IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DIALYSIS PATIENT CITIZENS 1012 14th Street, NW, Suite 1475 Washington, DC 20005,	:	
JANE DOE 1,	:	CIVIL ACTION NO.
JOHN DOE 2,	:	JURY TRIAL DEMANDED
JANE DOE 4, and	:	
JOHN DOE 5,	:	
Plaintiffs,	:	
v.	:	
INDEPENDENCE BLUE CROSS 1901 Market Street, Philadelphia, PA 19103, and	:	
QCC INSURANCE COMPANY 1901 Market Street, Philadelphia, PA 19103,	:	
Defendants.	:	

VERIFIED COMPLAINT

1. Defendants Independence Blue Cross ("IBC") and its subsidiary, the QCC Insurance Company ("QCC") (collectively referred to as IBC) are discriminating against hundreds of poor, chronically ill Pennsylvanians, who are disabled by end stage renal disease ("ESRD"). IBC accomplishes this by dropping these individuals from, or denying them, health insurance coverage – a practice also referred to as "patient dumping" – by refusing to accept charitable grants that enable them to pay for their health insurance.

2. ESRD is the last stage of chronic kidney disease. Individuals suffering from

ESRD lose the ability to clean toxins from their blood. ESRD patients can be treated only by dialysis or a kidney transplant, absent which, they will die. To save itself money, IBC issued as policy for removing people with ESRD from its insurance rolls by unlawfully cancelling their health insurance contracts and discriminating against them in violation of the Affordable Care Act ("ACA") and other laws. More particularly, no law and no provision in IBC's insurance contracts allows IBC to decline premium assistance from third parties. Instead, IBC abruptly adopted a "policy" targeted at ESRD patients which precludes any party with a "financial interest" in the payment of health insurance claims from providing premium assistance to a low-income patient. See https://www.ibx.com/pdfs/individuals/member_resources/third_party_payment_policy.pdf, a copy of which is attached as Exhibit 1. See also Exhibit 2 and Exhibit 3. IBC has self-proclaimed the American Kidney Fund ("AKF") to be self-interested because it receives donations from, inter alia, dialysis providers to help fund its patient grants.

3. Many, if not most, of IBC's insureds receive some form of premium assistance from third-parties. For example, employers sponsor and contribute towards health insurance coverage for approximately 150 million Americans. See http://kff.org/report-section/ehbs-2016-section-three-employee-coverage-eligibility-and-participation/. Employers pay an average of 68% of employees' family medical insurance premiums. See https://www.bls.gov/news.release/ebs2.t04.htm. And 84% of individuals purchasing insurance through the Exchanges established under the Affordable Care Act have low incomes and receive premium support from the IRS through advance tax credits.

4. If IBC were to apply its policy even-handedly, it would have to reject premium assistance from the employers of the 10.3% of Pennsylvania employees who work in the

healthcare sector. See http://kff.org/other/state-indicator/health-care-employment-as-total/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Additionally, if IBC were to apply its policy even-handedly, if a healthcare company such as GlaxoSmithKline or Pfizer contributed to the United Way, and the United Way provided premium assistance (which it does, see https://www.unitedwaydanecounty.org/2014/02/united-way-expands-healthconnect-program-to-help-individuals-up-to-150-fpl/), IBC would not be able to accept the money from the United Way.

5. IBC does not, however, apply this policy across-the-board. For most patients without expensive-to-treat disabilities, IBC does not police the source of their premium payments. Instead, IBC reserves that discriminatory conduct for ESRD patients who receive support from a charity that IBC knows makes grants only to ESRD patients, namely the AKF, whose financial support is specifically targeted by IBC's anti-charity policy.

