IN THE UNITED STATES COURT OF FEDERAL CLAIMS

QCC INSURANCE COMPANY, KEYSTONE HEALTH PLAN EAST, INC., AMERIHEALTH INSURANCE COMPANY OF NEW JERSEY, & AMERIHEALTH HMO, INC., [1] **Plaintiffs,** **v.** **THE UNITED STATES OF AMERICA,** **Defendant.**	)	**No. 17-1312C** **Judge Mary Ellen Coster Williams**

FIRST AMENDED COMPLAINT

Plaintiffs QCC Insurance Company ("QCC"), Keystone Health Plan East, Inc. ("Keystone"), AmeriHealth Ins. Company of New Jersey ("AmeriHealth New Jersey"), and AmeriHealth HMO, Inc. ("AmeriHealth HMO") (collectively "Plaintiff Insurers" or "Plaintiffs") bring this action against the United States Government ("United States" or "Defendant") for money damages resulting from the U.S. Department of Health and Human Services' ("HHS" or "Secretary" or the "Government") failure to make full payments to Plaintiff Insurers in order to compensate them for certain losses resulting from their sale of qualified health plans for calendar years 2014, 2015, and 2016 as mandated by Section 1342 of the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"), the risk corridors program administered by HHS. Plaintiff Insurers state and allege as follows:

[1] As a result of corporate restructuring effective July 1, 2014, Independence Health Group, Inc., became the ultimate parent corporation of several entities including the entities bringing suit herein, namely, QCC Insurance Company, Keystone Health Plan East, Inc., AmeriHealth Insurance Company of New Jersey, and AmeriHealth HMO, Inc.

NATURE OF THE CASE

1. Section 1342 of the Affordable Care Act mandates a risk corridors program through which issuers of qualified health plans ("QHPs"), such as Plaintiff Insurers, and the Government must annually share in losses and profits exceeding certain thresholds from the sale of QHPs during the three benefit and calendar years 2014, 2015, and 2016 ("CY 2014," "CY 2015," and "CY 2016," respectively), the first three years of operation of the health insurance exchanges established by the ACA (the "Marketplaces"). Pub. L. No. 111-148 § 1342, 124 Stat. 119, as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010) [42 U.S.C. § 18062].

2. Section 1342 mandates that when "a participating plan's [*i.e.*, QHP issuer's] allowable costs for any plan year are more than 103 percent . . . of the target amount," defined as "total premiums . . . reduced by the administrative costs of the plan," the "Secretary *shall pay* to the plan an amount" specified by a statutory formula. 42 U.S.C. §§ 18062(b)(1)(A), (c)(2) (emphasis added). When, on the other hand, a QHP issuer's allowable costs are *less* than the target amount by a certain percentage, then "the plan [*i.e.*, the QHP issuer] shall pay to the Secretary an amount" set by statute. *Id.* at § 18062(b)(2)(A).

3. The Government has admitted its obligations to make payments to Plaintiff Insurers pursuant to the risk corridors program but has failed to pay the full amount due for CY 2014 and has failed to pay any amounts due to Plaintiffs for CY 2015 and CY 2016.

4. The ACA created a new health insurance market – the Marketplaces – to expand access to affordable healthcare coverage, including to individuals who previously were unable to obtain or to afford such coverage, such as individuals with pre-existing conditions. Health insurance issuers such as Plaintiff Insurers lacked reliable data and experience in assessing the risks and setting premiums for this new population of insureds created by the ACA, including

their health status and health care needs. The ACA therefore mandated implementation of three premium-stabilization programs – including the risk corridors program – to support the launch of the new Marketplaces. These programs were intended, *inter alia*, to encourage health insurance issuers to participate in the Marketplaces, to reduce the likelihood that the insurers would include in their premium development an additional amount to guard against the risk and uncertainty of insuring this new and unknown population, and to provide for some year-over-year stability in premiums for consumers, particularly during the initial years of the Marketplaces' operations.

5. The Centers for Medicare & Medicaid Services ("CMS"), which is part of HHS, is charged with implementing the risk corridors program. CMS has explained that the program requires "the Federal Government and [QHP issuers] to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016." 78 Fed. Reg. 15,410, 15,412 (March 11, 2013) (Exhibit 1[2]). It is designed to permit issuers such as Plaintiff Insurers "to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Id.* at 15,413.

6. Between the enactment of the ACA in 2010 and the launch of the Marketplaces on January 1, 2014, Plaintiff Insurers designed and priced QHPs to be sold on the Marketplaces. Plaintiff Insurers recognized the substantial uncertainty regarding the cost of providing health coverage to a previously uninsured population. Consistent with the plain terms of the ACA, its regulations, and the assurances provided by CMS and HHS, Plaintiff Insurers understood that the Government would annually share in their losses and profits from the sale of QHPs during CY 2014, CY 2015, and CY 2016.

[2] Exhibits 1 through 22 were attached the Plaintiff Insurers' Complaint, filed on September 22, 2017 and are available at ECF No. 1-2, 1-3, 1-4, 1-5.

7. For CY 2014, the first year of the Marketplaces and the risk corridors program, QHP issuers who made profits in excess of a certain threshold paid in the aggregate a total of $362 million into the risk corridors program. In the Individual Market in CY 2014, QCC paid $1,308,105.69 into the risk corridors program and AmeriHealth New Jersey paid $2,318,123.55 into the program. AmeriHealth HMO and Keystone suffered losses in the CY 2014 Individual Market, triggering the Government's obligation under the program to compensate them in the amount of $3,360,296.37 and $14,274,873.45 respectively. In the CY 2014 Small Group Market, Plaintiff Insurers suffered losses triggering the Government's obligation to compensate them in the amounts of $10,769,563.46 (QCC), $14,996,681.97 (Keystone), $138,744.96 (AmeriHealth HMO), and $1,157,648.85 (AmeriHealth New Jersey). In total, 2014 QHP issuers that experienced excess losses requested compensation of $2.87 billion under the risk corridors program.

8. For CY 2015, the second year of the Marketplaces and the risk corridors program, QHP issuers who made profits in excess of a certain threshold were again required to pay into the program. As with CY 2014, however, Plaintiff Insurers suffered losses in the CY 2015 Individual Market triggering the Government's obligation under the program to compensate them for the Government's share of those losses in the amount of $7,891,991.13 (QCC), $17,725,832.87 (Keystone), $5,486,703.07 (AmeriHealth HMO), and $12,445,206.11 (AmeriHealth New Jersey). In the CY 2015 Small Group Market, Plaintiff Insurers also suffered eligible losses in the amount of $11,108,682.39 (QCC), $22,879,073.98 (Keystone), $1,333,811.00 (AmeriHealth HMO), and $2,462,716.68 (AmeriHealth New Jersey).

9. For CY 2016, the third year of the Marketplaces and the risk corridors program, QHP issuers who made profits in excess of a certain threshold were again required to pay into the program. As with CY 2014 and CY 2015, however, Plaintiff Insurers suffered losses in the CY

2016 Individual Market triggering the Government's obligation under the program to pay them for the Government's share of those losses in the amount of $9,763,812.15 (QCC), $8,955,428.25 (Keystone), $3,974,893.09 (AmeriHealth HMO), and $73,160,117.68 (AmeriHealth New Jersey). In the CY 2016 Small Group Market, Plaintiff Insurers also suffered eligible losses in the amount of $105,954.94 (AmeriHealth HMO), and $344,230.91 (AmeriHealth New Jersey).

10. Before and after Plaintiff Insurers decided to offer QHPs in the individual market in 2014, CMS and HHS repeatedly acknowledged that "the Affordable Care Act requires the Secretary to make full payments to issuers." 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (Exhibit 2); *see also* 78 Fed. Reg. at 15,473 ("Regardless of the balance of payments and receipts, HHS will remit payment as required under section 1342 of the Affordable Care Act.") (Exhibit 1). Despite the unequivocal mandate in the ACA that the Government must annually share profits and losses with issuers, the Government has not paid Plaintiff Insurers in full for the Government's share of their CY 2014 losses, or at all for its share of Plaintiff Insurers' CY 2015 and CY 2016 losses.

11. Instead, for CY 2014, CMS prorated the $362 million of payments received from QHP issuers across the $2.87 billion in due compensation for the Government's share of losses under the risk corridors program. In late 2015, CMS announced that Plaintiff Insurers would be paid only about 12.6% of what they were owed under the program for CY 2014. *See* CMS, Risk Corridors Payments for the 2014 Benefit Year, Nov. 19, 2015 (Exhibit 3). CMS advised that it was "recording those amounts that remain unpaid" for CY 2014—$9,410,674.32 for QCC, $25,578,109.63 for Keystone, $1,011,578.26 for AmeriHealth New Jersey, and $3,057,536.97 for AmeriHealth HMO—"as fiscal year 2015 obligation[s] of the United States Government for which

full payment is required." *Id.*; CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, Nov. 19, 2015, at Tables 31 and 39 (Exhibit 6).

12. In September 2016, CMS and HHS stated that "all 2015 benefit collections [would] be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." *See* CMS, Risk Corridors Payments for 2015, Sept. 9, 2016 (Exhibit 4).

13. On November 18, 2016, CMS and HHS announced the issuer-level risk corridors payments and charges for CY 2015. *See* CMS, Risk Corridors Payments and Charge Amounts for the 2015 Benefit Year, Nov. 18 2016 (Exhibit 5). CMS announced that Plaintiff Insurers would be paid an additional amount still owed for CY 2014. CMS also announced that Plaintiff Insurers would not be paid in 2016 for any eligible losses in the CY 2015 markets: $19,000,673.52 for QCC, $40,604,906.85 for Keystone, $14,907,922.79 for AmeriHealth New Jersey, and $6,820,514.07 for AmeriHealth HMO. *Id.*

14. On November 15, 2017, CMS and HHS announced the issuer-level risk corridors payments and charges for CY 2016. *See* CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, Nov. 15, 2017 (Exhibit 23). As in CY 2015, HHS announced that it will use "2016 benefit year collections to make additional payments toward 2014 year payment balances." *Id.* CMS announced that Plaintiff Insurers would be paid an additional amount still owed for CY 2014. CMS also announced that Plaintiff Insurers would not be paid for any eligible losses in the CY 2016 markets: $9,763,812.15 for QCC, $8,955,428.25 for Keystone, $73,504,348.59 for AmeriHealth New Jersey, and $4,080,848 for AmeriHealth HMO. *Id.*

15. CMS unambiguously stated that it would not make full and timely risk corridors payments to owed issuers for CY 2015 in 2016. *See* CMS, Risk Corridors Payments and Charge

Amounts for the 2015 Benefit Year, Nov. 18 2016 (Exhibit 5). ("Today, we are confirming that all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments."). CMS also unambiguously stated that it would not make full and timely risk corridors payments to owed issuers for CY 2015 or CY 2016 in 2017. *See* CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, Nov. 15, 2017 (Exhibit 23) ("Because 2015 benefit year collections were insufficient to pay 2014 benefit year payment balances in full, HHS will use 2016 benefit year risk corridors collections to make additional payments toward 2014 benefit year payment balances."). This deferral of payment violates the ACA. The risk corridors program requires payment on an annual basis. The risk corridors program was designed for issuers to share with the Government the financial risk of offering QHPs in the new Marketplaces for CY 2014, CY 2015, and CY 2016 and thus to encourage issuers to offer QHPs at lower premiums in the first three years of the Marketplaces. The effectiveness of the risk corridors program necessitates that the Government and participating health insurance issuers share financial risk *on an annual basis* in order to encourage issuers against building into premiums for QHPs sold in each of CY 2014, CY 2015, and CY 2016 an additional financial cushion due to the unknown cost of providing health insurance to the newly-covered population.

16. Pursuant to the Tucker Act, 28 U.S.C. § 1491, Plaintiff Insurers bring this action for money damages resulting from the Government's failure to pay their share of their losses from the sale of QHPs in CY 2014, CY 2015, and CY 2016 as required by a money-mandating statute, § 1342 of the ACA, its implied-in-fact contracts with Plaintiff Insurers, and its express contracts with Plaintiff Insurers.

PARTIES

17. Plaintiff QCC Insurance Company ("QCC") is a corporation organized under the laws of Pennsylvania with its principal place of business at 1901 Market Street, Philadelphia, Pennsylvania 19103. QCC has offered and continues to offer QHPs on the Pennsylvania Marketplace since its launch in 2014.

