be refused under Defendants' discriminatory policies, leaving the Plaintiff Class with no viable health insurance coverage option.

36. Adequacy of Representation. The named Plaintiff will represent fairly and adequately the interests of the class and subclasses defined above. Plaintiffs' attorneys include counsel experienced in insurance, health care, and civil rights matters who have litigated cases involving similar issues and claims, and have experience in class action litigation.

37. Common Questions of Law and Fact. Common questions of law and fact affecting the entire class are involved, including but not limited to questions of law and fact regarding Defendants' actions, such as adopting policies that discriminate against Plaintiffs on the basis of their disability.

38. Typicality of the Claims of Class Representatives. The named Plaintiff's claims are typical of the claims of the class as a whole, and of those of the Insured Plaintiffs subclass. The named Plaintiff is a member of the class and subclass defined herein and has suffered, and will continue to suffer, discriminatory denial of equal access to otherwise available health care coverage. The named Plaintiff alleges that he and the members of the class and subclass he seeks to represent are and will be subject to discrimination based on disability due to the conduct complained of in this action.

APPLICABLE LAW

39. Section 1557(a) of the Affordable Care Act, 42 U.S.C. § 18116(a), provides that "an individual shall not . . . be excluded from participation in, be denied the benefits of, or be

subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance" on the ground prohibited under, *inter alia*, section 504 of the Rehabilitation Act.

40. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, prohibits discrimination based upon disability. A "disability" under section 504 is "a physical or mental impairment that substantially limits one or more major life activities." 29 U.S.C. § 794(a); 29 U.S.C. § 705(20)(B); 42 U.S.C. § 12102(1)(A). "[A] major life activity . . . includes the operation of a major bodily function, including . . . functions of the immune system." 42 U.S.C. § 12102(1)(A) & (2)(B).

41. Section 1557 states that "[t]he enforcement mechanisms provided for and available under . . . section 504 . . . shall apply for purposes of [section 1557(a)]." 42 U.S.C. § 18116(a).

42. Section 504 may be enforced by "any person aggrieved by any act or failure to act . . ." according to the same "remedies, procedures and rights set forth in[, *inter alia*,] Title VI of the Civil Rights Act." 29 U.S.C. § 794(a)(2).

43. Section 1557 also prohibits discrimination on the basis of disability status by "any entity established under [title I of the Affordable Care Act] (or amendments)." 42 U.S.C. § 18116(a).

44. Section 1322 of the Affordable Care Act, 42 U.S.C. § 18042, establishes the Consumer Operated and Oriented Plan ("CO-OP") program.

45. Under section 1311(c)(1)(A) of the Affordable Care Act, a "qualified health plan" certified and offered on a federal exchange must "not employ marketing practices or benefit

designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs." 42 U.S.C. § 18031(c)(1)(A).

46. Section 2702(a) of the Public Health Services Act provides that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every . . . individual in the State that applies for such coverage." 42 U.S.C. § 300gg-1.

47. Louisiana Revised Statute section 22:1964 ("section 1964") declares what are, in the insurance business, "[m]ethods, acts, and practices which are defined as unfair or deceptive." LA. REV. STAT. § 22:1964.

48. Section 1964(7) enumerates "unfair discrimination" as an "unfair or deceptive" practice. Section 1964(7) (incorporating Louisiana Revised Statute section 22:34) defines "unfair discrimination," *inter alia*, as

> unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder.
>
> LA. REV. STAT. § 22:1964(7).

49. Section 1964(14)(a) enumerates as an "unfair or deceptive" practice the act of "[c]ommitting or performing with such frequency as to indicate a general business practice any of the following: (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue . . . " LA. REV. STAT. § 22:1964(14)(a).

50. Louisiana Revised Statute section 22:861 states that

> Any insurer may insert in its policies any provisions or conditions required by its plan of insurance or method of operation which are not prohibited by the provisions of this Code.
>
> LA. REV. STAT. § 22:861.

51. Louisiana Revised Statute section 22:880 states that

> Any insurance policy, rider, or endorsement hereafter issued and otherwise valid, which contains any condition or provision not in compliance with the requirements of this Code, shall not be rendered invalid, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this Code.

LA. REV. STAT. § 22:880.

FACTS

The Current State of Low-Income People Living with HIV in Louisiana

52. According to a study by the Centers for Disease Control and Prevention ("CDC"), Louisiana is the State with the second highest rate of HIV infection in the United States and the fourth highest rate of AIDS among adults and adolescents.

53. As of 2012 there were nearly 19,000 people living with HIV in Louisiana. As of 2009, there were 9,228 total HIV-related deaths among people living with HIV in the state.

54. HIV and AIDS disproportionately affect low-income populations, including in Louisiana. According to remarks by the Director of the CDC's National Center for HIV/AIDS, Dr. Jonathan Mermin, individuals with household incomes below $10,000 per year are 10 times more likely to have HIV than individuals with household incomes above $50,000 per year.

55. Twenty-two percent of people in Louisiana are living below the Federal Poverty Level, which is set at an annual income of $11,670 for an individual in 2014.

Critical Importance of Continuous Health Care Coverage for People Living with HIV

56. According to the CDC and many peer-reviewed articles, retention and continuity of health care for people living with HIV is directly linked to better health outcomes and a significantly decreased chance of transmitting HIV to others.

57. Continuity of care is critical for people living with HIV because it allows them to obtain and maintain a regimen of antiretroviral medication, reduce their viral load, and ultimately reduce mortality rates.

58. Viral load is a measurement of the amount of HIV in an individual's blood. It indicates the degree of infection and is used to determine treatment strategies. A health care provider will typically test an HIV patient's viral load every three to six months, and more often when changing or starting treatment.

59. Antiretroviral medications are the primary method of combatting HIV infection and reducing viral load. Antiretroviral medications work by interfering with the replication process of HIV. Standard antiretroviral treatment typically involves a combination of at least three drugs taken daily.

60. Consistent care and treatment, including access to antiretroviral medication, has been shown to greatly reduce illness and death attributable to HIV, particularly when introduced at an early stage of infection, and can lead to a reduction in viral load to undetectable levels.

61. Studies have shown that an undetectable viral load dramatically reduces the chance of HIV transmission and results in a life expectancy commensurate with individuals in the general population.

62. Unfortunately in Louisiana, late diagnosis and lack of medical care contributes to a rate of death from AIDS nearly double the national average.

63. In Louisiana, 25% of people who received an AIDS diagnosis between 2002 and 2006 died within 36 months of receiving their diagnosis. Nationally, over the same period, 17% of people receiving an AIDS diagnosis died within 36 months.

Health Insurance Options for Low-Income People Living with HIV in Louisiana

64. There are significant gaps in availability of affordable health care coverage for low-income people living with HIV in Louisiana.

65. Louisiana has not expanded Medicaid coverage to include all individuals with a household income at or below 133% of the federal poverty level, as contemplated by the Medicaid expansion provisions of the Affordable Care Act. Accordingly, low-income people living with HIV in Louisiana who are not yet eligible for Medicare may obtain health insurance coverage through Medicaid only under limited circumstances.

66. While the Affordable Care Act's new provision for private health insurance exchanges provides an opportunity for some low-income people living with HIV to obtain insurance, affordability remains a problem.

67. Indeed, according to a state health reform modeling project undertaken by the Harvard Law School, only 8% of Louisiana's Ryan White Funds-eligible clients will be eligible for health insurance subsidies under the Affordable Care Act. Individuals with a household income below 100% of the Federal Poverty Level do not qualify for premium assistance through the health care exchanges. For people living with HIV in this income group, purchasing private insurance on the exchange is impossible without the assistance of Ryan White Funds.

68. Even people living with HIV who qualify for a subsidy to purchase private health insurance on the exchange still need Ryan White Funds to assist them in meeting their remaining individual premium obligation.

69. Plaintiff John East is one such. Mr. East, who is currently under-employed, cannot afford the premiums for his legacy insurance policy without assistance from the Ryan White HIV/AIDS Program. While Mr. East also would be eligible to apply for a plan on the federal exchange, and he may qualify for a subsidy, any subsidy he would qualify for still would

not suffice to cover his premium payment, and he continues to need the Ryan White HIV/AIDS Program's assistance.

70. The good news is that, with the assistance of Ryan White Funds, Plaintiffs can obtain insurance under the Affordable Care Act's protections, because no health insurance plan offered on the exchange can discriminate in coverage or price of premium based on their condition living with HIV.

The Ryan White HIV/AIDS Program

71. The Ryan White HIV/AIDS Program is a critical bridge over the health insurance coverage gap for Plaintiffs, making it possible for these low-income individuals living with HIV to pay premiums for private health care coverage that they would not otherwise be able to afford.