6. IBC's practices are discriminatory because they are based on the subscribers' medical condition and disability, and also have a disproportionate impact on African-Americans. IBC's refusal to accept premium support for ESRD patients – which also violates Pennsylvania laws and regulations – will leave many ESRD patients with no insurance at all, or, at best, force them to obtain inferior Medicare or Medicaid coverage. Without insurance, they cannot pay for life-sustaining dialysis. Even if they obtain Medicare and Medicaid coverage – and putting aside the time gap during which ESRD patients dumped by IBC may be forced to go without the treatment that keeps them alive – those programs each have limitations and drawbacks – including high and unlimited co-payments that IBC's policies do not have. To compound that harm, IBC also has refused to accept charitable support that enables low-income patients

enrolled in Medicare to obtain Medigap coverage to mitigate those costs.

7. This action seeks injunctive and declaratory relief to prohibit IBC from breaching its insurance contracts and discriminating against disabled ESRD patients by refusing to accept premium payments on their behalf. It also seeks relief from IBC's violations of the ACA and the Pennsylvania Consumer Protection Law.

PARTIES

8. Plaintiff Dialysis Patient Citizens ("DPC") is a non-profit educational and social welfare organization operating under section 501(c)(4) of the Internal Revenue Code. DPC is headquartered at 1012 14th Street, NW, Suite 1475, Washington, DC 20005. DPC was founded in 2003, and has over 29,000 members, all of whom are kidney disease patients or their family members. DPC's board of directors is comprised entirely of kidney disease patients, and, under DPC's bylaws the President, Vice President and a majority of its board members (typically 60+ percent) must be current kidney dialysis patients.

9. DPC's mission is to improve the quality of life of patients with kidney disease through advocacy and education. DPC initiatives have included promoting legislation included in the Cures Act that will in the future enable Medicare-eligible kidney dialysis patients to enroll in Medicare Advantage plans (which they cannot currently do). DPC also advocates for broader access to Medigap policy coverage for renal patients who are under 65 years old.

10. DPC's advocacy includes fighting for the rights of indigent ESRD patients to access charitable support that enables them to participate in a commercial insurance plan if they choose such coverage for themselves and their families. DPC is not affiliated with the AKF, but many of its members depend on AKF funding to afford commercial insurance or "Medigap" coverage.

11. Because of the debilitating nature of the condition, most individuals suffering from ESRD become too incapacitated to maintain employment, and a substantial portion of ESRD patients are of low income. Twenty-three percent of DPC members with ESRD – more than 6,000 individuals – presently receive assistance to help pay their premiums, including premiums for Medicare, Medigap and private coverage. Approximately 1,100 of DPC's members live in Pennsylvania.

12. DPC has representative standing to bring this lawsuit on behalf of its members as an "association" because (i) its members would otherwise have standing to sue in their own right; (ii) the interests DPC seeks to protect in this action are germane to DPC's purpose; and (iii) neither the claims asserted nor the relief requested require the participation of individual members as parties in this action. See Hunt v. Washington State Apple Advertising Commission, 432 U.S. 333, 343 (1977); PA Prison Society v. Cortes, 622 F.2d 215, 228 (3d Cir. 2010).

13. DPC also has derivative third-party standing that may be exercised on behalf of its members. Third-party standing in this Circuit requires that (i) the plaintiff must suffer injury; (ii) the plaintiff and third party have a close relationship; and (iii) the third party faces a practical impediment to pursuing his claims individually. See Pennsylvania Psychiatric Society v. Green Spring Health Services, Inc., 280 F.3d 278, 288-89 (3d Cir. 2002) (affirming standing of psychiatric association to fight denials of mental health treatments of its members' patients).

14. Under the jurisprudence of Green Spring, (i) the adverse impact of IBC's policy on DPC's members' and mission satisfies the first prong; (ii) DPC and its members have a close relationship based on DPC's advocacy and education on their behalf; and (iii) DPC's members are impeded from pursuing their claims as a practical matter due to fear of retaliation by IBC.

Should, for example, the John and Jane Doe plaintiffs in this lawsuit identify themselves as ESRD patients receiving premium support, they would risk IBC terminating their policies or rejecting their premiums and jeopardizing their coverage for life-saving treatments. This impediment, along with concerns about broadly publicizing the details of their medical conditions, has prompted the Individual Plaintiffs in this action to proceed anonymously.