18. Plaintiff Keystone Health Plan East, Inc. ("Keystone"), is a corporation organized under the laws of Pennsylvania with its principal place of business at 1901 Market Street, Philadelphia, Pennsylvania 19103. Keystone has offered and continues to offer QHPs on the Pennsylvania Marketplace since its launch in 2014.

19. Plaintiff AmeriHealth Insurance Company of New Jersey ("AmeriHealth New Jersey") is a corporation organized under the laws of New Jersey with its principal place of business at 259 Prospect Plains Road, Building M, Cranbury, New Jersey 08512. AmeriHealth New Jersey has offered and continues to offer QHPs on the New Jersey Marketplace since its launch in 2014.

20. Plaintiff AmeriHealth HMO, Inc. ("AmeriHealth HMO"), is a corporation organized under the laws of Pennsylvania with its principal place of business at 259 Prospect Plains Road, Building M, Cranbury, New Jersey 08512. AmeriHealth HMO has offered and continues to offer QHPs on the New Jersey Marketplace since its launch in 2014.

21. Defendant is the United States of America. HHS and CMS are agencies of Defendant.

JURISDICTION

22. Jurisdiction and venue in this Court are proper pursuant to the Tucker Act, 28 U.S.C. § 1491(a), which allows the United States Court of Federal Claims to hear claims for

monetary damages against the United States "founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the Government, or for liquidated or unliquidated damages in cases not sounding in tort."

23. Jurisdiction is founded on Section 1342 of the ACA, which specifies that the "Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," 42 U.S.C. § 18062(a); the implied-in-fact contracts with the Government for payment of certain losses under the risk corridors program; and the express contracts with the Government to include the full amount of the risk corridors payments due in its monthly payments and collections reconciliation process.

24. This controversy is ripe because CMS and HHS have recognized that additional amounts are presently due to Plaintiff Insurers for CY 2014, CY 2015, and CY 2016 but the Government has not paid those amounts in the manner required by Section 1342 of the ACA.

STATUTORY AND REGULATORY FRAMEWORK

25. The ACA substantially altered the rules governing the provision of health insurance coverage, including the pricing and benefits of health insurance coverage. Among other things, the ACA provides that "each health insurance issuer that offers health insurance coverage in the individual . . . market in a State must accept every . . . individual in the State that applies for such coverage." 42 U.S.C. §§ 300gg-1(a). The ACA also bars issuers from charging higher premiums on the basis of a person's gender or health status, including pre-existing conditions. *See* 42 U.S.C. §§ 300gg-1. To prevent adverse selection that occurs when consumers wait to obtain coverage until they have an injury or illness, the ACA imposes a financial penalty on individuals who do not obtain health care coverage.

26. The ACA established the Marketplaces through which consumers purchasing coverage in the individual or small group markets could compare different QHPs. The Marketplaces provide a number of mechanisms, also established by the ACA, to make QHPs more affordable; these mechanisms include the availability of premium tax credits and cost-sharing subsidies for eligible consumers purchasing certain QHPs.

27. As a result of the ACA's changes, insurers expected that a substantial number of people who had not previously had health insurance would purchase QHPs. Like all QHP issuers, Plaintiff Insurers faced substantial uncertainty as to who would enroll, the health status of new enrollees, and the cost of providing health care coverage for these newly-insured individuals. At the time, neither the insurance industry, including Plaintiff Insurers, nor the Government, had data or models to accurately predict the total cost to provide this new coverage.

28. To mitigate the financial risk insurers faced due to these uncertainties, ACA Section 1342 mandates a temporary risk corridors program through which all QHP issuers and the Government share in losses and profits exceeding certain thresholds for QHPs offered during the first three years of the Marketplaces' operations. By enacting Section 1342 of the ACA, Congress recognized that, due to uncertainty about the population entering the Marketplaces during the first few years, QHP issuers may not be able to predict their risk accurately, and their premiums may reflect assumptions regarding costs that are ultimately lower or higher than anticipated.

29. Congress intended the ACA's three-year risk corridors program to be an important protection for consumers and health insurance issuers as millions of Americans obtained newly available, affordable coverage in newly established Marketplaces. The risk corridors program was one of three premium stabilization programs intended to induce participation in the Marketplaces by reducing the potential financial loss posed to health insurers when estimating enrollments and

costs for the unknown population gaining access to affordable health care coverage. This risk mitigation program provided for sharing of the financial risk between the Government and issuers of QHPs in each of the first three years of the Marketplace.

30. The risk corridors program is designed to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013) (Exhibit 1). In addition, the program is designed to maintain affordability in the first three years of the health insurance exchanges by "permit[ting] issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Id.* at 15,413. It does so by permitting the "Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016." *Id*. at 15,412.

31. Section 1342(a) is the statutory mandate for the risk corridors program:

> (a) IN GENERAL.—The Secretary **shall** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market **shall** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program **shall** be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

42 U.S.C. § 18062(a) (emphasis added).

32. Section 1342(b)(1) specifies when and how the Government must reimburse QHP Issuers, such as Plaintiff Insurers, for a share of losses sustained during CYs 2014, 2015, and 2016:

> (b) PAYMENT METHODOLOGY. —
>
> (1) PAYMENTS OUT.—The Secretary **shall** provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary **shall** pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary **shall** pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

Id. § 18062(b)(1) (emphasis added). The "target amount" is premiums net the administrative costs of the QHP. *Id*. § 18062(c)(2).

33. Section 1342(b)(2) specifies when and how QHP issuers must pay a share of profits earned during CYs 2014, 2015, and 2016 to the Government:

> (2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

Id. § 18062(b)(2). Section 1342 of the Affordable Care Act has not been amended or repealed since its enactment in 2010.

34. Consistent with Section 1342(a) of the ACA, HHS and CMS established regulations to further clarify their implementation of the risk corridors program. *See* 45 C.F.R. §§ 153.500 *et seq*.

35. Section 153.510 of the Code of Federal Regulations specifies the circumstances when the Government must pay QHP issuers for losses pursuant to the risk corridors program:

> (b) HHS payments to health insurance issuers. **QHP issuers will receive payment** from HHS in the following amounts, **under the following circumstances**:
>
> (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, **HHS will pay**

> **the QHP issuer** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
>
> (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, **HHS will pay to the QHP issuer** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

45 C.F.R. § 153.510 (emphasis added).

36. QHP issuers are obligated to bear the risk of potential gains and losses for offering QHPs on the Marketplaces *up to a specific threshold* set forth in Section 1342. Issuers of QHPs that pay more in benefits than they collect in premiums by a pre-determined percentage, though, are entitled under the risk corridors program to receive a payment from the Government, and issuers of QHPs that pay less in benefits than they collect in premiums by a pre-determined percentage must make a payment to the Government under the program. Thus, the risk corridors program allows issuers of QHPs and the Government to annually share in the risk of inaccurate calculation of premiums for QHPs during the first three years of the Marketplaces.

37. If a QHP issuer such as Plaintiff Insurers owes the Government money under the program, the issuer must make that payment within 30 days after being notified of the amount owed. 45 C.F.R. § 153.510(d). The ACA equally calls for CMS and HHS to remit payment annually to QHP issuers on behalf of the Government.

38. HHS and CMS acknowledged in the Federal Register on July 15, 2011 and again on March 23, 2012, that "QHP issuers who are owed these amounts will want prompt payment" and that risk corridors "payment deadlines should be the same for HHS and QHP issuers." 76 Fed. Reg. 41930, 41943 (July 15, 2011) (Exhibit 7); 77 Fed. Reg. 17220, 17238 (Mar. 23, 2012) (Exhibit 8). This prompt payment of amounts due for a prior benefit year is necessary to effectuate the purpose of the risk corridors program, to share between the Government and QHP issuers the

financial risk associated with offering QHPs during the initial years of the Marketplaces and to encourage QHP issuers to refrain from increasing premiums in CYs 2014, 2015, and 2016 to account for the cost uncertainty in connection with the same.

39. In Section 1342(a), Congress instructed that the ACA risk corridors program "shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act." The referenced program is colloquially known as "Medicare Part D" – the program that provides Medicare coverage of outpatient prescription drugs. *See* Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 42 U.S.C. §§ 1395w-101 *et seq.* (2003). Under Medicare Part D, HHS makes annual risk corridors payments to Part D Plan Sponsors without regard for budget neutrality. *See* Government Accountability Office, Report GAO-15-447, at 14 (April 2015) ("For the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions.") (Exhibit 9). Although the statutory language for the ACA risk corridors program differs slightly from the Medicare Part D risk corridors program, the differences do not equate to an intentional departure from annual payments for the ACA risk corridors program. Rather, the express direction that the risk corridor program "shall be based on . . ." the Part D risk corridors program indicates Congress intended to incorporate into the ACA risk corridors program the key features of the Part D risk corridors program, including annual payments into and out of the program by the Government and participating issuers, and the absence of budget neutrality in such payments.

FACTUAL BACKGROUND

40. Since the enactment of the ACA, HHS and CMS have publicly acknowledged their statutory and regulatory obligation to make full and timely payments under the risk corridors program to Plaintiff Insurers and other QHP issuers.

41. These public statements by HHS and CMS were made by representatives of the Government who had actual authority to bind the it, including but not limited to Kevin Counihan, Director of the CMS Center for Consumer Information and Insurance Oversight ("CCIIO") and CEO of the Health Insurance Marketplaces, and his predecessors in that position; Andrew Slavitt, Administrator of CMS, and his predecessors in that position; and/or other CMS officials, all of whom had actual authority to bind the Government.

42. In March 2013, HHS issued the Notice of Benefit and Payment Parameters for 2014, the first year of the Marketplaces and the risk corridors program. HHS and CMS stated, "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under Section 1342 of the Affordable Care Act." *See* 78 Fed. Reg. at 15,473 (Exhibit 1).

43. Plaintiff Insurers decided to participate in the 2014 and 2015 individual market by selling QHPs both "on" and "off" the Pennsylvania and New Jersey Marketplaces. In designing and pricing its QHPs, Plaintiff Insurers relied on the Government's representation that it would share in the risk of providing universal QHP coverage on the Marketplace by making annual payments under the risk corridors program.

44. For CY 2014, Plaintiff Insurers had to elect to participate on the Marketplaces by September 2013, with open enrollment beginning on October 1, 2013. They designed and priced

their QHPs for CY 2014 in the spring and summer of 2013, and began selling these QHPs in October 2013. Coverage under the QHPs was effective on January 1, 2014.

45. On March 11, 2014, after Plaintiff Insurers had already designed, priced, and sold many of their CY 2014 QHPs, and could no longer withdraw from selling QHPs for CY 2014, HHS proposed that its implementation of the risk corridors program would be budget neutral—that is, payments out under the program would be funded only by payments in. HHS's proposed rulemaking stated:

> We intend to implement this program in a budget neutral manner, and may make future adjustments, either upward or downward to this program (for example, as discussed below, we may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal.

79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014) (Exhibit 10).

46. One month later, however, CMS abandoned its proposal to fund risk corridors payments solely by risk corridors receipts. Instead, CMS explained that "if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year . . . ." CMS, Risk Corridors Budget Neutrality, A1, Apr. 11, 2014 (Exhibit 11). HHS later explained that it "recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (Exhibit 2). HHS stated that if "risk corridors collections . . . are insufficient to make risk corridors payments" after 2016, then "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." *Id.*

47. For CY 2015, QHP issuers had to elect to participate by October 2014, with open enrollment beginning on November 15, 2014. Plaintiff Insurers designed and priced their CY 2015

QHPs in the spring and summer of 2014, and began selling CY 2015 QHPs in November 2014; the coverage was effective January 1, 2015.

48. In December 2014, Congress passed the Consolidated and Further Continuing Appropriations Act of 2015, which included an appropriations rider that prohibited CMS and HHS from using three specific sources of funds to make ACA risk corridors program payments:

> SEC. 227. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Pub. L. No. 113-235, at 362.

49. Congress's failure to appropriate sufficient funds for the risk corridors program payments due for CY 2014 and the restrictions enacted on the use of funds "made available by this Act" did not modify or repeal ACA Section 1342 and did not affect the Government's statutory obligation under Section 1342 to make a fully and timely risk corridor payment to Plaintiff Insurers. Moreover, the passage of the appropriations rider in December 2014 came more than a year *after* Plaintiff Insurers agreed to offer (and had priced, designed and sold) QHPs through the Pennsylvania and New Jersey Marketplaces and only two weeks before the *end* of Plaintiff Insurers' provision of health coverage under those plans for 2014. Thus, Plaintiff Insurers already had determined the premiums for QHPs sold in CY 2014 and already had incurred significant losses by paying for health care services covered under these QHPs prior to the passage of the appropriations rider.