72. In 1990, Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act (Ryan White CARE Act), funding what is now the Ryan White HIV/AIDS Program. The Ryan White HIV/AIDS Program makes grants to states, cities, and non-profit organizations to provide people living with HIV with access to health care, including by assisting in the payment of health insurance premiums.

73. At the federal level, Ryan White Funds are administered by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

74. In 2010, the U.S. government released the "National HIV/AIDS Strategy for the United States," reemphasizing the Ryan White HIV/AIDS Program's important role as part of the national HIV/AIDS prevention and treatment strategy. A critical goal of the "National HIV/AIDS Strategy for the United States" is to increase by 2015 the "proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care)."

75. In Louisiana, the Louisiana Health Insurance Program administers the Ryan White HIV/AIDS Program. In fiscal year 2012, Louisiana received $50,704,888 in total funding for Ryan White Program activities.

76. Louisiana state and municipal grantees have been accepting and utilizing Ryan White Program Funds since 1991. These funds and the programs they support are central to Louisiana's strategy for combating HIV/AIDS.

77. Since 1994, the Louisiana Health Insurance Program has been assisting eligible individuals—Louisiana residents living with HIV who have a household income below 300% of the Federal Poverty Level—to make their individual health insurance premium payments.

78. The HIV/AIDS Alliance for Region II (the "HIV/AIDS Alliance") is the not-for-profit entity that administers the Louisiana Health Insurance Program's health insurance premium payment function.

79. Potential Ryan White HIV/AIDS Program premium assistance recipients apply through the HIV/AIDS Alliance. Once a recipient becomes enrolled, the HIV/AIDS Alliance sends premium checks to insurers on behalf of the participant.

80. The Health Resources and Services Administration HIV/AIDS Bureau, which is the Federal Administrator of the Ryan White HIV/AIDS Program, requires Ryan White HIV/AIDS Program Grantees to make payments directly to service providers and insurance companies. Grantees are not permitted to make direct payment to Ryan White HIV/AIDS Program beneficiaries.

81. Well before the Affordable Care Act's implementation, Insured Plaintiffs including John East, received Ryan White HIV/AIDS Program support to pay their premiums for health insurance plans purchased in the private marketplace from BCBS and Vantage, making

this a critically important means for low-income people living with HIV to obtain care and treatment.

82. With the implementation of the federally sponsored health insurance exchange in Louisiana beginning in October 2013, the federal government made clear that Ryan White HIV/AIDS Program premium support will play an equally important role in assisting low-income people living with HIV pay their private health insurance premiums for plans purchased through the exchange.

83. Indeed, the Health Resources and Services Administration has issued many policy statements providing guidance on the continued use of Ryan White Funds as premium assistance for eligible people living with HIV to purchase and maintain health insurance plans offered on the federal exchange.

Defendants' Past Acceptance of Ryan White Funds

84. Long before the implementation of the Affordable Care Act's health exchanges, Defendant BCBS, and upon information and belief Defendant Vantage, established an unequivocal pattern and practice of accepting Plaintiffs' Ryan White Funds premium payments.

85. BCBS has continuously and habitually accepted Ryan White Funds for its policy holders' premium payments at least since as early as 2009.

86. Vantage and Louisiana Health Cooperative also have received and accepted Ryan White Funds for its policy holders' premium payments.

87. Plaintiff John East's most recent BCBS insurance policy includes a section entitled "Due Date for Premium Payments," which states:

> 1. Premiums are owed by Subscriber. Premiums may not be paid by third parties unless related to the Subscriber by blood or marriage. Premiums may not be paid by Hospitals, Pharmacies, Physicians, automobile insurance carriers or other insurance carriers. Company will not accept premium payments by third parties unless required by law to do so. The fact that We may have

> previously accepted a premium from an unrelated third party does not mean that we will accept premiums from these parties in the future.

88. Despite this term in BCBS's recent written policy, when announcing its policy of refusing Ryan White HIV/AIDS Program and other third-party premium payments on February 10, 2014 and again on February 13, 2014, BCBS made no mention that such a term already existed in its insurance policies. Rather, BCBS made its announcements on February 10 and 13, 2014 as if no such term previously existed.

89. Despite this term in its recent written policy, BCBS announced on February 10 and 13, 2014 that the policy would not take effect until March 1, 2014, and that BCBS would continue honoring third-party premium payments up through February 28, 2014.

90. Despite this term in its recent written policy, BCBS went on to accept Mr. East's (and others') Ryan White HIV/AIDS Program premium payments after Mr. East undertook his most recent policy renewal.

91. Wanting to ensure that his coverage never lapses, Mr. East routinely called BCBS to ensure that BCBS had received his premium payment of Ryan White Funds and applied it toward his account. BCBS representatives always assured Mr. East that his Ryan White HIV/AIDS Program premium had been received and accepted like any other premium payment.

92. Defendants' policy, pattern, and custom of accepting Ryan White Funds caused Insured Plaintiffs to repeatedly renew their coverage in reliance on Defendants' prior practices, and based on their understanding that their only means of paying their premium in full—via Ryan White Funds—was acceptable to Defendants.

93. For instance, Plaintiff John East annually had the opportunity to renew his BCBS policy or shop for health insurance elsewhere. While Mr. East did make inquiries with other

health insurers, he always renewed his BCBS policy, largely based on his belief that there would be no issue with his Ryan White Funds payments being accepted by BCBS.

94. Defendant BCBS's longstanding policy, pattern, and custom of accepting Ryan White Funds persisted even after BCBS inserted boilerplate language in its insurance policies that it would not receive third party premium payments.

95. Defendants outwardly maintained their policy, pattern, and custom of accepting Ryan White Funds even on the eve of Defendants' changing that position, including at times when Defendants knew they would soon be changing that position, in furtherance of receiving and benefiting from Plaintiffs' Ryan White Funds premium payments.

Defendants' Abrupt Change of Policy and Purported Justification

96. In January 2014, BCBS abruptly advised state agencies and entities administering Ryan White funds, including the Louisiana Health Insurance Program and the HIV/AIDS Alliance for Region II, that it would no longer accept Ryan White Funds for Plaintiffs' premium payments.

97. At that time, healthcare advocates and case workers of HIV and AIDS support programs such as the NO/AIDS Task Force ("NO/AIDS") also learned that BCBS would be refusing Ryan White premium payments and that BCBS's explanation for its policy was that the November 2013 Regulatory Guidance prevented BCBS from accepting premium payments from third parties.

98. In mid-January, Plaintiff John East learned of BCBS's policy of refusing Ryan White funds from his case worker at NO/AIDS.

99. BCBS provided Mr. East himself with no such notice. However, BCBS did send Mr. East his premium bill as usual. If not for his conversation with NO/AIDS, Mr. East would

have continued to believe that BCBS would accept his Ryan White HIV/AIDS Program premium payments as it always had.

100. The November 2013 Regulatory Guidance that BCBS purportedly relied on addressed CMS' concern that private or commercial parties might distort the marketplace in attracting patients to consume their healthcare services, or in shifting the costs of uncompensated care, by paying those patients' premiums or cost-sharing payments.

101. To that end, the November 2013 Regulatory Guidance stated that "HHS [Department of Health and Human Services] discourages this practice and encourages issuers to reject such third party payments."

102. Consistent with its purpose of targeting the practice of third parties who seek to attract patients with offers to pay premiums and cost-sharing obligations, the November 2013 Regulatory Guidance was limited to discouraging the acceptance of third-party premiums paid only by "hospitals, other healthcare providers, and other commercial entities."

103. Nonetheless, BCBS announced publically in a February 10, 2014 media release that its policy of not accepting any third-party payments (including Ryan White Funds) was in response to the November 2013 Regulatory Guidance, which BCBS characterized as "strongly advising [insurers] not to take ***any*** third-party payments." (Emphasis added.)

104. In another media release on February 13, 2014, BCBS again offered only one justification for its policy—its purported concerns based on the November 2013 Regulatory Guidance that people or organizations might fraudulently seek to attract health care consumers with promises to make their premium payments or to defray the costs of otherwise uncompensated care by paying the premiums of those whose coverage would soon lapse.

105. BCBS has offered no justification for its refusal to accept Ryan White Funds from Plaintiffs, other than its claimed inapposite concerns over "fraud, waste and abuse" as discussed in November 2013 Regulatory Guidance.

The November 2013 Regulatory Guidance Never Supported BCBS's Only Purported Justification, and the Centers for Medicare & Medicaid Services Expressly Refuted BCBS's Incoherent Justification

106. BCBS's only justification for its refusal to accept Plaintiffs' Ryan White Funds premiums is a false pretext under which BCBS is attempting to keep what it perceives to be a more expensive class of insureds—people living with HIV—off its insurance rolls.