15. Plaintiff Jane Doe 1 is a 61 year old African-American resident of Philadelphia, Pennsylvania, who has been diagnosed with ESRD. As a result of her ESRD, she became (and is) disabled and unable to work. Jane Doe 1 receives dialysis three times a week, and has contracted with IBC for health insurance. She purchased her insurance, known as a Qualified Health Plan (or "QHP") from IBC on the Federal Exchange established pursuant to the Affordable Care Act ("ACA"). She both receives and requires premium assistance from the AKF to pay her premiums. Jane Doe 1 has filed this lawsuit anonymously because she has a fear of adverse action – namely the cancellation of her insurance, which provides her with the only way she can obtain life-sustaining dialysis – if IBC learns her name and that she is suing IBC for the right to receive premium assistance from the AKF. Given IBC's actions, as more fully described in this complaint, her fear is reasonable.

16. Plaintiff John Doe 2 is a 66 year old African-American resident of Philadelphia, Pennsylvania, who has been diagnosed with ESRD. He receives dialysis three times a week and has purchased a Medigap policy from IBC. He both receives and requires premium assistance from the AKF to pay his premiums. In late 2016, IBC refused to accept premium support from the AKF on John Doe 2's behalf. As a result, John Doe 2 lost his Medigap coverage between December 2016 and March 2017. His coverage has since been reinstated. John Doe 2 has filed this lawsuit anonymously because he has a fear of adverse action – namely the cancellation of his

insurance, which provides him with the only way he can obtain life-saving dialysis – if IBC learns his identity and that he is suing IBC for the right to receive premium assistance from the AKF. Given IBC's actions, as more fully described in this complaint, his fear is reasonable.

17. Plaintiff Jane Doe 4 is a 47 year old African American resident of Philadelphia, Pennsylvania, who has been diagnosed with ESRD. She receives dialysis three times a week and has contracted with IBC for Medigap insurance coverage. Jane Doe 4's Medigap premiums have been paid directly by the AKF since she started dialysis. However, IBC recently refused to cash the AKF check and returned it to the clinic and demanded that Jane Doe 4 pay IBC directly. She is unemployed due to her kidney disease and dialysis and requires AKF assistance to afford Medigap and avoid exposure to out-of-pocket, and uncapped Medicare fees. Jane Doe 4 has filed this lawsuit anonymously because she has a fear of adverse action – namely the cancellation of her insurance, which provides her with the only way she can obtain life-saving dialysis – if IBC should learn her name and that she is suing IBC for the right to receive premium assistance from the AKF. Given IBC's actions, as more fully described in this complaint, her fear is reasonable.

18. Plaintiff John Doe 5 is a 29 year old Caucasian resident of Palm, Pennsylvania who has been diagnosed with ESRD. John Doe 5 undergoes peritoneal dialysis at home every night. Although he works part time, he does not receive insurance through his employer. Instead, he has applied for and receives Medicare. He purchased a Medigap policy from IBC. The AKF has provided John Doe with premium support to pay his Medicare Part B premiums and his Medigap premiums for several years. IBC recently refused to cash the AKF check and demanded that John Doe 5 pay IBC directly. John Doe 5 has filed this lawsuit anonymously because he has a fear of severe harm – namely the cancellation of his insurance, which provides

him with the only way he can obtain life-saving dialysis – if he told IBC his name and that he was suing IBC for the right to receive premium assistance. Given IBC's actions, as more fully described in this complaint, his fear is reasonable.

19. Jane Doe 1, John Doe 2, Jane Doe 4 and John Doe 5 are referred to collectively as the "Individual Plaintiffs."

20. Defendant IBC is a Pennsylvania Health Plan Corporation organized and licensed under the laws of Pennsylvania, with its principal place of business located at 1901 Market Street, Philadelphia, PA 19103. As a Pennsylvania Health Plan Corporation, (i.e., a "Blue Plan"), IBC receives a tax exemption from the Commonwealth of Pennsylvania, in exchange for which it is deemed "an insurer of last resort" and may not deny insurance to any willing applicants who are able to purchase coverage.