50. Furthermore, at the time of the enactment of the appropriation in December 2014, QHP issuers that intended to offer QHPs on the Marketplaces in CY 2015 had already been required to commit to participate in the Marketplaces for CY 2015. *See* 45 C.F.R. § 155 Subpart

K; CCIIO, 2015 Letter to Issuers in Federally-facilitated Marketplaces, at 8, 27 (Mar. 14, 2014) (requiring issuers to commit by September 2014 to offer plans for the upcoming plan year) (Exhibit 12).

51. Once a QHP issuer has signed its QHP agreement with CMS, the issuer may not withdraw any of its QHPs from the Marketplaces and must accept all eligible applicants for coverage. *See* 45 C.F.R. § 156.290(a)(2); 45 C.F.R. § 147.104. Thus, by the time the December 2014 appropriations rider was enacted, Plaintiff Insurers already had incurred significant losses associated with offering QHPs in CY 2014, had already designed and priced the QHPs Plaintiff Insurers would offer in CY 2015, and already had committed to providing such QHPs for CY 2015. Plaintiff Insurers could not reverse their losses for CY 2014, nor could they withdraw their CY 2015 QHPs from the Marketplace, nor change the pricing for such QHPs, nor deny any eligible applicants such coverage.

52. On July 21, 2015, CMS issued a letter to state insurance commissioners for consideration as premium rates for CY 2016 were being finalized. The letter includes a paragraph entitled "CMS remains committed to the risk corridor program" and states a belief that the 2014 risk corridors payments should be taken into account before decisions are made on final rates for 2016. Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 21, 2015) (Exhibit 13).

53. In 2014, the Government's share of Plaintiff Insurers' claimed losses under the risk corridors program is $44,697,809.06, meaning it was due that amount from CMS under the risk corridors program for CY 2014, although Plaintiff Insurers incurred greater losses from offering QHPs in CY 2014. CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, Nov. 19, 2015, at Tables 31 and 39 (Exhibit 6).

54. On November 19, 2015, CMS announced that it would pay $5,639,909.88 for CY 2014 to Plaintiff Insurers during the winter of 2015-2016, which is only about 12.6 percent of payments due from the Government. *Id*. The Government calculated this percentage by prorating the $363 million paid into the program by QHP issuers across the $2.8 billion due to QHP issuers for 2014. *Id.*

55. Prior to this CMS announcement on November 19, 2015, CMS had required issuers like Plaintiff Insurers to design and price their CY 2016 QHPs, to decide whether to participate in the Marketplaces for CY 2016 and to begin selling CY 2016 QHPs. *See* CCIIO, FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 20, 2015) (setting the deadline for commitment to offer plans by September 25, 2015 and the commencement of open enrollment as November 1, 2015) (Exhibit 14). Plaintiff Insurers were thus locked into participation in the Marketplace for each of the CYs 2015, and 2016 prior to HHS or CMS issuing statements that the full risk corridors program payment due for 2014 would not be paid and that Plaintiff Insurers would receive only a small pro rata share of the payment due.

56. In December 2015, Congress passed the Consolidated Appropriations Act, 2016, which included an appropriations rider that again prohibited CMS and HHS from using three specific sources of funds to make ACA risk corridors program payments:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Pub. L. No. 114-113.

57. Again, this restriction on the use of funds "made available by this Act" did not modify or repeal Section 1342 of the Affordable Care Act or otherwise change the Government's statutory obligation to make payment to Plaintiff Insurers under Section 1342.

58. In September 2016, CMS announced that it would make additional risk corridors payments to QHP issuers during the winter of 2016-2017 for their CY 2014 losses. CMS, Risk Corridors Payments for 2015, Sept. 9, 2016 (Exhibit 4). CMS further announced that it would make no risk corridors payments for CY 2015 losses during the winter of 2016-2017. *Id*.

59. On November 18, 2016, CMS confirmed that none of its CY 2015 risk corridors collections would be used to pay CY 2015 risk corridors payments. CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, Nov. 18, 2016 (Exhibit 5).

60. On November 18, 2016, CMS announced that it would pay an additional $1,484,786.05 to Plaintiff Insurers for their CY 2014 losses, beginning in December 2016 (as collections are received). *Id*.

61. In May 2017, Congress passed the Consolidated Appropriations Act, 2017, which again included an appropriations rider that prohibited CMS and HHS from using three specific sources of funds to make ACA risk corridors program payments:

> SEC. 223. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid—Program Management" account, may be used for payments under Section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Pub. L. No. 115-31. This restriction on the use of funds "made available by this Act" did not modify or repeal Section 1342 of the Affordable Care Act or otherwise change the Government's statutory obligation to make payment to Plaintiff Insurers under Section 1342.

62. On November 15, 2017, CMS announced that none of its CY 2016 risk corridors collections would be used to pay CY 2015 or CY 2016 risk corridors payments. CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, Nov. 15, 2017 (Exhibit 23). Further, according to CMS, Plaintiffs Insurers will only be paid an additional $388,816.52 to Plaintiff Insurers for their CY 2014 losses, beginning in January 2018 (as collections are received). *Id.*

63. To date, Plaintiff Insurers received from CMS only $7,484,849.49 of the $44,697,809.06 owed to them for CY 2014. Plaintiff Insurers have received no payments from CMS for CY 2015 or CY 2016.

64. Plaintiff Insurers offered QHPs for each of the CYs 2014, 2015, and 2016 to which the risk corridors program applies, and they complied in all material respects with all of the statutory and regulatory requirements to be eligible for the Government's payment of its share of their losses under the risk corridors program, but they have not been paid. *See* 45 C.F.R. §§ 153.500 *et seq*.

65. Congress' failure to appropriate sufficient funds for risk corridors payments due for CYs 2014, 2015, and 2016 without modifying or repealing Section 1342 of the ACA, did not eliminate or abrogate the Government's obligation to make full and timely risk corridors payments to QHP issuers, including Plaintiff Insurers.

66. HHS recorded the 2014 amounts "that remain unpaid . . . as fiscal year 2015 obligation[s] of the United States Government for which full payment is required." CMS, Risk Corridors Payments for the 2014 Benefit Year, Nov. 19, 2015 (Exhibit 3). In September 2016, HHS announced that it was recording the 2014 and 2015 amounts that would remain unpaid as fiscal year 2016 obligations for which full payment is required. *See* CMS, Risk Corridors

Payments for 2015, Sept. 9, 2016 (Exhibit 4). In November 2017, HHS announced 2016 risk corridors charges collected would be used for 2014 benefit year payment balances. CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, Nov. 15, 2017 (Exhibit 23). Payment is thus presently due for the remainder of the Government's share of Plaintiff Insurers' eligible losses in CYs 2014, 2015, and 2016. No appropriation is available, however, for HHS to make the payment.

COUNT I

Violation of Statutory Mandate to Make Payments

67. Plaintiff Insurers incorporate by reference paragraphs 1 through 66 above as if fully set forth herein.

68. Pursuant to Section 1342 of the ACA, the United States "shall establish" a risk corridors program under which the "Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount" for calendar year 2014.

69. On April 27, 2020, the Supreme Court issued its decision in *Maine Community Health Options v. United States*, No. 18-1023, 590 U.S. --- (2020). The Supreme Court held that Section 1342 of the ACA created a Government obligation to pay insurers the full amount set out in Section 1342's formula, Congress did not repeal that obligation through appropriations riders, and insurers may seek to collect payment through a damages action in the Court of Federal Claims.

70. Plaintiff Insurers offered certified QHPs on the Pennsylvania and New Jersey Marketplaces in accordance with the processes prescribed by statute, and Plaintiff Insurers are QHP issuers for purposes of payment under the risk corridors program. *See* 45 C.F.R. §§ 153.500, 155.20.

71. In CY 2014, CY 2015, and CY 2016, Plaintiff Insurers' allowable costs exceeded their target amount by more than 108%. Plaintiffs timely submitted all of the necessary data and complied with all other requirements for obtaining a payment under the risk corridors program. *See* 45 C.F.R. § 153.530.

72. Accordingly, ACA Section 1342 mandates compensation by the Government to Plaintiff Insurers in the amount of $44,697,809.06 for CY 2014, $81,334,017.23 for CY 2015, and $96,304,437.02 in CY 2016.

73. To date, the Government has not fully compensated Plaintiff Insurers for their eligible CY 2014 losses. For CY 2014, QCC is still owed $8,966,151.55, Keystone is still owed $24,369,901.47, AmeriHealth HMO is still owed $2,913,111.14, and AmeriHealth New Jersey is still owed $963,795.41.

74. The Government also failed to fully compensate Plaintiff Insurers for their eligible CY 2015 losses. For CY 2015, the Government presently owes $19,000,673.52 to QCC, $40,604,906.85 to Keystone, $6,820,514.07 to AmeriHealth HMO, and $14,907,922.79 to AmeriHealth New Jersey.

75. The Government also failed to fully compensate Plaintiff Insurers for their eligible CY 2016 losses. For CY 2016, the Government presently owes $9,763,812.15 to QCC, $8,955,428.25 to Keystone, $4,080,848.03 to AmeriHealth HMO, and $73,504,348.59 to AmeriHealth New Jersey.

76. The Government's failure to provide full and timely compensation to Plaintiff Insurers in the amounts set forth in paragraph 72 above for CY 2014, in paragraph 73 above for CY 2015, and paragraph 74 above for CY 2016 is a violation of ACA Section 1342, and Plaintiff Insurers have been damaged thereby.

COUNT II

Breach of Implied-In-Fact Contract

77. Plaintiff Insurers incorporate by reference paragraphs 1 through 66 above as if fully set forth herein.

78. Plaintiff Insurers entered into valid implied-in-fact contracts with the Government regarding its obligation to make full and timely payments under the risk corridors program in exchange for Plaintiff Insurers becoming QHP issuers and offering QHPs in each of CYs 2014, 2015, and 2016.

79. The Government made an unambiguous offer to contract with Plaintiff Insurers, provided that they fulfilled certain criteria, which they could accept by performance.

80. Specifically, ACA Section 1342 authorized HHS to enter into contracts to share in the profits and losses of issuers who offered QHPs on the Marketplaces in CYs 2014, 2015, and 2016. HHS's Notices of Benefit and Payment Parameters represented an offer to Plaintiff Insurers that if they sold QHPs, "[r]egardless of the balance of payments and receipts, HHS will remit payment as required under section 1342 of the Affordable Care Act," 78 Fed. Reg. at 15,473, meaning the Government would reimburse them for a share of their losses if their allowable costs were "more than 108 percent of the target amount," 42 U.S.C. § 18062(b)(1)(B).

81. ACA Section 1342 is an objective manifestation of the Government's intent to contract with insurers like Plaintiffs.

82. By complying with their obligations under Section 1342 as well as 45 C.F.R. §§ 153.500, *et seq.*, and submitting all required data for risk corridors calculations by the deadline, Plaintiff Insurers accepted the Government's offer and thereby manifested their assent in the manner required by the ACA.

83. There were implied-in-fact contracts between Plaintiff Insurers and the Government.

84. The implied-in-fact contracts were authorized or ratified by and through the words and actions of Kevin Counihan, Director of CCIIO and CEO of the Health Insurance Marketplaces, and his predecessors in that position; Andrew Slavitt, Administrator of CMS, and his predecessors in that position; and/or other CMS officials, all of whom had actual authority to bind the Government, and were entered into with mutual assent and consideration by the parties.

85. Plaintiff Insurers satisfied and complied with their obligations and/or conditions that existed under the implied-in-fact contracts.

86. Pursuant to the implied-in-fact contracts for CY 2014, the Government presently owes $8,966,151.55 to QCC, $24,369,901.47 to Keystone, $2,913,111.14 to AmeriHealth HMO, and $963,795.41 to AmeriHealth New Jersey.

87. Pursuant to the implied-in-fact contracts for CY 2015, the Government presently owes $19,000,673.52 to QCC, $40,604,906.85 to Keystone, $6,820,514.07 to AmeriHealth HMO, and $14,907,922.79 to AmeriHealth New Jersey.

88. Pursuant to the implied-in-fact contracts for CY 2016, the Government presently owes $9,763,812.15 to QCC, $8,955,428.25 to Keystone, $4,080,848.03 to AmeriHealth HMO, and $73,504,348.59 to AmeriHealth New Jersey.