107. On February 7, 2014, very shortly after BCBS began advising that it would reject Ryan White Funds from Plaintiffs, CMS responded with clarifying guidance (the "February 2014 Regulatory Guidance"), in Question-and-Answer format, entitled, "Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces."

108. In response to the question whether the November 2013 Regulatory Guidance applied to "premium and cost sharing payments on behalf of [Qualified Health Plan] enrollees from . . . state and federal government programs or grantees (such as the Ryan White HIV/AIDS Program)," the February 2014 Regulatory Guidance stated that it did not apply:

> ***No. The November 4, 2013 FAQ does not apply to payments for premiums and cost sharing made on behalf of . . . state and federal government programs or grantees (such as the Ryan White HIV/AIDS Program). QHP issuers and Marketplaces are encouraged to accept such payments***.

(Emphasis added.)

109. The February 2014 Regulatory Guidance went on to confirm that earlier Health Resources and Services Administration guidance on the Ryan White HIV/AIDS Program "specifically describes how grantees can use grant funds to pay premiums and cost sharing for eligible individuals enrolled in QHPs."

110. BCBS's media releases of February 10, 2014 and February 13, 2014 each acknowledged the February 2014 Regulatory Guidance, but asserted that, in this more recent guidance, "CMS [Centers for Medicare & Medicaid Services] changed its position" and "issued a different communication."

111. BCBS supported its assertion that "CMS changed its position" by asserting that the earlier November 2013 Regulatory Guidance "strongly advis[ed insurers] not to take ***any*** third-party payments." (Emphasis added.)

112. The foregoing statements by BCBS on February 10 and 13, 2014, are deliberately false and misleading.

113. The November 2013 Regulatory Guidance did not discourage insurers from taking "any" third-party payments, but rather explicitly tailored its caution to those third-party payors that might actually seek to exploit patients with premium assistance for their own personal gain—"hospitals, other healthcare providers, and other commercial entities."

114. The November 2013 Regulatory Guidance certainly did not include federal Ryan White Funds or any other government program specifically designed to assist people living with HIV to pay their health insurance premiums.

115. Contrary to BCBS's assertion that "CMS changed its position" through its February 2014 Regulatory Guidance, the February 2014 Regulatory Guidance was ***consistent with*** the November 2013 Regulatory Guidance. Neither supports a policy of refusing federal funds to assist Plaintiffs to pay their health insurance premiums.

116. BCBS has not explained in any of its public statements how refusing Ryan White Funds premium payments from Plaintiffs, rather than refusing payments only from hospitals,

other healthcare providers, and other commercial entities, furthers BCBS's purported goal of safeguarding against patient-steering by private actors and other fraudulent activity.

117. BCBS's justification based solely on BCBS's characterization of the policy is unsupported by any regulatory guidance and is explicitly negated by the February 2014 Regulatory Guidance.

118. The vast majority of Blue Cross and Blue Shield affiliates across the country have not adopted this policy.

Defendants' True Motivation in Refusing Ryan White Funds Is to Exclude Individuals Based on Their HIV/AIDS Status from Defendants' Insurance Rolls

119. In reality, Defendants' policy is intended to exclude Louisianans living with HIV who cannot by themselves afford to pay the premiums for the health insurance offered by Defendants.

120. Defendants are motivated to keep people living with HIV off their insurance rolls and reduce the increased costs associated with paying for the care and treatment provided to people living with HIV.

121. This is demonstrated in an email made public via various news outlets, in which a Congressional staffer in Senator Mary Landrieu's office reported that,

> ***BCBS LA told me their decision was not due to the CMS [Centers for Medicare & Medicaid Services] guidance or any confusion (as we thought before) but was in fact due to adverse selection concerns.***

(Emphasis added.)

122. As defined by the National Association of Insurance Commissions:

> Adverse selection . . . occurs whenever people make insurance purchasing decisions based on their own knowledge of their insurability or likelihood of making a claim on the insurance coverage in question. This can happen in a variety of ways. For example, the applicant might have information about the risk that is not known to the insurer, or the insurer might have access to the

> information but be unable to incorporate it fully into the price of coverage, due to factors such as antidiscrimination laws . . .

Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act, Nat'l Ass'n of Ins. Comm'rs (2011), *available at* http://www.naic.org/store/free/ASE-OP.pdf.

123. People living with HIV have medical needs requiring regular doctor visits (preferably with an infectious disease specialist), periodic blood tests and other lab work, and uninterrupted access to the medications they take on a daily basis.

124. Without regular medical care and monitoring and continuous access to (often expensive) medications, people living with HIV face the strong likelihood of a deteriorating immune function, debilitating illness, and premature death.

125. In light of their pressing need for consistent medical care and their lack of sufficient resources to pay for such care out of pocket, Plaintiffs' need for health insurance is particularly high.

126. Pursuant to Affordable Care Act reforms effective January 1, 2014, Plaintiffs cannot be prevented from purchasing most private health insurance plans, including Defendants', from which they historically have been excluded based on pre-existing condition exclusions.

127. The Affordable Care Act's reforms also prevent insurers from denying claims or basing premiums on a person' pre-existing condition, such as HIV or AIDS.

128. Plaintiffs' elevated need for health care and correspondingly high demand for health insurance, combined with the Affordable Care Act's provisions preventing Defendants from discriminating against people living with HIV in coverage or in premium cost, is consistent with BCBS's admission to Senator Landrieu's aide that its policy not to accept Ryan White Funds is intended to exclude Plaintiffs and thereby avoid "adverse selection."

129. Defendants' sudden refusal to accept Ryan White Funds also has the ***effect of*** discriminating against people living with HIV.

130. By definition, all individuals eligible for Ryan White HIV/AIDS Program are living with HIV (or AIDS) and find themselves currently unable to afford private health insurance premiums without Ryan White Funds.

131. Accordingly, 100% of those affected by Defendants' refusal to accept Ryan White Funds are individuals with a disability as defined by the Rehabilitation Act, and 100% of those affected will be unable to purchase health insurance on the federal exchange or otherwise.

132. Tellingly, in its February 13, 2014 media release, BCBS specifically assured the public that Ryan White HIV/AIDS Program recipients were not the only individuals affected by its new policy of refusing third party payments.

133. BCBS, however, cited only one example, concluding that "some Louisiana universities pay for student athletes' premiums. This policy affects them as well."

134. Like its justification for its discriminatory policy, BCBS's conclusory attempt to paint its policy as one of general application appears wholly unsupported.

135. In fact, Louisiana State University, the largest public university in Louisiana, has stated that BCBS's policy does not affect it or its student athletes.

Defendants' Abrupt Change in Policy to Refuse Ryan White Funds Leaves Plaintiffs with No Access to Health Insurance

136. In early February 2014, after BCBS publicized its plan to refuse Ryan White funds, Defendant Louisiana Health Cooperative, announced it too would refuse Ryan White Funds. The remaining Defendant, Vantage, announced that it would reexamine its policy of accepting Ryan White Funds in the near future, signaling an intent to adopt positions similar to

BCBS's and Louisiana Health Cooperative's if those insurers are allowed to continue their practice.

137. The concerted effort by these three insurers to exclude Plaintiff Ryan White HIV/AIDS Program beneficiaries effectively freezes Plaintiffs out of the federal health insurance exchange—the only market offering affordable health insurance plans that cannot exclude Plaintiffs or charge more on the basis of their HIV or AIDS diagnosis.

138. BCBS, the Louisiana Health Cooperative, and Vantage, represent three out of the four Louisiana health insurers that offer plans on the federal health insurance exchange.

139. The fourth insurer offering health insurance through the federal insurance exchange offers policies in only Jefferson Parish.

140. According to BCBS's own media release, BCBS is the only "meaningful" state-wide insurance option offered in the federal exchanges in Louisiana:

> [BCBS] is the only insurer that is fully participating in the Marketplace, offering plans at every metal level in every parish and every ZIP code in the state. . . . Our competition has chosen, for the most part, not to participate in any meaningful way.

141. With Defendants' new discriminatory policy in place, there are no health insurance policies offered through the federal insurance exchange that cover the other 63 Parishes of Louisiana (besides Jefferson Parish) in which Plaintiffs could participate, because now no provider of such policies accepts Ryan White Funds premium payments.

142. As noted above, Plaintiffs fall into Louisiana's insurance gap of individuals who do not qualify for Medicaid, Medicare, or other federal health care programs, but who cannot afford private health care insurance on their own.

143. Beyond their need for Ryan White Funds to afford their insurance premiums, Plaintiffs are qualified to participate in and receive the benefits of their existing or prospective

health insurance plans. The lone obstacle to Plaintiffs retaining or obtaining insurance is Defendants' sudden refusal to accept Ryan White Funds.