21. Defendant QCC is a health insurance company organized and licensed under the laws of Pennsylvania with a principal place of business located at 1901 Market Street, Philadelphia, PA 19103. QCC is a wholly-owned subsidiary of IBC and does business under the name of IBC.

JURISDICTION AND VENUE

22. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 because this lawsuit asserts federal causes of action under, inter alia, the anti-discrimination provision of the Affordable Care Act, codified at 42 U.S.C. § 18116, which incorporates other federal civil rights laws including the Civil Rights Act of 1964 and the Rehabilitation Act.

23. This court has supplemental jurisdiction pursuant to 28 U.S.C. § 1367(a) over the state law claims asserted in this lawsuit because they form part of the same case or controversy under Article III of the United States Constitution.

24. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)(1) & (2) because both defendants reside in this District, and because a substantial part of the events giving rise to the claims asserted in this lawsuit occurred in this District.

25. The Court has personal jurisdiction over both defendants because they are both organized in Pennsylvania, their principal places of business are in Pennsylvania, and they insure thousands of Pennsylvanians.

END STAGE RENAL DISEASE AND ITS EFFECTS

26. End stage renal disease is the last stage of chronic kidney disease. At this stage, the kidneys can no longer filter and clean blood. The most common causes of ESRD are diabetes and high blood pressure, although it may also be caused by a variety of other conditions, including lupus and nephrotic syndrome.

27. Dialysis is a process of artificially cleaning blood and removing excess fluid from it, essentially simulating working kidneys. The process involves removing blood from a patient's body and filtering it through a man-made membrane called a dialyzer, or artificial kidney, and then returning the filtered blood to the body. It is accomplished using specialized equipment in a specialized dialysis facility, or at home following training and under the general oversight and periodic care of a renal professional.

28. These diseases also require the attention of specialized doctors and other healthcare providers. Managing these chronic conditions takes a considerable toll on ESRD patients physically, mentally, and financially.

29. A person suffering from ESRD will die within a short period of time if he or she does not receive dialysis or a kidney transplant. Individuals with ESRD also frequently have serious co-morbidities such as diabetes and heart disease.

30. The amount and frequency of dialysis needed varies depending on each patient's physical characteristics. For example, Jane Doe 1's in-center hemodialysis treatments last about four hours, and are done at least three times per week. John Doe 5s in-home peritoneal dialysis treatments last between eight and ten hours and are done every night.

31. This rigorous treatment schedule is a constant burden for ESRD patients, and dramatically impacts their life activities, including their ability to work.

32. ESRD also disproportionately affects individuals of African-American descent, who are at least three times more likely to be diagnosed with ESRD than Caucasians. See https://www.usrds.org/2010/pdf/v2_02.pdf?zoom_highlight=disparities#search=%22disparities%22. Although only 13.2% of the United States population is African-American, 35% of the ESRD patients in the United States are African-American.

33. At least some of ESRD's disproportionate impact on African-Americans is driven by the fact that African-Americans are twice as likely as Caucasians to be diagnosed with diabetes, a leading cause of ESRD, and are between seven and twenty times more likely than Caucasians to be diagnosed with hypertension, another leading cause of kidney failure. See https://academic.oup.com/ndt/article/17/2/198/1808880/End-stage-renal-failure-in-African-Americans. African-Americans also develop hypertension an average of ten years earlier than Caucasians. See https://academic.oup.com/ndt/article/17/2/198/1808880/End-stage-renal-failure-in-African-Americans.

34. African-Americans disproportionately suffer from the more severe Type 2 diabetes (as opposed to the less severe Type 1 diabetes). Type 2 diabetes is more likely to lead to other health complications and co-morbidities.

35. Even controlling for both income and age, African-Americans still suffer from

ESRD at a rate 3.5 times as great as Caucasians. See http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0048407.