89. On behalf of the Government, CMS and HHS have acknowledged their obligation to render full risk corridors payments for CYs 2014, 2015, and 2016.

90. Plaintiff Insurers are entitled to damages equal to the benefit of their bargain with the Government: reimbursement as alleged in this lawsuit.

91. The Government breached its contract with Plaintiff Insurers by failing to timely pay the full amounts owed for CYs 2014, 2015, and 2016 in accordance with the terms of the risk corridors program.

92. Plaintiff Insurers have not been paid amounts owed by the Government for CYs 2014, 2015, and 2016, which has resulted in injury and damages to them as a result of the Government's breach of its contractual obligations.

COUNT III

Breach of Express Contract

93. Plaintiff Insurers incorporate by reference paragraphs 1 through 66 above as if fully set forth herein.

94. On September 10, 2013, Plaintiff QCC entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 15)

95. On September 19, 2013, Plaintiff Keystone entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 16)

96. On September 19, 2013, Plaintiff AmeriHealth New Jersey entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 17)

97. On September 19, 2013, Plaintiff AmeriHealth HMO entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 18)

98. On October 21, 2014, Plaintiff QCC entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 19)

99. On October 21, 2014, Plaintiff Keystone entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 20)

100. On October 27, 2014, Plaintiff AmeriHealth New Jersey entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 21)

101. On October 27, 2014, Plaintiff AmeriHealth HMO entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 22)

102. On September 23, 2015, Plaintiff QCC entered into a valid written QHP Issuer Agreement with CMS for 2016. (Exhibit 24)

103. On September 23, 2015, Plaintiff Keystone entered into a valid written QHP Issuer Agreement with CMS for 2016. (Exhibit 25)

104. On September 25, 2015, Plaintiff AmeriHealth New Jersey entered into a valid written QHP Issuer Agreement with CMS for 2016. (Exhibit 26)

105. On September 25, 2015, Plaintiff AmeriHealth HMO entered into a valid written QHP Issuer Agreement with CMS for 2016. (Exhibit 27)

106. The 2014, 2015, and 2016 QHP Issuer Agreements were executed by a representative of the Government who had actual authority to bind the Government, and were entered into with mutual assent and consideration of the parties.

107. The 2014, 2015, and 2016 QHP Issuer Agreements require that "[a]s part of a monthly payments and collections reconciliation process," CMS must "net payments due to QHPI against amounts owed to CMS by QHPI . . . with respect to offering of QHPs." 2014 Agreement ¶ II.c; 2015 Agreement ¶ III.b; 2016 Agreement ¶ III.b.

108. The "HHS Notice of Benefit and Payment Parameters for 2014" established the payment parameters for payments due with respect to the offering of QHPs in 2014, including with respect to the risk corridors program and other premium stabilization programs. 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013) ("In that rule, we stated that the specific payment parameters for

those [premium stabilization] programs would be published in this final rule. In this final rule, we describe these standards, and include payment parameters for these programs.").

109. The payment parameters for risk corridors payments included that full risk corridors payments were owed by HHS, regardless of receipts. 78 Fed. Reg. at 15,473 ("Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.").

110. The QHP Issuer Agreements require CMS to include risk corridors payments due to Plaintiff Insurers in the "monthly payments and collections reconciliation process" because those payments are due "with respect to offering of QHPs." 2014 Agreement ¶ II.c; 2015 Agreement ¶ III.b; 2016 Agreement ¶ III.b; *see also* 45 C.F.R. § 156.1215(b).

111. Plaintiff Insurers satisfied and complied with their obligations and/or conditions under the 2014, 2015, and 2016 QHP Issuer Agreements.

112. CMS has not, in fact, included the full amount of the risk corridors payments due to Plaintiff Insurers in their monthly payments and collections reconciliation process.

113. The Government's failure to include the full amount of the risk corridors payments due in its monthly payments and collections reconciliation process is a material breach of CMS's obligations under the QHP Issuer Agreements.

114. As a result of the Government's material breach of the QHP Issuer Agreements, Plaintiff Insurers have been damaged in the amount of $37,730,637.22 for QCC, $73,930,236.57 for Keystone, $13,814,473.24 for AmeriHealth HMO, and $89,376,066.79 for AmeriHealth New Jersey.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff Insurers pray for judgment as follows:

A. Award Plaintiff Insurers monetary damages in the amount of $37,730,637.22 for QCC, $73,930,236.57 for Keystone, $13,814,473.24 for AmeriHealth HMO, and $89,376,066.79 for AmeriHealth New Jersey, for a total for $214,851,413.82 for the four entities, for the Government's failure to make the payments required by Section 1342, for CY 2014, CY 2015, and CY 2016 and any such other amounts due through the date of judgment;

B. Award post-judgment interest at the maximum rate permitted by law;

C. Award Plaintiff Insurers consequential damages, special damages, or other damages that result as a consequence of the Government's non-performance;

D. Award Plaintiff Insurers costs and attorney's fees as are available under applicable law; and

E. Award such other relief with respect to all risk corridor payments due Plaintiff Insurers under the risk corridors program for CY 2014 through CY 2016 as justice may require.

Dated: May 21, 2020

Respectfully Submitted:

/s/ Robert K. Huffman

Robert K. Huffman
rhuffman@akingump.com
AKIN GUMP STRAUSS HAUER & FELD LLP
2001 K St, NW
Washington, D.C. 20006
Tel: (202) 887-4000
Fax: (202) 887-4288

Of Counsel:
Thomas P. McLish
tmclish@akingump.com
Elise A. Farrell
efarrell@akingump.com
AKIN GUMP STRAUSS HAUER & FELD LLP
2001 K St, NW
Washington, D.C. 20006
Email: rhuffman@akingump.com
Tel: (202) 887-4000
Fax: (202) 887-4288

Counsel for Plaintiff Insurers

EXHIBIT 23

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 15, 2017

Subject: Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of Exchange operations.

HHS established a three-year payment framework for the risk corridors program and outlined the details of this payment framework in our April 11, 2014 guidance entitled *Risk Corridors and Budget Neutrality*.[1] As set forth in that guidance, if risk corridors collections for a particular benefit year are insufficient to make full risk corridors payments as calculated for that benefit year, risk corridors payments are reduced pro rata to the extent of any shortfall. HHS then uses risk corridors collections for the subsequent benefit year toward risk corridors payment balances for the previous benefit years, until issuers have been reimbursed in full for the previous benefit year, before making payments for the current benefit year. Consistent with this framework, HHS announced on November 18, 2016 that all 2015 benefit year risk corridors collections would be applied toward 2014 benefit year risk corridors payment balances.[2]

Today, HHS is announcing issuer-level risk corridors payments and charges for the 2016 benefit year. Because 2015 benefit year collections were insufficient to pay 2014 benefit year payment balances in full, HHS will use 2016 benefit year risk corridors collections to make additional payments toward 2014 benefit year payment balances. The table below shows risk corridors payments and charges calculated for the 2016 benefit year, by State and issuer, and the amount of anticipated 2016 risk corridors collections that HHS expects to pay for issuers that have 2014 benefit year payment balances.[3]

HHS intends to collect the full 2016 risk corridors charge amounts indicated in the tables below, however, the 2014 payment amounts listed in the tables below will be reduced pro rata based on

[1] *Risk Corridors and Budget Neutrality*, available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

[2] *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year*, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf

[3] Risk corridor payment and charge amounts published in this bulletin reflect risk corridors data submitted to HHS by September 30, 2017 and do not account for amounts that may be held back for administrative appeals.

collections received. HHS is collecting 2016 risk corridor charges in November 2017 and will begin remitting risk corridors payments to issuers in January 2018, as collections are received.

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
AK	38344	Premera Blue Cross Blue Shield of Alaska	$0.00	$0.00	$71,752.90
AK	73836	Moda Health Plan, Inc.	$2,331,107.54	$2,535,475.85	$14,666.28
AL	44580	Humana Insurance Company	$5,347,297.70	$0.00	$8,238.76
AL	46944	Blue Cross and Blue Shield of Alabama	$31,253,329.90	$0.00	$3,086.00
AL	59809	UnitedHealthcare Life Insurance Company	N/A	N/A	$0.00
AL	68259	UnitedHealthcare of Alabama, Inc.	$4,226,662.97	$0.00	N/A
AR	37903	QualChoice Life & Health Insurance Company, Inc.	$6,742,797.09	$0.00	N/A
AR	62141	Celtic Insurance Company	-$435,672.31	$0.00	$0.00
AR	65817	UnitedHealthcare of Arkansas, Inc.	-$171,378.54	$0.00	N/A
AR	70525	QCA Health Plan, Inc.	$5,894,850.51	$0.00	$36,371.03
AR	75293	USAble Mutual Insurance Company	$19,022,135.87	-$1,727.51	$0.00
AZ	23307	Humana Health Plan, Inc.	$3,030,258.28	$0.00	$16,107.78
AZ	51485	Health Net Life Insurance Company	$6,406,342.85	$0.00	$390,038.18
AZ	53901	Blue Cross Blue Shield of Arizona, Inc.	$10,845,468.60	$0.00	$101,672.21
AZ	60761	Meritus Health Partners	N/A	N/A	$30,355.96
AZ	65441	Phoenix Health Plans, Inc.	$14,356,552.64	$0.00	N/A
AZ	70239	Health Choice Insurance Co.	$12,591,097.47	$0.00	$10,944.97
AZ	78611	Aetna Health Inc. (a PA corp.)	$2,200,505.68	$0.00	N/A
AZ	84251	Aetna Life Insurance Company	N/A	N/A	$522.54

[4] N/A indicates that the issuer was not required to submit risk corridors data for the benefit year referenced.
[5] $0.00 indicates that the issuer submitted risk corridors data for the 2014 benefit year but does not have a 2014 benefit year risk corridors payment balance.

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
AZ	86830	Cigna Health and Life Insurance Company	N/A	N/A	$1,507.99
AZ	88925	University of Arizona Health Plans-University Healthcare, Inc.	N/A	N/A	$5,611.56
AZ	91450	Health Net of Arizona, Inc.	$10,827,593.54	$1,688,379.12	$398,961.79
AZ	92045	Meritus Mutual Health Partners	N/A	N/A	$16,297.96
AZ	97667	Cigna HealthCare of Arizona, Inc	$1,709,445.01	$0.00	N/A
AZ	98971	All Savers Insurance Company	$2,787,630.49	-$49,087.07	N/A
CA	10544	Oscar Health Plan of California	$4,167,289.22	$0.00	N/A
CA	18126	MOLINA HEALTHCARE OF CALIFORNIA	$0.00	$0.00	$0.00
CA	27603	Blue Cross of California(Anthem BC)	$55,180,958.69	$0.00	$0.00
CA	37873	UnitedHealthcare Benefits Plan of California	$510,269.44	$0.00	N/A
CA	40513	Kaiser Foundation Health Plan, Inc.	$22,533,814.62	$133,003,881.28	$321,273.85
CA	47579	Chinese Community Health Plan	$523,908.24	$763,358.71	$6,200.40
CA	67138	Health Net of California, Inc	$0.00	$0.00	$0.00
CA	70285	CA Physician's Service dba Blue Shield of CA	$0.00	$0.00	$0.00
CA	84014	County of Santa Clara	$233,230.49	$0.00	$0.00
CA	92499	Sharp Health Plan	$652,496.53	$630,358.81	$67.63
CA	92815	Local Initiative Health Authority for Los Angeles County	$3,948,187.97	$0.00	$117,969.86
CA	93689	Western Health Advantage	$995,351.80	$700,089.44	$50.58
CA	99110	Health Net Life Insurance Company	$8,099,981.20	$0.00	$44,005.99
CA	99483	CONTRA COSTA HEALTH PLAN	N/A	N/A	$0.00
CO	11555	New Health Ventures Inc	N/A	N/A	$926.60
CO	20472	Colorado Health Insurance Cooperative, Inc.	N/A	N/A	$124,396.13