144. The introduction of the Affordable Care Act's health insurance exchanges offered new and more favorable options to Insured Plaintiffs with existing policies, and finally offered to Plaintiffs currently without insurance an opportunity to secure insurance and not be turned away or gouged based on an HIV or AIDS diagnosis.

145. Plans purchased outside of an exchange are far less likely to be affordable because Plaintiffs will not be eligible for premium credits or cost sharing subsidies, as they will be in connection with plans purchased through an exchange.

146. Even the plans in the federal exchange, however, despite the availability of premium credits and cost-sharing subsidies, are still too costly for Plaintiffs to carry the premiums themselves, making Ryan White Funds essential for Plaintiffs to be able to participate in, and enjoy the benefits of, the new market of health insurance free of discrimination based on disability or pre-existing conditions. Defendants know this fact.

147. With the major market player, BCBS, refusing Ryan White Funds, and with ***all*** insurance options outside of Jefferson Parish doing likewise (or, as to Vantage, threatening to do so in the near future), Defendants' discriminatory policy freezes Plaintiffs out of any access to health care coverage.

148. Even Plaintiffs living in Jefferson Parish, from whom one insurer may accept Ryan White Funds, are frozen out of coverage from BCBS, who, by its own assertion, is the only health insurer "to participate [in the exchange] in any meaningful way."

The Effect of Defendants' Intentional Discrimination Could Mean Illness and Death for Plaintiffs Forced Off Their Insurance Coverage

149. The circumstances facing Plaintiffs due to Defendants' intentionally discriminatory policy could not be more dire.

150. Plaintiff John East described the effect of this policy as being a "matter of life and death."

151. As set forth above, most Plaintiffs must take a number of costly prescription drugs every day, in various combinations tailored to boost their individual immune systems.

152. These drugs literally keep Plaintiffs alive. As Plaintiff John East has stated, "I could die if I don't get my meds."

153. To ensure that the medications remain effective and that the virus has not mutated and developed a resistance to the particular medications being taken, Plaintiffs also must engage in routine doctor visits and regularly undergo blood work and other medical monitoring tests.

154. Without health insurance coverage, the Plaintiff class members, including Plaintiff John East, cannot afford any of the care that they need to remain healthy and, ultimately, to stay alive.

155. With Defendants' policy of refusing Ryan White Funds in place, premiums due this month will go unpaid, Plaintiffs' prescriptions will begin to run out, and Plaintiffs may be turned away from their health care providers if there is uncertainty as to whether their coverage remains in place.

156. In addition, the health effects of losing—or even the threat of losing—health coverage for Plaintiffs, who so desperately depend on it, substantially impair Plaintiffs' ability to work and support themselves and their families.

CAUSES OF ACTION

FIRST CLAIM FOR RELIEF- AS TO THE PLAINTIFF CLASS
(Intentional discrimination in violation of section 1557(a) of the Patient Protection and Affordable Care Act)

157. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

158. Defendants meet the qualifications for being a "health program or activity, any part of which is receiving Federal financial assistance" under section 1557 of the Affordable Care Act.

159. Plaintiffs are "individual[s] with a disability" under section 504 of the Rehabilitation Act.

160. Plaintiffs are qualified to participate in and receive the benefits of their respective health insurance plans.

161. Defendants have violated and continue to violate section 1557(a) of the Affordable Care Act by intentionally causing Plaintiffs to "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance" based on their disability, which is a prohibited ground of discrimination under section 504 of the Rehabilitation Act.

162. Plaintiffs have been aggrieved by this violation of section 1557 of the Affordable Care Act and have no adequate remedy at law for Defendants' violation of their rights. Defendants' unlawful discrimination will irreparably harm Plaintiffs because they will be unable to obtain necessary medical care.

163. Declaratory and injunctive relief are required to define Plaintiffs' rights under section 1557 and related statutes, to remedy the Defendants' violation of section 1557 of the

Affordable Care Act, and to secure ongoing compliance with the antidiscrimination provisions of the Affordable Care Act and incorporated federal law

SECOND CLAIM FOR RELIEF- AS TO THE PLAINTIFF CLASS
(Disparate impact discrimination in violation of section 1557(a) of the Patient Protection and Affordable Care Act)

164. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

165. Even if Defendants did not act with discriminatory intent, Defendants' refusal to accept premium payments from third parties other than those CMS considers to be potentially problematic has a disparate impact on individuals with a disability, namely their HIV or AIDS diagnosis, who as a result of Defendants' policy necessarily will be denied meaningful access to, excluded from participation in, and denied the benefits of any health program or activity, any part of which is receiving Federal financial assistance, in violation of Affordable Care Act section 1557(a).

166. Plaintiffs' request that Defendants maintain the status quo and continue to accept Ryan White Funds—as they have for years—requests only a "reasonable accommodation" under, not a substantial modification to or fundamental alteration of, Defendants' insurance programs, to ensure Plaintiffs meaningful access to Defendants' health insurance.

167. Plaintiffs have been aggrieved by this violation of section 1557 of the Affordable Care Act and have no adequate remedy at law for the Defendants' violation of their rights. Plaintiffs will be irreparably harmed by Defendants' unlawful discrimination by being unable to obtain necessary medical care.

168. Declaratory and injunctive relief are required to define Plaintiffs' rights under section 1557 and related statutes, to remedy the Defendants' violation of section 1557 of the

Affordable Care Act, and to secure ongoing compliance with the antidiscrimination provisions of the Affordable Care Act.

THIRD CLAIM FOR RELIEF- AS TO THE PLAINTIFF CLASS
(Employment of unlawful marketing practice to discourage enrollment in health insurance plans by individuals with significant health needs in violation of section 1311(c)(1)(A) of the Patient Protection and Affordable Care Act)

169. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

170. Defendants offer "qualified health plans" on federal insurance exchanges established under the Affordable Care Act.

171. Defendants' refusal to accept Ryan White Funds is a "marketing practice[] . . . that [has] the effect of discouraging the enrollment in [Defendants' insurance plans] by individuals with significant health needs," namely individuals with HIV or AIDS.

172. Plaintiffs have been aggrieved by this violation of section 1311 of the Affordable Care Act and have no adequate remedy at law for the Defendants' violation of their rights. Plaintiffs will be irreparably harmed by Defendants' unlawful discrimination by being unable to obtain necessary medical care.

173. Declaratory and injunctive relief are required to define Plaintiffs' rights under section 1311, to remedy the Defendants' violation of section 1311 of the Affordable Care Act, and to secure ongoing compliance with the antidiscrimination provisions of the Affordable Care Act.

FOURTH CLAIM FOR RELIEF - AS TO THE PLAINTIFF CLASS
(Violation of the Guaranteed Availability requirements of section 2702 of the Public Health Service Act)

174. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

175. Defendants offer health insurance coverage in the individual and group markets of Louisiana.

176. By engaging in discriminatory marketing practices prohibited by section 1311 of the Affordable Care Act, Defendants refused to accept each individual in Louisiana who applied for coverage and thus violated the guaranteed availability requirements of section 2702 of the Public Health Service Act (42 U.S.C. § 300gg-1), as amended by section 1201 of the Affordable Care Act.

177. Defendants' refusal to accept Ryan White Funds is a "marketing practice[] . . . that [has] the effect of discouraging the enrollment in [Defendants' insurance plans] by individuals with significant health needs," namely individuals with HIV or AIDS.

178. Plaintiffs have been aggrieved by this violation of section 2702 of the Public Health Service Act and have no adequate remedy at law for the Defendants' violation of their rights. Plaintiffs will be irreparably harmed by Defendants' unlawful discrimination by being unable to obtain necessary medical care.

179. Declaratory and injunctive relief are required to define Plaintiffs' rights under section 1311, to remedy the Defendants' violation of section 2702 of the Public Health Service Act, and to secure ongoing compliance with the antidiscrimination provisions of the Affordable Care Act.

FIFTH CLAIM FOR RELIEF- AS TO THE PLAINTIFF CLASS
(Equitable Estoppel)

180. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

181. Defendants have, by their words and conduct, long represented that they will receive and accept Ryan White Funds as payment for health insurance premiums and that those payments will be treated no differently than any other health insurance premium payments.

182. Insured Plaintiffs have justifiably relied on Defendants' policy and custom of accepting Ryan White Funds.

183. Insured Plaintiffs have maintained, renewed, or applied for health insurance policies offered by Defendants, and have forborn from making alternative arrangements based on their justifiable reliance induced by Defendants.

184. As a result of Defendants' abrupt change in position that Defendants now will not accept Ryan White Funds, Insured Plaintiffs have been aggrieved, and have been and will continue to be irreparably harmed by being unable to obtain necessary medical care and medications.

185. Injunctive relief is required to equitably estop Defendants from changing their longstanding policy of accepting Ryan White Funds.