THE IMPORTANCE OF INSURANCE TO END STAGE RENAL DISEASE PATIENTS

36. The strict dialysis regimen necessary to keep ESRD patients alive is very costly. The cost of dialysis is out of reach for most Pennsylvanians without health care insurance to pay the medical bills.

37. The availability of, and ability to pay for, comprehensive insurance is a constant source of anxiety for ESRD patients because the treatment for ESRD is so expensive and because ESRD severely limits one's ability to work.

38. Congress has long recognized the unique hardships and expense of coping with ESRD. In 1972, Congress amended the Social Security Act to allow individuals under the age of 65 who suffer from ESRD, and who meet certain eligibility requirements, to enroll in Medicare. Those requirements include U.S. citizenship, having a certain number of work credits, and paying Social Security taxes. As a result, although many of DPC's members are eligible for Medicare, some are not.

39. Medicare coverage "gaps" are substantial. Patients with Medicare Part B coverage (for which they must pay) are personally responsible for deductibles and 20% co-payments for physician fees and of outpatient dialysis treatments. Patients also have personal financial responsibility for 20% of oral drugs that are not included within the dialysis maintenance treatment fees. Unlike Individual Coverage purchased through an ACA Exchange, there is no upper limit on out-of-pocket costs under Medicare. ESRD patients enrolled in Medicare consequently are exposed to significant out-of-pocket expenses.

40. Out-of-pocket costs for patients enrolled in Medicare can be covered or greatly

mitigated by Medigap coverage, which supplements coverage under Medicare Parts A and B. Medigap must be privately purchased.

41. Medigap policies are available to individuals who receive fee-for-service coverage under Medicare Part A (hospital and institutional care) and Medicare Part B (physician services, outpatient renal dialysis, medical equipment and supplies, diagnostic tests, and other non-institutional services) designed to insure against amounts Medicare will not pay (and thus fill in the "gaps" in Medicare coverage).

42. Medigap policies must be privately purchased. In many states, Medigap policies are not available to ESRD patients who are covered by Medicare but under 65 years of age, but Medigap policies are available to persons under 65 under Pennsylvania state law.

43. Until the enactment of the ACA in March 2010, individuals with ESRD generally could not obtain coverage in the private insurance market because issuers would reject them based on their preexisting condition, or charge exorbitant and unaffordable premiums for coverage, either under disease-rated coverage, or coverage available only through a state high risk pool product.

44. The ACA, however, required insurers to "accept every employer and individual . . . who applies for" coverage. See 42 U.S.C. § 300gg-1(a). Through such "guaranteed coverage," the ACA for the first time has enabled people with pre-existing conditions – including those with ESRD – to buy private health insurance as a matter of right. ESRD is "covered" under every QHP's mandated coverage, including those qualified health plans offered by IBC, under essential health benefit requirements.

45. In addition to requiring health insurers to accept all applicants regardless of health status, the ACA prohibits insurers from non-renewing or discontinuing coverage (except in

limited circumstances not relevant here). See 42 U.S.C. § 300gg-2(b).

46. The ACA also prohibits insurer marketing practices or benefit designs that discourage the enrollment of individuals "with significant health needs." See 42 U.S.C. § 13031(c)(1)(A). It further prohibits the denial of benefits based on "disability, degree of medical dependency, or quality of life." See 42 U.S.C. § 18022(b)(4)(D).

47. Finally, the ACA required issuers of non-grandfathered plans to use a "community rating" rather than individual rating. This allows for a relatively limited (3-to-1) "spread" between the lowest and highest amounts that an issuer may charge for a qualified health plan, and prevents issuers from charging vastly higher fees based on the enrollee's medical condition.