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
CO	21032	Kaiser Foundation Health Plan of Colo.	$76,429,472.92	$0.00	$123,181.64
CO	49375	Cigna Health and Life Insurance Company	$3,811,568.48	$0.00	$0.00
CO	59036	UnitedHealthcare of Colorado, Inc.	$719,427.07	$0.00	N/A
CO	63312	Colorado Choice Health Plans	$900,328.41	$4,055,983.33	$52,260.66
CO	66699	Denver Health Medical Plan, Inc	-$688,815.34	$0.00	$2,501.26
CO	74320	Humana Health Plan	$0.00	$0.00	$27,693.60
CO	76680	HMO Colorado, Inc., dba HMO Nevada	$2,015,531.53	$45,449.80	$12,871.37
CO	80208	Rocky Mountain Health Care Options	$0.00	$4,463,039.51	$3,832.28
CO	87269	Rocky Mountain Hospital and Medical Service, Inc., dba Anthem Blue Cross and Blue Shield	$14,813,129.30	$0.00	N/A
CO	92137	All Savers Insurance Company	-$422,444.96	$0.00	$0.00
CO	97879	Rocky Mountain HMO	$11,392,994.52	$3,230,381.44	$17,816.32
CT	49650	UnitedHealthcare Insurance Company	$793,529.41	-$34,355.06	$98.29
CT	76962	ConnectiCare Benefits, Inc.	$10,110,217.78	$0.00	$0.00
CT	86545	Anthem Health Plans Inc (Anthem BCBS)	$6,673,451.37	$0.00	$0.00
CT	91069	HealthyCT, Inc.	$22,557,147.20	$3,025,676.93	$15,952.57
DC	21066	UnitedHealthcare of the Mid-Atlantic Inc	$0.00	$53,160.65	N/A
DC	41842	UnitedHealthcare Insurance Company	$0.00	$0.00	$0.00
DC	73987	Aetna Health Inc. (a PA corp.)	$0.00	$236,018.31	$0.00
DC	75753	Optimum Choice, Inc.	$0.00	-$153,126.12	$0.00
DC	77422	Aetna Life Insurance Company	$0.00	$1,348,005.01	$0.00
DC	78079	GHMSI	$54,354.10	$379,836.03	$0.00
DC	86052	CareFirst BlueChoice, Inc.	$18,583.46	$120,537.46	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
DC	94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$643,071.50	$1,364,900.88	$10,935.98
DE	13537	Coventry Health and Life	N/A	N/A	$0.00
DE	29497	Aetna Life Insurance Company	$474,963.04	$0.00	N/A
DE	67190	Aetna Health Inc. (a PA corp.)	$0.00	$126,849.04	N/A
DE	76168	Highmark BCBSD Inc.	$15,159,604.02	$0.00	$52,848.57
DE	81914	Coventry Health Care of Delaware, Inc.	N/A	N/A	$0.00
FL	16842	Blue Cross and Blue Shield of Florida	$0.00	$0.00	$125,572.05
FL	18628	Aetna Health Inc. (a FL corp.)	$0.00	$0.00	N/A
FL	21663	Celtic Insurance Company	$0.00	$0.00	N/A
FL	23841	Aetna Life Insurance Company	N/A	N/A	$0.00
FL	27357	Health First Health Plans, Inc.	$1,432,717.01	$0.00	$895.97
FL	30252	Health Options, Inc.	$0.00	$0.00	$99,007.22
FL	35783	Humana Medical Plan, Inc.	$32,890,544.08	$173,712.62	$358,660.25
FL	48121	Cigna Health and Life Insurance Company	N/A	N/A	$35,388.79
FL	51398	Preferred Medical Plan, Inc.	N/A	N/A	$302,522.11
FL	54172	Molina Healthcare of Florida, Inc	$26,068,734.68	$0.00	$339.56
FL	56503	Florida Health Care Plan, Inc.	$0.00	$0.00	$0.00
FL	57451	Coventry Health Care of Florida, Inc.	$0.00	$0.00	$266,187.17
FL	68398	UnitedHealthcare of Florida, Inc.	$9,330,450.46	$0.00	N/A
FL	77150	Health First Insurance, Inc.	$0.00	$205,230.49	$16,113.18
FL	83883	Florida Health Solution HMO Company	$0.00	$0.00	N/A
FL	86382	Sunshine State Health Plan	N/A	N/A	$0.00
GA	43802	UnitedHealthcare of Georgia, Inc.	$4,356,433.40	$0.00	N/A
GA	45495	Peach State Health Plan	N/A	N/A	$0.00
GA	49046	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	$212,623.53	$0.00	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
GA	50491	Cigna Health and Life Insurance Company	$1,901,757.01	$0.00	N/A
GA	70893	Ambetter of Peach State Inc.	$0.00	$0.00	N/A
GA	82824	Aetna Health Inc. (a GA corp.)	$780,032.71	$0.00	N/A
GA	83761	Alliant Health Plans	$4,529,064.09	$0.00	$1.08
GA	89942	Kaiser Foundation Health Plan of Georgia	$29,343,780.25	$667,124.28	$17,236.52
GA	93332	Humana Employers Health Plan of Georgia, Inc.	$102,932,298.50	$1,410,936.48	$730,465.11
GA	95852	Harken Health Insurance Company	$12,210,414.34	$0.00	N/A
HI	18350	Hawaii Medical Service Association	$14,609,115.03	$1,514,974.14	$0.00
HI	60612	Kaiser Foundation Health Plan, Inc.	$15,458,919.49	$714,193.48	$161,886.27
IA	18973	Aetna Health Inc. (a IA corp.)	$1,370,536.30	$0.00	$23,553.76
IA	27651	Gundersen Health Plan, Inc.	$75,831.31	$5,595.73	$990.27
IA	51902	UnitedHealthcare of the Midlands, Inc.	$1,351,512.14	$0.00	N/A
IA	71268	CoOportunity Health	N/A	N/A	$487,173.70
IA	74980	Avera Health Plans, Inc.	$155,933.71	$207,564.57	$877.81
IA	77638	Health Alliance Midwest, Inc.	N/A	N/A	$0.00
IA	85930	Sanford Health Plan	$0.00	$163,552.53	$1,123.32
IA	88678	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
IA	93078	Medica Insurance Company	$1,748,293.69	$0.00	N/A
ID	26002	SelectHealth	$51,028,512.58	$6,672,365.27	$225,833.45
ID	38128	Montana Health Cooperative	$13,010,336.93	$179,300.09	N/A
ID	44648	Regence Blue Shield of Idaho	N/A	N/A	$0.00
ID	59765	BridgeSpan Health Company	$847,275.91	$0.00	$242.85
ID	60597	PacificSource Health Plans	$1,205,143.84	$0.00	$19,508.86
ID	61589	Blue Cross of Idaho Health Service, Inc.	$14,535,162.34	$0.00	$348,280.50
IL	16724	UnitedHealthcare of the Midwest, Inc.	$157,038.37	$0.00	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
IL	20129	Health Alliance Medical Plans, Inc.	$21,342,103.01	$71,969.35	$24,131.15
IL	27833	Celtic Insurance Company	$1,846,059.24	$0.00	N/A
IL	35670	Coventry Health & Life Co.	$0.00	$0.00	$2,942.33
IL	36096	Blue Cross Blue Shield of Illinois	$112,457,984.78	$3,412,467.14	$1,715,156.95
IL	58288	Humana Health Plan, Inc.	$102,828.49	$0.00	$6,967.57
IL	68303	Humana Insurance Company	N/A	N/A	$41,765.42
IL	72547	Aetna Life Insurance Company	N/A	N/A	$1,361.64
IL	78463	Harken Health Insurance Company	$28,285,818.16	$0.00	N/A
IL	79763	Land of Lincoln Mutual Health Insurance Company	$42,901,843.98	$9,846,132.23	$39,077.05
IL	96601	Coventry Health Care of Illinois, Inc.	$0.00	$0.00	$27,641.33
IL	99129	Aetna Health Inc. (a PA corp.)	$7,352,468.06	$0.00	N/A
IN	17575	Anthem Ins Companies Inc(Anthem BCBS)	$0.00	$0.00	$7,068.45
IN	20855	Advantage Health Solutions, Inc.	$0.00	$0.00	N/A
IN	33380	Indiana University Health Plans, Inc.	$403,177.29	$0.00	N/A
IN	35065	Coordinated Care Corporation Indiana	N/A	N/A	$0.00
IN	36373	All Savers Insurance Company	$6,211,732.83	$0.00	N/A
IN	50816	Physicians Health Plan of Northern Indiana, Inc.	$4,482,634.94	$0.00	$28,751.69
IN	54192	CareSource Indiana, Inc.	$10,568,031.40	$0.00	N/A
IN	62033	MDwise Marketplace, Inc.	$9,751,130.86	$0.00	N/A
IN	67920	Southeastern Indiana Health Organization	$105,200.90	$0.00	N/A
IN	76179	Celtic Insurance Company	-$1,099,796.09	$0.00	N/A
IN	85320	MDwise, Inc.	N/A	N/A	$0.00
KS	18558	Blue Cross and Blue Shield of Kansas, Inc.	$17,567,910.47	$408,112.19	$122,123.61

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
KS	27811	BlueCross BlueShield Kansas Solutions, Inc.	$28,453,460.78	$142,714.94	N/A
KS	50274	UnitedHealthcare of the Midwest, Inc.	$0.00	$0.00	N/A
KS	61430	Coventry Health and Life	N/A	N/A	$199,115.09
KS	65598	Coventry Health Care Of Kansas Inc	N/A	N/A	$82,617.01
KS	94248	Blue Cross and Blue Shield of Kansas City	$11,222,745.35	$2,304,584.43	$10,973.78
KS	94968	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
KY	15411	Humana Health Plan, Inc.	$2,625,179.37	$0.00	$52,445.04
KY	23671	UnitedHealthcare of Kentucky, Ltd.	$0.00	$0.00	$0.00
KY	34822	Aetna Health Inc. (a PA corp.)	$0.00	$0.00	N/A
KY	36239	Anthem Health Plans of KY(Anthem BCBS)	$0.00	-$37,294.97	$0.00
KY	40586	Bluegrass Family Health, Inc.	$9,865,154.55	$2,898,208.49	$12,805.35
KY	45636	CareSource Kentucky Co.	$3,087,507.35	$0.00	N/A
KY	47949	Golden Rule Insurance Company	N/A	N/A	$0.00
KY	72001	WELLCARE HEALTH PLANS OF KENTUCKY, INC	-$13,574.40	$0.00	N/A
KY	77894	Kentucky Health Cooperative	N/A	N/A	$670,458.18
LA	19636	HMO Louisiana, Inc.	$4,490,022.42	$687,627.16	$27,646.68
LA	38499	UnitedHealthcare of Louisiana, Inc.	$200,537.78	$0.00	N/A
LA	44965	Humana Health Benefit Plan of Louisiana, Inc.	$3,092,925.82	$0.00	$3,607.09
LA	67202	Louisiana Health Cooperative, Inc.	N/A	N/A	$104,030.52
LA	67243	Vantage Health Plan, Inc.	$8,130,698.29	-$15,784.88	$210.66
LA	97176	Louisiana Health Service & Indemnity Company	$21,756,614.82	$1,822,667.19	$307,395.02
MA	29125	Tufts Associated Health Maintenance Org	$0.00	$0.00	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
MA	31234	CeltiCare Health Plan of MA	$0.00	$0.00	$1,746.54
MA	31779	UnitedHealthcare Insurance Company	$492,333.25	$0.00	N/A
MA	34484	Health New England, Inc.	$591,143.39	$1,823,346.74	$0.00
MA	36046	Harvard Pilgrim Health Care Inc.	$945,497.81	$7,745,516.62	$0.00
MA	41304	Neighborhood Health Plan	$0.00	$0.00	$155,998.39
MA	42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	$0.00	$0.00	$0.00
MA	59763	Tufts Health Public Plans Inc.	$0.00	$0.00	$0.00
MA	73331	Minuteman Health, Inc	$2,916,284.01	$311,545.12	$9,904.80
MA	82569	Boston Medical Center Health Plan, Inc.	$0.00	$0.00	$15,106.14
MA	88806	Fallon Community Health Plan, Inc.	$1,606,849.24	$328,544.25	$4,875.12
MA	95878	HPHC Insurance Company Inc.	$8,976,329.97	$9,268,445.40	$10,565.74
MD	14468	Coventry Health Care of Delaware, Inc.	N/A	N/A	$0.00
MD	23620	UnitedHealthcare Insurance Company	$0.00	$0.00	$0.00
MD	28137	CareFirst BlueChoice, Inc.	$41,057,486.62	-$46,498.46	$155,946.37
MD	31112	UnitedHealthcare of the Mid-Atlantic Inc	$0.00	-$27,309.80	$0.00
MD	32812	Cigna Health and Life Insurance Company	$743,128.94	$0.00	N/A
MD	36677	All Savers Insurance Company	$0.00	$0.00	$1,205.34
MD	45532	CareFirst of Maryland, Inc.	$11,539,940.12	$62,844.74	$47,341.07
MD	65635	MAMSI Life and Health Insurance Company	$0.00	-$117,035.51	$0.00
MD	66516	Aetna Health Inc. (a PA corp.)	$0.00	$0.00	N/A
MD	68541	Coventry Health and Life	$0.00	$0.00	$0.00
MD	70767	Aetna Life Insurance Company	$0.00	$34,442.90	N/A
MD	72375	Optimum Choice, Inc.	$0.00	$0.00	$0.00
MD	72564	Evergreen Health Cooperative, Inc.	$5,446,190.67	$15,614,288.59	$35,975.13