SIXTH CLAIM FOR RELIEF- AS TO INSURED PLAINTIFFS
(Breach of Contract)

186. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

187. A valid insurance contract exists between BCBS and Plaintiff John East, and exists or has existed as well as between one of more Defendants and all other Insured Plaintiffs.

188. Defendants are under an obligation to provide health insurance coverage to Insured Plaintiffs in exchange for receiving health insurance policy premium payments.

189. Plaintiff John East and Insured Plaintiffs have performed all the obligations required of them under their policies, and remain ready, willing, and able to continue performing, including allowing the continued payment of their health insurance premiums.

190. Any term in Insured Plaintiffs' insurance policy with Defendants relating to the refusal of third party payments is waived and modified by Defendants' past conduct.

191. Unfairly discriminating against individuals with like insuring risk in the terms or conditions of any insurance contract violates the Louisiana Insurance Code, including without limitation, section 22:1964(7)(c) and section 22:34.

192. Any term in Insured Plaintiffs' insurance policy with Defendants relating to the refusal of third party payments is void as against Louisiana public policy and must be read out of any insurance policy, rider, or endorsement issued by Defendants, pursuant to the Louisiana Insurance Code section 22:861(4) and section 22:880.

193. Defendants breached their contractual obligations by refusing to accept premium payments on Insured Plaintiffs' accounts, whether received from the Ryan White HIV/AIDS Program (via the Louisiana Health Insurance Program or the HIV/AIDS Alliance) or otherwise.

194. Defendants' refusal to accept Insured Plaintiffs' premium payments constitutes a unilateral repudiation of Defendants' contractual obligations to cover Insured Plaintiffs during the policy term so long as premium payments are made.

195. As a result of Defendants' breach of their agreement to provide health insurance coverage, Insured Plaintiffs have been aggrieved, and have been and will continue to be irreparably harmed by being unable to obtain necessary medical care and medicine.

196. Monetary damages are not adequate to remedy Defendants' breach of their contractual obligations.

197. Declaratory and injunctive relief are required to define Plaintiffs' rights under their insurance policies and to require specific performance by Defendants of their vital contractual obligations.

SEVENTH CLAIM FOR RELIEF- AS TO INSURED PLAINTIFFS
(Breach of the Duty of Good Faith and Fair Dealing)

198. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

199. Defendants owe a duty of good faith and fair dealing to Insured Plaintiffs, their insureds.

200. Defendants have breached their duties of good faith and fair dealing not to discriminate against individuals with like insuring risk in the terms or conditions of any insurance contract, pursuant to the Louisiana Insurance Code section 22:1964(7)(c) and section 22:34.

201. Defendants have breached their duties of good faith and fair dealing not to misrepresent to Insured Plaintiffs over a period of time that they would accept premium payments to induce Insured Plaintiffs to continue choosing Defendants' health insurance coverage when Defendants knew they later would not accept such payments, pursuant to the Louisiana Insurance Code section 22:1964(14)(a).

202. As a result of Defendants' breaches of their duties of good faith and fair dealing, Insured Plaintiffs have been aggrieved, and have been and will continue to be irreparably harmed by being unable to obtain necessary medical care and medicine.

203. Declaratory and injunctive relief are required to enjoin Defendants from their continued and ongoing breaches of their duties not to discriminate and not to mislead Insured Plaintiffs.

EIGHTH CLAIM FOR RELIEF - AS TO INSURED PLAINTIFFS
(Negligent Misrepresentation)

204. Plaintiff realleges and incorporates, as though fully set forth herein, each and every allegation contained above.

205. Defendants owe a duty of care to Insured Plaintiffs, their insured.

206. Defendants have a pecuniary interest in their relationship with Insured Plaintiffs insured by Defendants.

207. Defendants have long represented, for the guidance of Insured Plaintiffs, that Defendants will receive and accept Ryan White Funds as payment for health insurance premiums and that those payments will be treated no differently than any other health insurance premium payments.

208. Defendants carelessly maintained that guidance even after including in some of their insurance policies terms relating to the refusal of third party payments, continuing to induce Insured Plaintiffs' reliance in maintaining and applying for Defendants' health insurance plans.

209. Defendants carelessly maintained that guidance even immediately before Defendants announced their refusal to accept Ryan White Funds, continuing to induce Insured Plaintiffs' reliance in maintaining and applying for Defendants' health insurance plans.

210. Insured Plaintiffs justifiably relied on Defendants' policy and custom of accepting Ryan White Funds.

211. Insured Plaintiffs have maintained, renewed, or applied for health insurance policies offered by Defendants, and have forborn from making alternative arrangements based on their justifiable reliance induced by Defendants.

212. As a result of Defendants' longstanding practice of accepting Ryan White Funds followed by Defendants' abrupt change in position, Defendants breached their duty of care to

Insured Plaintiffs and Insured Plaintiffs have been aggrieved, and have been and will continue to be irreparably harmed by being unable to obtain necessary medical care and medicine.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request the Court to enter an Order

(a) Certifying the proposed class and subclasses of Plaintiffs;

(b) With respect to the class:

(i) Enjoining Defendants from changing their policy of accepting Ryan White HIV/AIDS Program funds from current or prospective applicants to, or policy holders of, Defendants' health insurance plans;

(ii) Enjoining Defendants from implementing or executing their new policy of refusing Ryan White HIV/AIDS Program funds from current or prospective applicants to, or policy holders of, Defendants' health insurance plans; and

(iii) Declaring that Defendants' actions described above constitute discrimination in violation of section 1557 of the Affordable Care Act;

(iv) Estopping Defendants from taking the position of refusing to accept Ryan White HIV/AIDS Program funds for Plaintiffs' health insurance premium payments; and

(c) With respect to the subclass of Insured Plaintiffs:

(i) Requiring specific performance by Defendants of their contractual obligations to accept Ryan White HIV/AIDS Program premium payments from Plaintiffs currently insured by Defendants, and to maintain coverage so long as such premium payments are received;

(ii) Declaring that Defendants' actions described above constitute unfair discrimination in violation of Louisiana Revised Statute section 22:1964(7) and is therefore void pursuant to Louisiana Revised Statute 22:861(4) and section 22:880;

(iii) Declaring that Defendants' actions described above constitute a breach of Defendants' contractual obligations to Plaintiffs currently insured by Defendants;

(iv) Declaring that Defendants' actions described above constitute a breach of Defendants' duty of good faith and fair dealing to Plaintiffs currently insured by Defendants;

(d) Awarding reasonable attorneys' fees and costs; and

(e) Awarding other equitable and further relief as the Court deems just and proper.

JURY DEMAND

Plaintiffs request a trial by jury on all issues so triable.

Respectfully submitted,

Dated: February 20, 2014

/s/ Harry Rosenberg

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Attorneys for Plaintiff John East and all others similarly situated

JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
John East, individually and on behalf of all other persons similarly situated

(b) County of Residence of First Listed Plaintiff Orleans Parish
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
See attached.

DEFENDANTS
Blue Cross and Blue Shield of Louisiana, Louisiana Health Cooperative, Inc., and Vantage Health Plan, Inc.

County of Residence of First Listed Defendant East Baton Rouge Parish
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ❒ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ❒ 2 U.S. Government Defendant
- ❒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	❒ 1	❒ 1	Incorporated *or* Principal Place of Business In This State	❒ 4	❒ 4
Citizen of Another State	❒ 2	❒ 2	Incorporated *and* Principal Place of Business In Another State	❒ 5	❒ 5
Citizen or Subject of a Foreign Country	❒ 3	❒ 3	Foreign Nation	❒ 6	❒ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ❒ 110 Insurance
- ❒ 120 Marine
- ❒ 130 Miller Act
- ❒ 140 Negotiable Instrument
- ❒ 150 Recovery of Overpayment & Enforcement of Judgment
- ❒ 151 Medicare Act
- ❒ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ❒ 153 Recovery of Overpayment of Veteran's Benefits
- ❒ 160 Stockholders' Suits
- ❒ 190 Other Contract
- ❒ 195 Contract Product Liability
- ❒ 196 Franchise

REAL PROPERTY
- ❒ 210 Land Condemnation
- ❒ 220 Foreclosure
- ❒ 230 Rent Lease & Ejectment
- ❒ 240 Torts to Land
- ❒ 245 Tort Product Liability
- ❒ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ❒ 310 Airplane
- ❒ 315 Airplane Product Liability
- ❒ 320 Assault, Libel & Slander
- ❒ 330 Federal Employers' Liability
- ❒ 340 Marine
- ❒ 345 Marine Product Liability
- ❒ 350 Motor Vehicle
- ❒ 355 Motor Vehicle Product Liability
- ❒ 360 Other Personal Injury
- ❒ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ❒ 365 Personal Injury - Product Liability
- ❒ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ❒ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ❒ 370 Other Fraud
- ❒ 371 Truth in Lending
- ❒ 380 Other Personal Property Damage
- ❒ 385 Property Damage Product Liability