48. Enrollment in Medicare for many ESRD patients is optional, not mandatory.

49. There are a number of reasons, even aside from exposure to unlimited 20% co-payments, why even individuals eligible for Medicare may prefer private commercial coverage. For example, providers participating in private insurance networks may choose not to participate in Medicare, or to not accept new Medicare patients or renal failure patients enrolled in Medicare. Private insurance also may offer subscribers broader access to providers, or better access to their preferred providers than Medicare. As another example, even if an ESRD patient is eligible for Medicare, his or her dependents may not be, and a family policy may be both cheaper and preferable to maintaining separate coverage for the ESRD patient and his or her dependents.

50. Many providers participate as in-network (i.e., contracted) providers in Medicare Advantage Organizations ("MAOs"), in which Medicare recipients increasingly choose to enroll in lieu of receiving "traditional" Medicare coverage. Despite the increasing popularity of

Medicare Advantage, which may include greater protections against out-of-pocket expenses than Original Medicare, ESRD patients not already enrolled in an MAO are prohibited under current law from enrolling in an MAO.

THE AMERICAN KIDNEY FUND AND ITS SUPPORT FOR PLAINTIFFS AND OTHER END STAGE RENAL DISEASE PATIENTS, AND CMS' GUIDANCE ON THIRD-PARTY INSURANCE PREMIUM SUPPORT

51. The American Kidney Fund ("AKF") is a 501(c)(3) non-profit organization founded in 1971. The AKF sponsors and conducts prevention activities, provides educational resources, and sponsors clinical research. It also provides financial support to patients with kidney failure.

52. Plaintiff DPC is not "related" to or affiliated with the AKF. That being the case, DPC members often are benefited by qualifying for AKF grants that enable them to pay for private or Medigap insurance coverage.

53. AKF premium assistance for low-income dialysis patients has been authorized and encouraged by the U.S. Department of Health and Human Services ("HHS") for 20 years.

54. In 1997 the HHS Office of Inspector General ("OIG") issued an Advisory Opinion to the AKF – which remains "on the books" – specifically concerning premium assistance by the AKF. See https://oig.hhs.gov/fraud/docs/advisoryopinions/1997/kdp.pdf, a copy of which is attached as Exhibit 4.

55. The Advisory Opinion expressly authorized premiums to be paid by the AKF to support ESRD patients as long as certain conditions were met relating to the provision of charitable support to the patients.

56. The OIG specifically approved of the AKF receiving donations from dialysis providers to help fund premium and cost-sharing subsidies, as long as the donations were not

tracked, the availability of financial support was not advertised, the insurance coverage was purchased for not less than a year, and patients were not obligated to use any particular dialysis provider.

57. To this day, the federal government accepts AKF grants in payment of Medicare Part B premiums for ESRD patients.

58. In addition, both on its website and in its brochures, the National Institutes of Health ("NIH"), a component of HHS, continues to encourage low-income dialysis patients to contact the AKF, which the NIH explains "has grants to help pay health plan premiums." See https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/financial-help-treatment, a copy of which is attached as Exhibit 5.

59. On March 14, 2014, CMS promulgated the only currently enforceable regulations dealing with premium support. See 79 Fed. Reg. 15240. CMS affirmatively required QHP issuers to accept charitable premium and cost sharing support in the form of Ryan White HIV/AIDS grants, and from state governmental organizations (among others). CMS "discouraged" (but could not, and did not purport to prohibit) such support for QHP members from "hospitals, health care providers, and other commercial entities." In contrast, the rule did not "discourage" issuers from accepting payments from 501(c)(3) organizations like the AKF.

60. In 2016, the AKF made treatment-related grants to more than 93,000 low-income dialysis patients in 50 states, the District of Columbia, and every U.S. territory – representing one out of every five U.S. dialysis patients.

61. The AKF pays premiums only for those individuals diagnosed with ESRD and requiring dialysis. AKF grants are given for a one year period, and are based on financial need.

62. To qualify for AKF assistance, grant recipients must demonstrate that their

monthly household income does not exceed reasonable monthly expenses by more than $600, and that their total liquid assets, such as savings accounts and investment accounts, do not exceed $7,000. Grant recipients must also obtain a physician certification, a referral letter signed by a social worker or administrator at a dialysis provider, and complete an individual Patient Grant Application which requests detailed financial information about the patient's household.