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
MD	90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$31,064,359.51	$77,950.89	$4,896.36
MD	94084	GHMSI	$9,019,881.61	$0.00	$8,886.20
ME	33653	Maine Community Health Options	$21,050,424.64	$4,317,337.28	$2,102.64
ME	48396	Anthem Health Plans of ME(Anthem BCBS)	$0.00	$0.00	$0.00
ME	96667	Harvard Pilgrim Health Care Inc.	$747,510.63	$444,527.55	N/A
MI	15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	$5,296,176.54	$0.00	$0.00
MI	20393	McLaren Health Plan	$0.00	$781,057.65	$4,634.82
MI	29241	Priority Health Insurance Company (PHIC)	$7,075,598.39	$0.00	$9,411.44
MI	29698	Priority Health	$26,339,617.56	$0.00	$3,580.16
MI	37651	Health Alliance Plan (HAP)	$0.00	$0.00	$0.00
MI	40047	Molina Healthcare of Michigan, Inc.	-$39,105.84	$0.00	$0.00
MI	41895	Consumers Mutual Insurance of Michigan	N/A	N/A	$15,920.95
MI	45002	UnitedHealthcare Life Insurance Company	$0.00	-$906.46	$0.28
MI	46275	Humana Medical Plan of Michigan, Inc.	$9,529,350.76	$0.00	$70,478.35
MI	58594	Meridian Health Plan of Michigan, Inc.	$0.00	$0.00	$0.00
MI	60829	Physicians Health Plan	$277,579.39	$0.00	N/A
MI	63631	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
MI	67183	Total Health Care USA, Inc.	$0.00	-$2,047,580.25	$0.00
MI	67577	Alliance Health and Life Insurance Company	$846,068.00	$0.00	$562.17

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
MI	71667	UnitedHealthcare Community Plan, Inc.	$0.00	$0.00	N/A
MI	74917	McLaren Health Plan Community	$0.00	$0.00	N/A
MI	98185	Blue Care Network of Michigan	$20,617,731.68	$0.00	$149,563.12
MN	31616	Medica Insurance Company	$0.00	$0.00	$2,757.22
MN	34102	Group Health Plan, Inc.	$14,052,643.55	$0.00	$22,722.12
MN	49316	BCBSM, INC.	$61,016,505.39	$7,923,542.86	$60,505.56
MN	57129	HMO Minnesota	$5,336,936.71	$504,528.26	N/A
MN	65847	Medica Health Plans of Wisconsin	$35,597,185.27	$0.00	$0.00
MN	85736	UCare Minnesota	$10,114,026.06	$0.00	$0.00
MN	88102	PreferredOne Insurance Company	N/A	N/A	$461,585.23
MO	16049	All Savers Insurance Company	$0.00	$0.00	N/A
MO	30613	Humana Insurance Company	$373,172.66	$0.00	N/A
MO	32753	Healthy Alliance Life Co(Anthem BCBS)	$0.00	$0.00	$196.52
MO	34762	Blue Cross and Blue Shield of Kansas City	$21,589,143.65	$49,355.14	$24,424.21
MO	44240	Coventry Health and Life	$0.00	$0.00	$252,932.81
MO	74483	Cigna Health and Life Insurance Company	$1,404,505.78	$0.00	N/A
MS	48963	Humana Insurance Company	$9,041,890.00	$0.00	$0.00
MS	61794	UnitedHealthcare Life Insurance Company	$0.00	$0.00	$0.00
MS	90714	Ambetter of Magnolia Inc.	$0.00	$0.00	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
MS	94237	Magnolia Health Plan	N/A	N/A	$0.00
MS	97560	UnitedHealthcare of Mississippi, Inc.	$3,906,592.67	$0.00	N/A
MT	23603	PacificSource Health Plans	$9,717,931.78	$135,770.45	$16,858.72
MT	30751	Blue Cross and Blue Shield of Montana	$31,380,006.00	$3,027,515.02	$208,874.79
MT	32225	Montana Health Cooperative	$290,347.23	$355,758.03	$54,200.16
NC	11512	Blue Cross and Blue Shield of NC	$18,159,126.49	$0.00	$1,282,852.75
NC	54332	UnitedHealthcare of North Carolina, Inc	$0.00	$0.00	N/A
NC	56346	Coventry Health Care of the Carolinas, Inc.	N/A	N/A	$88,629.95
NC	61671	Aetna Health Inc. (a PA corp.)	$15,884,547.64	$0.00	N/A
ND	37160	Blue Cross Blue Shield of North Dakota	$0.00	$0.00	$3,987.33
ND	39364	Medica Insurance Company	$0.00	$19,371.92	N/A
ND	73751	Medica Health Plans	$0.00	$62,294.31	$2,090.31
ND	89364	Sanford Health Plan	$1,765,053.70	$108,586.34	$0.00
NE	15438	Coventry Health Care of Nebraska Inc.	$14,918,861.69	$0.00	$0.00
NE	20305	Medica Insurance Company	$7,670,841.68	$0.00	N/A
NE	29678	Blue Cross and Blue Shield of Nebraska	$25,923,663.23	$520,261.48	$123,027.09
NE	43198	CoOportunity Health	N/A	N/A	$643,281.99
NE	44751	UnitedHealthcare of the Midlands, Inc.	$6,406,781.24	$0.00	N/A
NE	68389	UnitedHealthcare Life Insurance Company	$0.00	$0.00	N/A
NE	73102	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
NE	77931	Health Alliance Midwest Inc.	N/A	N/A	$63.65
NH	19304	Maine Community Health Options	$5,826,502.09	$4,804,390.97	N/A
NH	59025	Harvard Pilgrim Health Care of NE	$291,440.74	$0.00	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
NH	61163	Minuteman Health, Inc	$10,710,229.92	$9,045.97	N/A
NH	75841	Celtic Insurance Company	-$10,549,229.99	$0.00	N/A
NH	96751	Matthew Thornton Hlth Plan(Anthem BCBS)	$0.00	$0.00	$0.00
NJ	10191	Freelancers CO-OP of New Jersey, Inc.	$36,610,266.63	$7,789,387.27	$1,306.25
NJ	48834	Oxford Health Plans (NJ), Inc.	$4,561,830.04	$0.00	N/A
NJ	50221	Oscar Insurance Corporation of New Jersey	$3,064,840.14	$0.00	N/A
NJ	77606	AmeriHealth HMO, Inc.	$3,974,893.09	$105,954.94	$30,437.40
NJ	91661	Horizon Healthcare Services, Inc.	$16,478,389.42	$0.00	$27,709.38
NJ	91762	AmeriHealth Ins Company of New Jersey	$73,160,117.68	$344,230.91	$10,070.13
NM	19722	Molina Health Care of New Mexico, Inc.	$0.00	$0.00	$0.00
NM	52744	Presbyterian Insurance Company, Inc.	$0.00	$8,019,908.13	$0.00
NM	57173	Presbyterian Health Plan, Inc.	$2,450,553.68	$350,630.79	$21,562.43
NM	72034	CHRISTUS Health Plan	$2,352,154.70	$0.00	N/A
NM	75605	Blue Cross Blue Shield of New Mexico	$2,231,211.41	$653,200.67	$57,124.04
NM	93091	New Mexico Health Connections	$13,116,504.33	$10,319,090.60	$36,636.23
NV	16698	Prominence HealthFirst	$0.00	$0.00	$0.00
NV	33670	Rocky Mountain Hospital and Medical Service, Inc., dba Anthem Blue Cross and Blue Shield	$4,030,060.93	$0.00	N/A
NV	34996	Nevada Health CO-OP	N/A	N/A	$93,079.06
NV	60156	HMO Colorado, Inc., dba HMO Nevada	$0.00	-$7,237.91	$23.62
NV	95865	Health Plan of Nevada, Inc.	$3,326,339.65	$0.00	$0.00
NY	11177	MetroPlus Health Plan	$14,216,773.89	$820,311.63	$76,155.52
NY	18029	Independent Health Benefits Corporation	$2,527,441.24	$12,491,216.10	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
NY	25303	New York State Catholic Health Plan, Inc.	$3,996,255.02	$0.00	$0.00
NY	31808	American Progressive Life & Health Insurance Company of New York	N/A	N/A	$0.00
NY	39595	WellCare of New York	$442,366.09	$0.00	N/A
NY	40064	HealthNow New York	$5,597,212.16	$23,522,343.21	$0.00
NY	54235	UnitedHealthcare of New York, Inc.	$4,509,245.86	$0.00	$0.00
NY	56184	MVP Health Plan, Inc.	$5,120,950.13	$1,162,229.18	$13,489.22
NY	57165	Affinity Health Plan, Inc.	$20,735,006.33	$0.00	$10,259.07
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	N/A	N/A	$1,299,031.53
NY	74289	Oscar Insurance Corporation	$107,138,699.40	$0.00	$81,270.32
NY	78124	Excellus Health Plan, Inc.	$0.00	$23,595,031.50	$65,471.29
NY	80519	Empire HealthChoice HMO, Inc.	$8,305,584.61	$0.00	$0.00
NY	82483	North Shore-LIJ Insurance Company Inc	$50,880,224.71	$62,252,325.98	$30,592.89
NY	85629	Oxford Health Insurance, Inc.	N/A	N/A	$0.00
NY	88582	Health Insurance Plan of Greater New York	$8,669,878.30	$1,686,044.58	$0.00
NY	91237	Healthfirst PHSP, Inc.	$6,891,430.55	$0.00	$656.96
NY	92551	CDPHP Universal Benefits Inc.	$0.00	$10,440,924.71	$127,063.72
NY	94788	CDPHP	$1,128,625.43	$0.00	$0.00
NY	95456	Atlantis Health Plan	N/A	N/A	$0.00
OH	16204	Coordinated Health Mutual, Inc.	$20,218,260.47	$310,347.28	N/A
OH	20126	HealthSpan Integrated Care	$1,619,850.19	$2,851,843.52	$97,447.70
OH	23340	Consumers Life Insurance Company	-$160,706.30	$0.00	N/A
OH	26734	Premier Health Plan, Inc.	$5,682,287.55	$0.00	N/A
OH	28162	AultCare Insurance Company	$0.00	$0.00	$5,685.81
OH	29276	Community Insurance Company(Anthem BCBS)	$0.00	$0.00	$139.50