CIVIL RIGHTS
- ❒ 440 Other Civil Rights
- ❒ 441 Voting
- ❒ 442 Employment
- ❒ 443 Housing/ Accommodations
- ❒ 445 Amer. w/Disabilities - Employment
- ❒ 446 Amer. w/Disabilities - Other
- ❒ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ❒ 463 Alien Detainee
- ❒ 510 Motions to Vacate Sentence
- ❒ 530 General
- ❒ 535 Death Penalty

Other:
- ❒ 540 Mandamus & Other
- ❒ 550 Civil Rights
- ❒ 555 Prison Condition
- ❒ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ❒ 625 Drug Related Seizure of Property 21 USC 881
- ❒ 690 Other

LABOR
- ❒ 710 Fair Labor Standards Act
- ❒ 720 Labor/Management Relations
- ❒ 740 Railway Labor Act
- ❒ 751 Family and Medical Leave Act
- ❒ 790 Other Labor Litigation
- ❒ 791 Employee Retirement Income Security Act

IMMIGRATION
- ❒ 462 Naturalization Application
- ❒ 465 Other Immigration Actions

BANKRUPTCY
- ❒ 422 Appeal 28 USC 158
- ❒ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ❒ 820 Copyrights
- ❒ 830 Patent
- ❒ 840 Trademark

SOCIAL SECURITY
- ❒ 861 HIA (1395ff)
- ❒ 862 Black Lung (923)
- ❒ 863 DIWC/DIWW (405(g))
- ❒ 864 SSID Title XVI
- ❒ 865 RSI (405(g))

FEDERAL TAX SUITS
- ❒ 870 Taxes (U.S. Plaintiff or Defendant)
- ❒ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ❒ 375 False Claims Act
- ❒ 400 State Reapportionment
- ❒ 410 Antitrust
- ❒ 430 Banks and Banking
- ❒ 450 Commerce
- ❒ 460 Deportation
- ❒ 470 Racketeer Influenced and Corrupt Organizations
- ❒ 480 Consumer Credit
- ❒ 490 Cable/Sat TV
- ❒ 850 Securities/Commodities/ Exchange
- ☒ 890 Other Statutory Actions
- ❒ 891 Agricultural Acts
- ❒ 893 Environmental Matters
- ❒ 895 Freedom of Information Act
- ❒ 896 Arbitration
- ❒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ❒ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ❒ 2 Removed from State Court ❒ 3 Remanded from Appellate Court ❒ 4 Reinstated or Reopened ❒ 5 Transferred from Another District *(specify)* ❒ 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
42 U.S.C. 18116(a) and 18031

Brief description of cause:
Injunctive and declaratory relief to halt Defendants' abrupt and systematic policy of discrimination based on Plaintiffs' disability

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ❒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
02/20/2014

SIGNATURE OF ATTORNEY OF RECORD
/s/Harry Rosenberg

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

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INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If the nature of suit cannot be determined, be sure the cause of action, in Section VI below, is sufficient to enable the deputy clerk or the statistical clerk(s) in the Administrative Office to determine the nature of suit. If the cause fits more than one nature of suit, select the most definitive.

V. **Origin.** Place an "X" in one of the six boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407. When this box is checked, do not check (5) above.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

ATTACHMENT TO CIVIL COVER SHEET

Section I.
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UNITED STATES DISTRICT COURT

for the

Middle District of Louisiana

JOHN EAST, individually and on behalf of all persons similarly situated,

Plaintiff(s)

v.

BLUE CROSS and BLUE SHIELD of LOUISIANA, LOUISIANA HEALTH COOPERATIVE, INC., and VANTAGE HEALTH PLAN, INC.

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* BLUE CROSS AND BLUE SHIELD OF LOUISIANA
c/o Its Registered Agent For Service of Process
Michele S. Calandro
5525 Reitz Avenue
Baton Rouge, LA 70809

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Harry Rosenberg
Bryan Edward Bowdler
Phelps Dunbar LLP
365 Canal Street, Suite 2000
New Orleans, LA 70130

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

UNITED STATES DISTRICT COURT

for the

Middle District of Louisiana

JOHN EAST, individually and on behalf of all persons similarly situated,

Plaintiff(s)

v.

BLUE CROSS and BLUE SHIELD of LOUISIANA, LOUISIANA HEALTH COOPERATIVE, INC., and VANTAGE HEALTH PLAN, INC.

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* LOUISIANA HEALTH COOPERATIVE, INC.
c/o Its Registered Agent For Service of Process
Rudolph R. Ramelli, Esq.
Jones Walker Waechter Poitevent Carrere & Denegre
201 St. Charles Avenue, Suite 5100
New Orleans, LA 70170

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Harry Rosenberg
Bryan Edward Bowdler
Phelps Dunbar LLP
365 Canal Street, Suite 2000
New Orleans, LA 70130

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

UNITED STATES DISTRICT COURT

for the

Middle District of Louisiana

JOHN EAST, individually and on behalf of all persons similarly situated,

Plaintiff(s)

v.

BLUE CROSS and BLUE SHIELD of LOUISIANA, LOUISIANA HEALTH COOPERATIVE, INC., and VANTAGE HEALTH PLAN, INC.

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* VANTAGE HEALTH PLAN, INC.
c/o Its Registered Agent For Service of Process
Robert Bozeman
130 Desiard Street, Suite 300
Monroe, LA 71201

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Harry Rosenberg
Bryan Edward Bowdler
Phelps Dunbar LLP
365 Canal Street, Suite 2000
New Orleans, LA 70130

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

EXHIBIT 3

[Names and addresses of Requestors have been redacted]

Re: Advisory Opinion No. 97-1

Dear [Names have been redacted]:

We are writing in response to your request for an advisory opinion, which we accepted pursuant to 42 C.F.R. § 1008.41 on April 11, 1997. Your request asks whether donations by renal dialysis providers to an independent 501(c)(3) charitable organization for the purpose of funding a program to pay for Supplementary Medical Insurance Program ("Medicare Part B") or Medicare Supplementary Health Insurance ("Medigap") premiums for financially needy Medicare beneficiaries with end-stage renal disease where such beneficiaries may be receiving treatment from the donor-dialysis providers (the "Proposed Arrangement") would constitute grounds for the imposition of a civil monetary penalty under Section 231(h) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

You have certified that all of the information you provided in your request, including all supplementary letters, is true and correct, and constitutes a complete description of the facts and agreements among the parties regarding the Proposed Arrangement. You have also certified that upon our approval of the Proposed Arrangement, you will undertake to effectuate the Proposed Arrangement.

In issuing this opinion, we have relied solely on the facts and information you presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed, this opinion is without force and effect.

Based on the information provided and subject to certain conditions described below, we have determined that the Proposed Arrangement would not constitute grounds for the imposition of civil monetary penalties under Section 231(h) of HIPAA. This opinion may not be relied on by any person other than the addressees and is further qualified as set out in Part III below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

The American Kidney Fund and Company A, Company B, Company C, Company D, Company E, and Company F, (collectively the "Companies") have made the following representations with respect to the Proposed Arrangement. The American Kidney Fund and the Companies are collectively the "Requestors".

A. End-Stage Renal Disease and Medicare's Dialysis Benefit

End-stage renal disease ("ESRD") is a chronic disease that requires regular dialysis, as well as monitoring of laboratory values, diet, and medication. In addition to chronic renal failure, ESRD patients also commonly suffer from certain co-morbid conditions, including diabetes, anemia, hypertension, and congestive heart failure.

In 1972, Congress created a special Medicare ESRD benefit. This benefit is for all individuals with ESRD who have earned a certain level of eligibility for Social Security benefits (or are dependents of those who have attained that level). People in this category are entitled to benefits under Medicare Part A and are eligible to enroll in Medicare Part B. Medicare Part B payments on behalf of ESRD patients generally cover eighty percent of the composite rate for Medicare-covered maintenance dialysis services, as well as eighty percent of physician services and certain ancillary services.[1] Medigap insurance can be purchased to cover a patient's annual Medicare coinsurance obligations for Medicare-covered services.

B. Parties to the Proposed Arrangement

1. The Companies

[Material redacted] [The companies have formed an association] to address issues that affect the dialysis industry and to improve the way the renal dialysis industry performs as a whole. While the Companies [as an association] have worked with the American Kidney Fund to develop the proposed arrangement, the individual providers have applied for the advisory opinion in their separate capacities.