63. Consistent with the OIG's Advisory Opinion, the AKF cannot require a grant recipient to receive treatment at any particular facility or from any particular entity or organization. This policy ensures that grantees are free to receive dialysis and other crucial services at their "provider of choice" – whether or not that provider donates to the AKF.

64. The Individual Plaintiffs each have relied on AKF grants to pay their insurance premiums to IBC under terms that comply with the OIG's Advisory Opinion.

65. Hundreds of DPC's members who live in Pennsylvania similarly have received AKF grants to help pay for their IBC insurance premiums under terms that comply with the OIG's Advisory Opinion.

66. Dialysis patients have almost uniformly urged support for AKF premium assistance.

67. IBC knew or should have known at all times that the Individual Plaintiffs' premiums, as well as the premiums for hundreds of DPC's members, were being paid from AKF grant proceeds, as premium payments have been made by the AKF to IBC.

68. When the Individual Plaintiffs and hundreds of DPC's members renewed their policies with IBC for 2017, IBC knew that they had received support for their premiums from AKF grant proceeds in 2016, and likely would continue to do so.

69. The insurance lobby urged CMS to issue a rule that would have required dialysis

providers to notify issuers of Qualified Health Plans sold through the Exchanges when their patients were receiving charitable support for QHP purchases, and seek confirmation that the issuers would accept third-party grants.

70. In issuing an Interim Final Rule in December 2016 at the behest of the insurance industry, see 81 Fed. Reg. 90211-90229 (Dec. 14, 2016), a copy of which is attached as Exhibit 10, CMS made clear that it was not prohibiting funding by such organizations. The December 2016 Interim Final Rule noted that some issuers who have communicated with CMS "have confirmed" their unwillingness to "accept certain third party premiums" accept charitable support for ESRD subscribers (81 Fed. Reg. 90217), but simultaneously acknowledged that doing so may be unlawful. CMS underscored that the proposed rule did not obviate the need for issuers to comply with "the guaranteed availability and renewability requirements of the Public Health Service Act and the non-discrimination-related regulations issued pursuant to the Affordable Care Act," i.e., 45 C.F.R. §§ 147.104, 156.225, 156.805. Section 147.104, for example, prohibits discrimination by QHPs against individuals with significant health care needs. See 81 Fed. Reg. at 90220.

71. A Federal District Court enjoined the Interim Final Rule on January 25, 2017. See Dialysis Patient Citizens v. Burwell, 2017 WL 365271 (E.D. Tex. Jan. 25, 2017), a copy of which is attached as Exhibit 11. It remains enjoined today, as the government has not appealed from the preliminary injunction. In enjoining this insurance industry-driven Interim Rule, the District Court chastised CMS, inter alia, for disregarding the needs, interests and comments of vulnerable ESRD patients who would be deprived of medical care, and for unlawfully enacting this rule for the financial benefit of private insurers without the legally required prior public notice.

72. While the Interim Final Rule cited issuers' concerns about the effects of the risk pools of sicker patients able to buy coverage with charitable premium assistance, IBC neglected to advise its members that the rule mentioning those concerns was enjoined by a Federal Court.

IBC'S BREACH OF ITS INSURANCE POLICIES AND ANTI-CHARITY POLICY

73. Jane Doe 1 contracted with IBC for health insurance under IBC's Personal Choice® PPO coverage plan. Her current plan was renewed at the end of 2016 for a one-year term, and automatically renew subject to certain restrictions not relevant to this matter.

74. John Doe 2, Jane Doe 4 and John Doe 5 each contracted with IBC for a Medigap policy.

75. Many of DPC's members similarly have purchased Personal Choice® PPO policies (i.e., QHPs) from IBC on the individual Federal Exchange marketplace.

76. Many of DPC's members who are enrolled in Medicare have purchased Medigap policies from IBC to cover the substantial deductibles and co-payments that would otherwise be unaffordable for many DPC members.