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
OH	33931	UnitedHealthcare of Ohio, Inc.	$3,833,592.57	$0.00	N/A
OH	41047	Buckeye Community Health Plan	$0.00	$0.00	$0.00
OH	52664	Summa Insurance Company, Inc.	$2,037,988.17	-$146,496.91	$18,755.19
OH	64353	MOLINA HEALTHCARE OF OHIO	$0.00	$0.00	$0.00
OH	66083	Humana Health Plan of Ohio, Inc.	$0.00	$0.00	$80,623.79
OH	67129	Aetna Life Insurance Company	$0.00	$0.00	N/A
OH	74313	Paramount Insurance Company	$267,351.46	$0.00	$0.00
OH	77552	CareSource	$32,086,445.80	$0.00	$0.00
OH	78726	All Savers Insurance Company	$446,164.50	$0.00	N/A
OH	92036	HealthSpan	$1,335,788.24	$211,049.76	$44,083.11
OH	98894	Coventry Health and Life	N/A	N/A	$4,981.15
OH	99969	Medical Health Insuring Corp. of Ohio	$13,342,648.57	-$8,758.40	$43,298.40
OK	45480	UnitedHealthcare of Oklahoma, Inc.	$3,012,668.48	$0.00	N/A
OK	53524	Coventry Health and Life	N/A	N/A	$1,394.42
OK	66946	Aetna Life Insurance Company	N/A	N/A	$3,740.86
OK	76668	Coventry Health Care of Kansas, Inc.	N/A	N/A	$10,986.77
OK	85408	GlobalHealth, Inc.	N/A	N/A	$24,404.54
OK	87571	Blue Cross Blue Shield of Oklahoma	$57,436,784.47	$787,973.67	$468,796.42
OK	87698	CommunityCare Life & Health Insurance Co	$0.00	$1,522,505.85	$1,332.98
OK	98905	CommunityCare HMO Inc.	$0.00	$677,742.83	$2,826.00
OR	10091	PacificSource Health Plans	$5,543,447.37	$1,501,673.38	$26,164.27
OR	10940	Health Net Health Plan of Oregon, Inc.	N/A	N/A	$20,486.10
OR	30969	ZOOM+Care Health Insurance	$1,045,273.45	$21,956.61	N/A
OR	32536	ATRIO Health Plans	$3,823,044.78	$0.00	$1,030.23
OR	39424	Moda Health Plan, Inc.	$33,246,324.18	$2,164,823.82	$763,234.82
OR	56707	Providence Health Plan	$66,897,686.23	$68,882.34	$16,551.00
OR	63474	BridgeSpan Health Company	$154,767.68	$0.00	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
OR	71287	Kaiser Foundation Healthplan of the NW	$15,251,167.48	$0.00	$0.00
OR	85804	LifeWise Health Plan of Oregon	$11,093,351.11	$0.00	$41,979.64
OR	95417	Trillium Community Health Plan	-$152,773.99	-$1,237.14	$0.00
OR	96383	Health Republic Insurance Company	N/A	N/A	$68,588.91
OR	99389	Community Care of Oregon, Inc.	$6,321,118.60	$4,270,863.90	$13,297.97
PA	16322	UPMC Health Options, Inc.	$59,842,450.12	$872,510.61	N/A
PA	16481	UPMC Health Network, Inc.	N/A	N/A	$1,933.41
PA	22444	Geisinger Health Plan	$13,244,631.61	$0.00	$199,187.89
PA	23489	UnitedHealthcare Insurance Company	$0.00	$2,903.41	N/A
PA	24872	UnitedHealthcare of Pennsylvania, Inc.	$2,254,922.55	$0.00	N/A
PA	31609	Independence Blue Cross (QCC Ins. Co.)	$9,763,812.15	$0.00	$93,682.09
PA	33709	Highmark Inc.	$13,432,627.24	$1,567,070.49	$1,390,214.34
PA	33871	Keystone Health Plan East, Inc	$8,955,428.25	$0.00	$254,626.90
PA	33906	Aetna Life Insurance Company	N/A	N/A	$2,655.77
PA	36247	Highmark Select Resources Inc.	$7,665,319.69	$0.00	N/A
PA	45127	Capital Advantage Assurance Company	$12,578,353.88	$6,463.00	N/A
PA	52899	UPMC Health Plan, Inc.	N/A	N/A	$118.37
PA	53789	Keystone Health Plan Central	$14,440,418.45	$60,166.33	$1,013.51
PA	55957	First Priority Life Insurance Company, Inc.	$15,373,532.92	$0.00	$95,110.60
PA	62560	UPMC Health Coverage, Inc.	$0.00	$281,136.83	N/A
PA	64844	Aetna Health Inc. (a PA corp.)	$7,165,507.59	$0.00	$0.00
PA	70194	Highmark Health Insurance Company	$13,156,877.36	-$406,467.62	$275,664.50
PA	75729	Geisinger Quality Options	$5,955,066.10	$0.00	$66,969.88

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
PA	82795	Capital Advantage Insurance Company CAIC	N/A	N/A	$2,523.63
PA	91303	HealthAmerica Pennsylvania, Inc.	N/A	N/A	$17,765.54
RI	15287	Blue Cross & Blue Shield of Rhode Island	$6,723,928.86	$0.00	$0.00
RI	77514	Neighborhood Health Plan of Rhode Island	-$2,475,751.37	-$38,745.91	$0.00
RI	79881	UnitedHealthcare of New England, Inc.	$0.00	$0.00	$6.63
SC	26065	Blue Cross and Blue Shield of South Carolina	$21,882,021.95	$0.00	$0.00
SC	38408	Aetna Health Inc. (a PA corp.)	-$4,047,046.75	$0.00	N/A
SC	41614	Coventry Health Care of the Carolinas, Inc.	N/A	N/A	$44,328.35
SC	49532	BlueChoice HealthPlan of South Carolina, Inc.	$29,862,056.07	$1,524,317.55	$0.00
SC	57860	UnitedHealthcare Insurance Company	$486,864.50	$0.00	N/A
SC	65122	Consumers' Choice Health Insurance Company	N/A	N/A	$108,084.37
SD	31195	Sanford Health Plan	$11,217,457.61	$0.00	$30,763.76
SD	60536	Avera Health Plans, Inc.	$13,756,105.86	$311,636.34	$69,300.60
SD	62210	South Dakota State Medical Holding Company, Inc.	N/A	N/A	$688.23
TN	14002	BlueCross BlueShield of Tennessee	$64,972,431.35	$0.00	$684,777.34
TN	66842	Community Health Alliance Mutual Insurance Company	N/A	N/A	$3,196.92
TN	69443	UnitedHealthcare Insurance Company	$2,134,105.98	$0.00	N/A
TN	82120	Humana Insurance Company	$2,795,659.26	$0.00	$63,434.93
TN	99248	Cigna Health and Life Insurance Company	$6,667,000.07	$0.00	$0.00
TX	20069	Oscar Insurance Company of Texas	$35,085,745.70	$0.00	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
TX	26539	SHA, LLC DBA FirstCare Health Plans	$7,590,347.71	$118,270.44	$18,539.02
TX	27248	Community Health Choice, Inc.	$3,212,369.47	$0.00	$0.00
TX	29418	Celtic Insurance Company	$0.00	$0.00	N/A
TX	32673	Humana Health Plan of Texas, Inc.	$15,164,712.65	$0.00	$532,622.61
TX	33602	Blue Cross Blue Shield of Texas	$157,277,306.72	$10,601,287.65	$2,560,124.49
TX	37392	Prominence HealthFirst of Texas, Inc.	$1,572,951.33	$0.00	N/A
TX	37755	Insurance Company of Scott & White	$75,429,033.03	$0.00	N/A
TX	40788	Scott and White Health Plan	$25,086,485.39	$0.00	$6,701.62
TX	45786	Molina Healthcare of Texas	$0.00	$0.00	$0.00
TX	46224	Community First Health Plans, Inc.	$0.00	$0.00	$85.01
TX	55409	Cigna Health and Life Insurance Company	$12,607,716.28	$0.00	$112,051.45
TX	63141	Humana Insurance Company	$1,157,247.50	$0.00	$44,137.59
TX	63509	Allegian Insurance Company	$6,758,866.06	$0.00	N/A
TX	66252	CHRISTUS Health Plan	$9,529,090.47	$0.00	N/A
TX	71837	Sendero Health Plans, inc.	$9,085,117.80	$0.00	$5,957.77
TX	76589	Cigna HealthCare of Texas, Inc.	$4,891,396.84	$0.00	N/A
TX	85947	All Savers Insurance Company	$37,545,522.88	$83,872.87	N/A
TX	87226	Superior Health Plan	N/A	N/A	$0.00
TX	91716	Aetna Life Insurance Company	$5,142,859.96	$0.00	$9,581.33
TX	98809	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
UT	18167	Molina Healthcare of Utah	$19,606,971.43	$0.00	$0.00
UT	27619	Arches Mutual Insurance Company	N/A	N/A	$104,531.54
UT	34541	BridgeSpan Health Company	$0.00	$0.00	$17,545.89
UT	38927	Aetna Health of Utah Inc.	N/A	N/A	$17,466.91
UT	42261	University of Utah Health Insurance Plans	$182,764.40	$0.00	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
UT	56764	Humana Medical Plan of Utah, Inc.	$1,711,863.52	$0.00	$84,119.08
UT	66413	UnitedHealthcare of Utah, Inc.	$0.00	$53,669.11	$0.00
UT	68781	SelectHealth	$129,565,046.28	$14,423,772.02	$726,669.04
VA	10207	CareFirst BlueChoice, Inc.	$8,737,341.69	$0.00	$6,356.82
VA	12028	Innovation Health Insurance Company	$32,520,623.08	$0.00	$3,713.14
VA	15668	Piedmont Community HealthCare, Inc.	$636,028.99	$579,061.87	N/A
VA	20507	Optima Health Plan	$8,636,390.10	$0.00	$0.00
VA	37204	Piedmont Community HealthCare HMO, Inc.	$737,160.77	$0.00	N/A
VA	38234	Aetna Life Insurance Company	$0.00	$0.00	$0.00
VA	38599	UnitedHealthcare of the Mid-Atlantic Inc	$1,646,134.28	$0.00	N/A
VA	40308	Group Hospitalization and Medical Services Inc.	$4,073,508.25	-$602,890.46	$0.00
VA	86443	Innovation Health Plan, Inc.	$0.00	$75,765.11	N/A
VA	88380	HealthKeepers, Inc.	$0.00	$0.00	$0.00
VA	95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$35,656,640.04	$1,309,812.93	$1,485.37
VA	99663	Coventry Health Care of Virginia, Inc	$3,614,943.00	$0.00	$0.00
VT	13627	Blue Cross Blue Shield of Vermont	$2,552,850.56	$3,784,868.82	$0.00
VT	77566	MVP Health Plan, Inc.	$257,849.50	$226,463.69	$13,596.16
WA	18581	Community Health Plan of Washington	$492,042.87	$0.00	$0.00
WA	23371	Kaiser Foundation Healthplan of the NW	$6,553,058.03	$0.00	$0.00
WA	38229	Health Alliance Northwest Health Plan Inc.	$16,154.71	$0.00	N/A
WA	38498	LifeWise Health Plan of WA	$2,511,858.16	$0.00	$0.00
WA	43861	UnitedHealthcare of Washington, Inc.	$917,117.57	$457,090.26	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
WA	49831	Premera Blue Cross	$27,211,442.78	$0.00	$0.00
WA	53732	BridgeSpan Health Company	$0.00	$0.00	$0.00
WA	61836	Coordinated Care Corporation	$0.00	$0.00	$0.00
WA	65907	Moda Health Plan, Inc.	$0.00	$264,613.60	N/A
WA	80473	Group Health Cooperative	$21,043,260.92	$0.00	$0.00
WA	84481	Molina Healthcare of Washington, Inc.	$2,547,925.84	$0.00	$0.00
WA	87718	Regence BlueShield	$0.00	$0.00	N/A
WI	32754	Managed Health Services Insurance Corporation	-$834,199.47	$0.00	N/A
WI	35334	MercyCare Insurance Company	$0.00	$690,228.89	$3,093.35
WI	37833	Unity Health Plans Insurance Corporation	$0.00	$0.00	$0.00
WI	38166	Security Health Plan of Wisconsin, Inc.	$24,508,429.21	$2,534,857.63	$7,617.14
WI	38345	Dean Health Plan	$5,406,793.42	$0.00	$122,558.13
WI	39924	All Savers Insurance Company	$925,020.38	$201,371.29	N/A
WI	47342	Health Tradition Health Plan	$733,565.54	$1,958,359.42	$5,048.00
WI	52697	Molina Healthcare of Wisconsin, Inc.	$27,554,627.62	$0.00	$0.00
WI	57637	Medica Insurance Company	$0.00	$573,305.09	$4,186.53
WI	57845	Medica Health Plans of Wisconsin	$0.00	$0.00	$0.00
WI	58326	MercyCare HMO, Inc.	$0.00	$1,966,338.04	$10,291.91
WI	58564	Physicians Plus Insurance Corporation	$464,542.33	$0.00	$0.00
WI	79475	Compcare Health Serv Ins Co(Anthem BCBS)	$0.00	$0.00	$42,897.95
WI	81413	Network Health Plan	$2,307,460.56	$0.00	N/A
WI	84670	WPS Health Plan, Inc.	$8,723,207.17	$663,495.55	$55,803.86
WI	87416	Common Ground Healthcare Cooperative	$26,987,917.60	$669,339.38	$393,547.93
WI	91058	Gundersen Health Plan, Inc.	$3,596,244.55	$53,602.89	$18,047.13
WI	94529	Group Health Cooperative-SCW	$385,820.36	-$126,846.57	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET) [4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
WV	31274	Highmark Blue Cross Blue Shield West Virginia	$23,939,268.98	$0.00	$125,468.50
WV	50328	CareSource West Virginia Co.	$1,239,716.45	$0.00	N/A
WY	11269	Blue Cross Blue Shield of Wyoming	$6,400,796.86	$83,778.46	$5,283.77
WY	53189	WINhealth Partners	N/A	N/A	$44,073.60

EXHIBIT 24

QUALIFIED HEALTH PLAN CERTIFICATION AGREEMENT AND PRIVACY AND SECURITY AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the party responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and Independence Blue Cross (QCC Ins. Co.) ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

4. QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **Breach** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized uses or for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII), whether physical or electronic.

e. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

f. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

g. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

h. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

i. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

j. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

k. **Enrollee** has the meaning set forth in 45 CFR 155.20.

l. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

m. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

n. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

o. **Incident**, or **Security Incident**, means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.

p. **Issuer** has the meaning set forth in 45 CFR 144.103.

q. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

r. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

t. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

u. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

v. **State** means the State that has licensed the Issuer that is a party to this Agreement.