2. American Kidney Fund

The American Kidney Fund ("AKF") is a bona fide, 501(c)(3) charitable and educational organization that has been in existence for over twenty-five years. AKF, a public charity, is governed by a board of twenty-five members. The board bylaws provide that membership on the board should be comprised of representatives involved with ESRD issues, including nephrology physicians, nephrology nurses, nephrology social workers, patients or family members of ESRD patients, and community leaders. Vacancies on the board are filled by vote of the remaining board members. Although two members of the current board are employees of subsidiaries of one Company, the AKF board is not directly or indirectly

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[1] We note that Medicare reimbursement for some medical services provided to ESRD patients, such as certain lab services, are not covered under the composite rate.

controlled by any Company or Companies. AKF has established a subcommittee of the board's Program and Grant Committee to have primary oversight authority for the Health Insurance Premium Program; membership on such subcommittee will be restricted to exclude any employees, officers, shareholders, or owners of any dialysis provider.

In addition to its educational efforts on behalf of those suffering from renal failure, AKF provides direct financial support in the form of grants to needy persons with ESRD for items such as transportation, medication, and insurance premiums. In the past, AKF has funded 100 percent of all eligible grant requests from ESRD patients. In 1995, AKF assisted over 12,000 patients with ESRD and received over $5 million in donations. Of that amount, less than ten percent was contributed by the Companies. The largest percentage of AKF's funds was directed towards patient aid. AKF disseminates information about its patient assistance and other programs throughout the national dialysis provider community, especially to social workers who work with ESRD patients.

C. Health Insurance Premium Program

AKF's Health Insurance Premium Program ("HIPP") provides financial assistance to financially needy ESRD patients for the costs of medicine, transportation, and health insurance premiums, including Medicare Part B and Medigap premiums. Assistance is available to all eligible patients on an equal basis. In general, eligibility for participation in AKF's assistance programs requires a physician certification, a referral letter signed by a social worker or administrator at a dialysis provider, and an individual Patient Grant Application. The Patient Grant Application requires patients to provide detailed financial information for their entire household.[2] While a patient can apply directly to AKF for a grant, most applications are submitted on the patient's behalf by dialysis providers or social workers employed by a dialysis provider.

Upon receipt of a patient's application, a member of AKF's staff reviews the application, gathers additional information, if necessary, and makes an initial recommendation as to the disposition of the application based upon AKF's needs assessment and eligibility criteria. A senior staff employee reviews the recommendation and makes a final determination. All

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[2] The information required includes: assets held in checking and savings accounts; the value of a home, stocks and bonds, and automobiles; monthly income (which is made up of take-home pay of the patient and spouse, social security, welfare, retirement income, veterans benefits, etc.); and monthly expenses for rent, mortgage, food, utilities, transportation, medical expenses, insurance, charge accounts, and loans. AKF further requires that the patient disclose all sources of alternative assistance available, such as Medicare, Medicaid, and state renal programs.

determinations are made by AKF employees who have no financial interest in the Companies or other dialysis providers and are based on their good faith assessment that the applicant is in financial need and eligible for assistance. If AKF determines that a patient is eligible for assistance, AKF notifies the dialysis provider's social worker that the insurance premium has been paid in order to ensure that the patient's billing information is accurate.

Because of AKF's limited financial resources, an AKF patient assistance grant is provided for a specific time period. Upon expiration of the period, the patient must submit another grant application. Grant requests are reviewed on a first-come, first-served basis to the extent funding is available.

D. The Proposed Arrangement

AKF proposes to expand significantly its patient assistance grants to financially needy ESRD patients for payment of medical insurance premiums through HIPP. Additional funding will be donated primarily by the Companies. Medical social workers at each Company's dialysis facility will assist patients in identifying all available sources of assistance for which they qualify, which may include assistance from HIPP, and if appropriate, will refer financially needy patients to AKF for such assistance. However, the Companies will not advertise the availability of possible financial assistance to the public and will not disclose directly or indirectly to individual patients they refer that such members have contributed to AKF to fund the grants.

AKF will continue to use its current procedures in assessing the financial need and eligibility of all patients, whether self-referred or referred by the Companies, or other non-donor dialysis providers. Determinations will be made solely on AKF's good faith assessment of a patient's financial need. AKF staff involved in awarding patient grants will not take the identity of the referring facility or the amount of any provider's donation into consideration when assessing patient applications or making grant determinations.

Under the Proposed Arrangement, the Companies will be free to determine whether to make contributions to AKF and, if so, how much to contribute. All the Companies have certified that they will not track the amount that AKF pays on behalf of patients dialyzing at their facilities in order to calculate future contributions. However, in calculating their contributions to AKF, the Companies have indicated that they may consider what they would have otherwise paid on behalf of financially needy patients utilizing their facilities. The Companies will not disclose to each other, or other dialysis providers, the amount or method of calculating their respective contributions to AKF, and AKF will not disclose one Company's contribution to another Company or to other dialysis providers.

Contributions will be made without any restrictions or conditions placed on the donation. The Companies have acknowledged that "contributions . . . will be gifts without any guarantee or promise on the part of AKF that patients referred to AKF for possible financial assistance with their insurance premiums will receive such assistance. AKF's discretion as to the uses of contributions will be absolute, independent, and autonomous."

II. LEGAL ANALYSIS

Section 231(h) of HIPAA, effective January 1, 1997, provides for the imposition of civil monetary penalties against any person who:

> offers or transfers remuneration to any individual eligible for benefits under [Federal health care programs (including Medicare or Medicaid)] that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, [by a Federal health care program].

Section 231(h) defines "remuneration", in relevant part, as "transfers of items or services for free or for other than fair market value."[3]

We conclude that the Proposed Arrangement would not constitute grounds for the imposition of civil monetary penalties under Section 231(h) of HIPAA. A violation of Section 231(h) requires that something of value be given to a beneficiary, either directly or on his or her behalf. Simply put, the contributions to AKF by the Companies are not made to or on behalf of beneficiaries.[4] Moreover, while the premium payments by AKF may constitute remuneration to beneficiaries, they are not likely to influence patients to order or receive services from particular providers. To the contrary, the insurance coverage purchased by AKF will follow a patient regardless of which provider the patient selects, thereby enhancing patient freedom of choice in health care providers.

A. Donations By The Companies Do Not Constitute

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[3] The statutory definition of remuneration provides an exception, not applicable here, for certain waivers of coinsurance and deductible amounts.

[4] The Proposed Arrangement differs from an arrangement where a renal dialysis provider directly pays premiums for beneficiaries, thus potentially influencing them to continue to use that particular dialysis provider in order to ensure continuing payment of premiums.

Remuneration To An Eligible Beneficiary

The Companies' contributions to AKF would not constitute grounds for the imposition of civil monetary penalties under Section 231(h), because such contributions are not made to or on behalf of an individual eligible for Federal heath care program benefits. AKF is a bona fide, independent, publicly-funded, 501(c)(3) charitable organization whose charitable purposes include aiding ESRD patients and their families and is not subject to control, directly or indirectly, by any Company or Companies. Under the Proposed Arrangement, AKF will have absolute discretion regarding the use of provider contributions made to AKF.

Moreover, eligibility for HIPP assistance is available to any financially needy ESRD patient regardless of provider; it is not limited to patients of the companies. AKF will make all AKF eligibility determinations using its own criteria, and AKF staff will not take into account the identity of the referring provider or the amount of any donation to AKF by such provider.

Finally, as an additional safeguard, the Companies have represented that they will not track the amounts that AKF pays on behalf of patients dialyzing at their facilities in order to calculate amounts of future contributions, although donations may take into account the amounts that the Companies would have otherwise expended on financially needy patients. Contributions will not be earmarked for the use of particular beneficiaries or groups of beneficiaries. The Companies may change the amount of their contributions or discontinue contributing to AKF at any time. The Companies have represented that they will individually determine the amount of their contributions without consulting with the other Companies or other contributing dialysis providers.

In sum, the interposition of AKF, a bona fide, independent, charitable organization, and its administration of HIPP provides sufficient insulation so that the premium payments should not be attributed to the Companies. The Companies who contribute to AKF will not be assured that the amount of HIPP assistance their patients receive bears any relationship to the amount of their donations. Indeed, the Companies are not guaranteed that beneficiaries they refer to HIPP will receive any assistance at all. In these circumstances, we do not believe that the donations by the Companies to AKF can reasonably be construed as payments to eligible beneficiaries of a Federal health care program.

B. AKF's Purchase of Premiums Is Not Likely to Influence A Beneficiary's Choice of a Particular Provider

Section 231(h) prohibits payments to or on behalf of Federal health care program beneficiaries only if the payments are likely to influence such beneficiaries to use a

particular provider. In the circumstances presented by the Proposed Arrangement, we believe that AKF's payments of premiums on behalf of financially needy beneficiaries is not likely to influence a beneficiary's selection of a particular provider.

As part of the application process for HIPP, AKF requires certain medical and financial certifications from the applicant's physician and social worker. While patients may apply directly to AKF, more commonly, the dialysis provider makes the application on behalf of the patient. Thus, a patient will often have already selected a provider prior to submitting his or her application for assistance or the initial payment of premiums by AKF. As an additional safeguard, HIPP will not be advertised to the public by the Companies; this should reduce the probability that a beneficiary would select a Company based on its participation in HIPP. Most importantly, once in possession of Medicare Part B or Medigap coverage, a beneficiary will be able to select any provider of his or her choice. Simply put, AKF's payment of premiums will expand, rather than limit, beneficiaries' freedom of choice.

III. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to AKF, Company A, Company B, Company C, Company D, Company E, and Company F, which are the Requestors of this opinion. This advisory opinion has no application, and cannot be relied upon, by any other individual or entity.

- This advisory opinion does not address any other current or past arrangement for the payment of Part B or Medigap premiums by any dialysis provider or any other charitable or non-profit organization. The U.S. Department of Health and Human Services does not accept or acquiesce in any characterizations of the propriety of such arrangements in the materials submitted by the Requestors.

- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a Requestor to this opinion.

- This advisory opinion is applicable only to the statutory provision specifically noted above. No opinion is herein expressed or implied with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed Arrangement, including any laws relating to insurance or insurance contracts.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

- This advisory opinion is prospective only. It has no application to conduct which precedes the date of this opinion.

- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the Requestors with respect to any action taken in good faith reliance upon this advisory opinion as long as all of the material facts have been fully, completely, and accurately presented, and the arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, modify or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the requestors with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion.

Sincerely,

/S/

D. McCarty Thornton
Chief Counsel to the Inspector General

EXHIBIT 4

blue of california

August 29, 2016

Subject: **Notification of November 7, 2016 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

We have revised our *Hospital and Facility Guidelines*. The changes listed on the following pages are effective November 7, 2016.

On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under the *Guidelines & Resources* tab.

The *Hospital and Facility Guidelines* is referenced in the agreement between Blue Shield of California (Blue Shield) and the hospitals and other facilities contracted with Blue Shield. If a conflict arises between the *Hospital and Facility Guidelines* and the agreement held by the hospital or other facility and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the November 7, 2016 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Network Management
Blue Shield of California

UPDATES TO THE
HOSPITAL AND FACILITY GUIDELINES

Section 1: Introduction

ENROLLMENT AND ELIGIBILITY

Added *the following new section regarding member premium payments:*

Premium Payment Policy

The member is responsible for payment of premiums to Blue Shield. Blue Shield does not accept direct or indirect payments of premiums from any person or entity other than the member, his or her family members or a legal guardian, or an acceptable third party payor, which are:

- Ryan White HIV/AIDS programs under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations or urban Indian organizations;
- A lawful local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf; and
- Bona fide charitable organizations and organizations related to the member (*e.g.*, church or employer) when all of the following criteria are met: payment of premiums is guaranteed for the entire plan year; assistance is provided based on defined financial status criteria and health status is not considered; the organization is unaffiliated with a healthcare provider; and the organization has no financial interest in the payment of a health plan claim. (Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a financial interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a financial interest in the payment of health insurance claims.)

Upon discovery that premiums were paid directly or indirectly by a person or entity other than the member or an acceptable third party payor, Blue Shield has the right to reject the payment and inform the member that the payment was not accepted and that the premiums remain due. Payment of member premiums by a Blue Shield contracted provider represents a material breach of the provider's agreement. Please note that processing any payment does not waive Blue Shield's right to reject that payment and future payments under this policy.

EXHIBIT 5

*Insurers block Obamacare coverage *** Move affects poor HIV/AIDS patients*

The Advocate (Baton Rouge, Louisiana)

February 13, 2014 Thursday, Main Edition

Section: B; Pg. 08

Length: 1035 words

Byline: TED GRIGGS

tgriggs@theadvocate.com

Body

Close to 2,000 poor Louisiana residents with HIV/AIDS won't be able to buy coverage under Obamacare because three of the four companies in the state offering coverage through the federal insurance exchange won't accept payments from a federal program that helps those patients pay their premiums.

The fourth company, Humana, accepts third-party payments from state and federal programs or grantees such as the Ryan White HIV/AIDS Program, spokesman Mitchell Lubitz said. However, Humana's offerings through the Obamacare marketplace are only available in Orleans Parish.

Scott Schoettes, HIV project director at Lambda Legal, said the insurance companies' actions completely defeat the purpose of the Affordable Care Act.

Schoettes said it's not surprising that other insurers respond when Blue Cross and Blue Shield of Louisiana, the state's largest insurer, skews the market by denying coverage to people the company knows have significant health needs. The other insurers will take whatever actions they can to avoid having those patients pushed onto their rolls, he said.

In the business, enrolling a disproportionately high percentage of high-cost individuals is known as "adverse selection."

Billy Justice, a spokesman for Vantage Health Plan in Monroe, said smaller health insurance companies have no choice but to follow Blue Cross's lead.

Eric Evans, advocacy coordinator at Shreveport's Philadelphia Center, said the Louisiana Health Cooperative has already informed some center clients the co-op will not accept third-party payments.

Officials with the cooperative could not be reached for comment.

Blue Cross spokesman John Maginnis said beginning March 1, the company will not accept third-party payments for individual members' premiums.

Blue Cross covers 1.4 million people in Louisiana, the vast majority through group policies. Only 139,000 are covered by individual policies.

Third-party payment recipients are a very small percentage of the company's individual policies, which are a very small percentage of the company's total business, Maginnis said.

"We realize that some organizations have directly paid premiums for members in the past .... Those organizations can still provide the members with financial support toward their premiums, but they must let the members make the premium payments directly for their health insurance policies," Maginnis said.

For example, the groups that now make the third-party payments could make grants to their clients, who could then use that money to pay health care premiums, he said.

The federal Health Resources and Services Administration, which oversees the Ryan White program, does not allow states, cities and nonprofits who receive funding to make payments to individuals.

"In no case may Ryan White HIV/AIDS Program funds be used to make direct payments of cash to recipients of services," the agency website says.

Maginnis said Blue Cross, which is the only insurer fully participating in the federal marketplace with plans at every level in every parish, developed the policy to prevent patient steering and other fraudulent activity.

Some providers and medical equipment suppliers will steer people to specific health plans and offer to pay the premiums so they can make more money by billing the insurance company for those patients' covered services, Maginnis said. This kind of activity can increase health care costs for everyone.

The insurer's policy affects more people than those receiving Ryan White funding, he said. Some Louisiana universities pay for student athletes' premiums.

LSU spokesman Michael Bonnete said Blue Cross's policy change does not affect LSU athletics.

According to the state Department of Health and Hospitals, as of Jan. 7, Louisiana used Ryan White funds to pay the insurance premiums for 1,355 people. An additional 493 were enrolled in the federally run Pre-Existing Condition Insurance Plan, which will stop offering coverage on March 31.

In addition, 329 individuals attempted to enroll in Blue Cross's Blue Plan with the intention of covering the premiums with Ryan White funds, according to DHH.

Schoettes said it's increasingly clear that Blue Cross is trying to avoid covering these high-cost patients.

The company made noises about preventing fraud or abuse, but CMS's most recent instructions make it clear third-party payments coming from the federal government are acceptable, he said.

Evans said the issue is much larger than rejecting third-party payments.

"This is them saying, 'We really don't want to insure people with HIV because there's no profit in it,'" Evans said.

The prescriptions for an HIV patient can cost $5,000 or $10,000 a month, Evans said. Those costs far outweigh the premiums patients pay, but insurance companies have known about this for decades.

America's Health Insurance Plans recently issued a brief noting: "The ACA's risk adjustment program is designed to spread risk among health plans to prevent problems associated with adverse selection. Under this program, health plans that enroll disproportionately higher risk populations (such as individuals with chronic conditions) will receive payments from plans that enroll lower risk populations."

People forget that the first two words in the Affordable Care Act's full title are "Patient Protection," Evans said. The law was designed to stop insurance companies from discriminating against people with pre-existing conditions.

Schoettes said Lambda is considering amending its complaint to include the other insurers who reject third-party payments.

The nonprofit group may also file a lawsuit, among other steps, if the complaint doesn't achieve the desired result, he said. Lambda hasn't set a deadline to file the lawsuit.

"Sooner rather than later because every day that goes by is another day where low-income people living with HIV don't know where to turn and don't know where they're going to get their insurance," Schoettes said.

Evans said the scary thing is that the full impact of Blue Cross's decision won't be seen until after March 1, just weeks before the Affordable Care Act open enrollment deadline of March 31.

"Then what are these people going to do for the next year?" Evans said. "It's very frustrating and very angering."

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