II. Acceptance of Standard Rules of Conduct

a. Standards regarding Personally Identifiable Information

QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2). QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth herein, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives directly from Exchange applicants and from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

(1) Safeguards. QHPI agrees to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 155.260(a)(5); and to inform the Exchange of any material change in its administrative, technical, or operational environments, or

that would require an alteration of the privacy and security standards within this Agreement.

(2) Downstream Entities. QHPI will satisfy the requirement in 45 CFR 155.260(b)(2)(v) to bind downstream entities by entering into written agreements, including where appropriate, Business Associate Agreements (as such term is defined under HIPAA), with any downstream entities that will have access to PII as defined in this Agreement.

b. Standards for Communication with the Hub

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Marketplace (FFM) Companion Guide Version most recently released by CMS and in effect at the time the transactions are sent, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

(7) Incident and Breach Reporting Policies and Procedures. QHPI agrees to report any Incident or Breach of PII to the CMS IT Service Desk by telephone at (410)786-2580 or 1-800-562-1963 or via email notification at cms_it_service_desk@cms.hhs.gov within seventy-two (72) to ninety-six (96) hours after discovery of the Incident or Breach.

III. CMS Obligations

a. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and/or processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

IV. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and terminates on December 31, 2016.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

---

the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. CMS acknowledges that QHPI has developed its products for the FFE based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event that this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law.

c. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

d. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions including those that are assigned or subcontracted to other entities and must ensure that subcontractors and assignees will perform all functions in accordance with all applicable requirements. QHPI shall further be subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"), unless a different effective date is required by law. Any amendments made under this provision will only have

prospective effect and will not be applied retrospectively unless required by law. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, thirty (30) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon

reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR OHPI

Signature of Person Authorized to Enter Agreement on behalf of QHPI

Brian Lobley, SVP Mktg & Consumer Business

Typed or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

Independence Blue Cross (QCC Ins. Co.)

Issuer Name

31609

Issuer HIOS ID

1901 Market Street, Philadelphia, PA 19103

Entity Address

09/23/2015

Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

Kevin J. Counihan
Marketplace Chief Executive Officer and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

9/30/15
Date

David J. Nelson
Deputy Chief Operating Officer and Chief Information Officer
Centers for Medicare & Medicaid Services

10-8-15
Date

EXHIBIT 25

QUALIFIED HEALTH PLAN CERTIFICATION AGREEMENT AND PRIVACY AND SECURITY AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the party responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and Keystone Health Plan East, Inc ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

4. QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **Breach** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized uses or for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII), whether physical or electronic.

e. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

f. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

g. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

h. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

i. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

j. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

k. **Enrollee** has the meaning set forth in 45 CFR 155.20.

l. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

m. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

n. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

o. **Incident**, or **Security Incident**, means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.

p. **Issuer** has the meaning set forth in 45 CFR 144.103.

q. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

r. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

t. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

u. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

v. **State** means the State that has licensed the Issuer that is a party to this Agreement.

II. Acceptance of Standard Rules of Conduct

a. Standards regarding Personally Identifiable Information

QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2). QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth herein, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives directly from Exchange applicants and from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

(1) Safeguards. QHPI agrees to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 155.260(a)(5); and to inform the Exchange of any material change in its administrative, technical, or operational environments, or

that would require an alteration of the privacy and security standards within this Agreement.

(2) Downstream Entities. QHPI will satisfy the requirement in 45 CFR 155.260(b)(2)(v) to bind downstream entities by entering into written agreements, including where appropriate, Business Associate Agreements (as such term is defined under HIPAA), with any downstream entities that will have access to PII as defined in this Agreement.

b. Standards for Communication with the Hub

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Marketplace (FFM) Companion Guide Version most recently released by CMS and in effect at the time the transactions are sent, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

(7) Incident and Breach Reporting Policies and Procedures. QHPI agrees to report any Incident or Breach of PII to the CMS IT Service Desk by telephone at (410)786-2580 or 1-800-562-1963 or via email notification at cms_it_service_desk@cms.hhs.gov within seventy-two (72) to ninety-six (96) hours after discovery of the Incident or Breach.

III. CMS Obligations

a. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and/or processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

IV. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and terminates on December 31, 2016.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

---

the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. CMS acknowledges that QHPI has developed its products for the FFE based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event that this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law.

c. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

d. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions including those that are assigned or subcontracted to other entities and must ensure that subcontractors and assignees will perform all functions in accordance with all applicable requirements. QHPI shall further be subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"), unless a different effective date is required by law. Any amendments made under this provision will only have

prospective effect and will not be applied retrospectively unless required by law. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, thirty (30) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

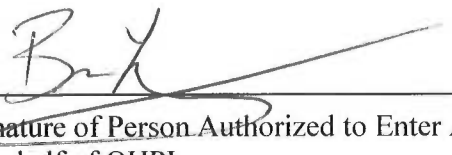
h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon

reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR QHPI



Signature of Person Authorized to Enter Agreement on behalf of QHPI

Brian Lobley, SVP Mktg & Consumer Business

Typed or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

Keystone Health Plan East, Inc.

Issuer Name

33871

Issuer HIOS ID

1901 Market Street, Philadelphia, PA 19103

Entity Address

09/23/2015

Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

9/30/15

Kevin J. Counihan
Marketplace Chief Executive Officer and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

Date

10-8-15

David J. Nelson
Deputy Chief Operating Officer and Chief Information Officer
Centers for Medicare & Medicaid Services

Date

EXHIBIT 26

QUALIFIED HEALTH PLAN CERTIFICATION AGREEMENT AND PRIVACY AND SECURITY AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the party responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and AmeriHealth Ins Company of New Jersey ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

4. QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **Breach** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized uses or for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII), whether physical or electronic.

e. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

f. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

g. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

h. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

i. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

j. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

k. **Enrollee** has the meaning set forth in 45 CFR 155.20.

l. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

m. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

n. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

o. **Incident**, or **Security Incident**, means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.

p. **Issuer** has the meaning set forth in 45 CFR 144.103.

q. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

r. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

t. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

u. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

v. **State** means the State that has licensed the Issuer that is a party to this Agreement.

II. Acceptance of Standard Rules of Conduct

a. Standards regarding Personally Identifiable Information

QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2). QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth herein, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives directly from Exchange applicants and from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

(1) Safeguards. QHPI agrees to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 155.260(a)(5); and to inform the Exchange of any material change in its administrative, technical, or operational environments, or

that would require an alteration of the privacy and security standards within this Agreement.

(2) Downstream Entities. QHPI will satisfy the requirement in 45 CFR 155.260(b)(2)(v) to bind downstream entities by entering into written agreements, including where appropriate, Business Associate Agreements (as such term is defined under HIPAA), with any downstream entities that will have access to PII as defined in this Agreement.

b. Standards for Communication with the Hub

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Marketplace (FFM) Companion Guide Version most recently released by CMS and in effect at the time the transactions are sent, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

(7) Incident and Breach Reporting Policies and Procedures. QHPI agrees to report any Incident or Breach of PII to the CMS IT Service Desk by telephone at (410)786-2580 or 1-800-562-1963 or via email notification at cms_it_service_desk@cms.hhs.gov within seventy-two (72) to ninety-six (96) hours after discovery of the Incident or Breach.

III. CMS Obligations

a. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and/or processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

IV. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and terminates on December 31, 2016.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

---

the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. CMS acknowledges that QHPI has developed its products for the FFE based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event that this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law.

c. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

d. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions including those that are assigned or subcontracted to other entities and must ensure that subcontractors and assignees will perform all functions in accordance with all applicable requirements. QHPI shall further be subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"), unless a different effective date is required by law. Any amendments made under this provision will only have

prospective effect and will not be applied retrospectively unless required by law. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, thirty (30) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

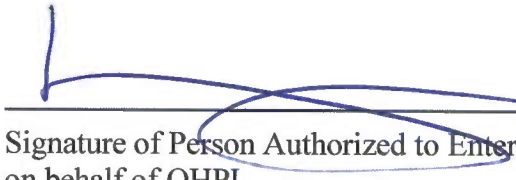
h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon

reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR QHPI



Signature of Person Authorized to Enter Agreement on behalf of QHPI

Michael Munoz, Senior Vice President

Typed or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

AmeriHealth Ins Company of New Jersey

Issuer Name

91762

Issuer HIOS ID

259 Prospect Plains Rd, Cranbury, NJ 08512

Entity Address

09/25/2015

Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

Kevin J. Counihan
Marketplace Chief Executive Officer and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

August 30, 2015
Date

David J. Nelson
Deputy Chief Operating Officer and Chief Information Officer
Centers for Medicare & Medicaid Services

10.8.15
Date

EXHIBIT 27

QUALIFIED HEALTH PLAN CERTIFICATION AGREEMENT AND PRIVACY AND SECURITY AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the party responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and AmeriHealth HMO, Inc. ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

4. QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **Breach** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized uses or for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII), whether physical or electronic.

e. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

f. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

g. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

h. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

i. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

j. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

k. **Enrollee** has the meaning set forth in 45 CFR 155.20.

l. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

m. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

n. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

o. **Incident**, or **Security Incident**, means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.

p. **Issuer** has the meaning set forth in 45 CFR 144.103.

q. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

r. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

t. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

u. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

v. **State** means the State that has licensed the Issuer that is a party to this Agreement.

II. Acceptance of Standard Rules of Conduct

a. Standards regarding Personally Identifiable Information

QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2). QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth herein, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives directly from Exchange applicants and from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

(1) Safeguards. QHPI agrees to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 155.260(a)(5); and to inform the Exchange of any material change in its administrative, technical, or operational environments, or

that would require an alteration of the privacy and security standards within this Agreement.

(2) Downstream Entities. QHPI will satisfy the requirement in 45 CFR 155.260(b)(2)(v) to bind downstream entities by entering into written agreements, including where appropriate, Business Associate Agreements (as such term is defined under HIPAA), with any downstream entities that will have access to PII as defined in this Agreement.

b. Standards for Communication with the Hub

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Marketplace (FFM) Companion Guide Version most recently released by CMS and in effect at the time the transactions are sent, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

(7) Incident and Breach Reporting Policies and Procedures. QHPI agrees to report any Incident or Breach of PII to the CMS IT Service Desk by telephone at (410)786-2580 or 1-800-562-1963 or via email notification at cms_it_service_desk@cms.hhs.gov within seventy-two (72) to ninety-six (96) hours after discovery of the Incident or Breach.

III. CMS Obligations

a. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and/or processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

IV. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and terminates on December 31, 2016.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

---

the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. CMS acknowledges that QHPI has developed its products for the FFE based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event that this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law.

c. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

d. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions including those that are assigned or subcontracted to other entities and must ensure that subcontractors and assignees will perform all functions in accordance with all applicable requirements. QHPI shall further be subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"), unless a different effective date is required by law. Any amendments made under this provision will only have

prospective effect and will not be applied retrospectively unless required by law. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, thirty (30) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon

reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR QHPI

Signature of Person Authorized to Enter Agreement on behalf of QHPI

Michael Munoz, Senior Vice President

Typed or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

AmeriHealth HMO, Inc.

Issuer Name

77606

Issuer HIOS ID

259 Prospect Plains Rd., Cranbury, NJ 08512

Entity Address

09/25/2015

Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

Kevin J. Counihan
Marketplace Chief Executive Officer and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

August 30, 2015
Date

David J. Nelson
Deputy Chief Operating Officer and Chief Information Officer
Centers for Medicare & Medicaid Services

10.8.15
Date