77. As noted, CMS accepts AKF grants for Medicare Part B premiums. And even though no law or CMS policy prohibits third-party charitable grants for premiums for QHPs, IBC has forged ahead anyway and has sought to justify its refusal to accept AKF grants based on "concerns" recited in the preamble to the Interim Final Rule that was enjoined by the federal court, breaching its own contracts and a host of state and federal anti-discrimination laws in the process. Notwithstanding the 1997 Advisory Opinion and HHS's historic encouragement for ESRD patients to seek out the AKF for help, IBC posted on its website a document entitled "Direct and/or Indirect Third-party Payment of Member Premiums and Cost-Sharing Policy," which announced that, with limited exceptions not relevant here, IBC will not accept payments

made by non-profit organizations on behalf of low-income policyholders. See https://www.ibx.com/pdfs/individuals/member_resources/third_party_payment_policy.pdf. See also Exhibit 1; Exhibit 2; Exhibit 3.

78. IBC's on-line policy states that IBC only will accept third-party premium assistance from religious and non-profit organizations if, inter alia:

> The institution or organization does not have any direct or indirect financial interests. For illustrative purposes only: (i) a direct financial interest may exist if the third-party itself has a financial interest in the payment of health insurance claims; (ii) an indirect financial interest may exist, for example, if the third-party receives funding from other individuals or entities that have a financial interest in the payments of the health insurance claims; and (iii) in the case of a nonprofit foundation or other charitable entity (including without limitation a religious organization), a financial interest may exist if the entity receives a financial contribution from a health care provider or supplier.

See https://www.ibx.com/pdfs/individuals/member_resources/third_party_payment_policy.pdf. See also Exhibit 1; Exhibit 2; Exhibit 3.

79. On information and belief, this IBC policy was aimed principally at contributions from the AKF towards insurance coverage of ESRD patients, which, as memorialized in the OIG's Advisory Opinion, is known to receive contributions from kidney dialysis providers.

80. IBC also sent letters starting in January 2017 to the Individual Plaintiffs and other DPC members, notifying them that, as of March 1, 2017, "If you do not make payment directly, the funds will be returned, and your health plan will be subject to cancelation for nonpayment." See, e.g., Exhibit 6. IBC also specified that it "will not accept payments from certain third parties, including the American Kidney Fund." See Exhibit 6.

81. IBC's New Jersey company, "AmeriHealth," wrote a similar letter to the AKF, advising that its support for ESRD patients was "in violation of this policy and will no longer be accepted." See Exhibit 7.

82. Starting in January 2017, IBC also issued notices to individuals who had purchased Medicare supplemental Medigap coverage from IBC, stating that:

> **For premiums due on or after March 1, 2017, you must pay your Independence premium directly. We will not accept premium payments from certain third parties, including the American Kidney Fund.** If you do not make payment directly, the funds will be returned, and your health plan will be subject to cancelation for nonpayment.

See Exhibit 8 (bold in original).

83. More recently, in early April 2017, IBC issued new form letters to its Medigap policyholders with ESRD. IBC's "Updated Notice about Your Medigap Premium" states:

> **Independence has decided to suspend application of this policy to our Medigap members. We will continue to evaluate the application of our policy to Medigap plans and reserve the right to reinstate our policy to Medigap members in the future. For now, however, we will continue to accept premium payments from certain third parties, including the American Kidney Fund.** For impacted Medigap members whose premium payment is due on or before April 1, 2017, you will be given until May 1, 2017 to make your premium payment.

See Exhibit 9 (bold in original).

84. The Updated Notice acknowledges that subscribers were adversely "impacted" by IBC's refusal to accept premium payments from the AKF. See Exhibit 9. It also sowed confusion, and gave cold comfort to individuals depending on Medigap to limit their exposure to potentially unlimited Medicare deductibles and co-payments, by indicating that IBC had merely "suspend[ed]" (not rescinded) IBC's anti-charity policy for Medigap premiums, and "reserve[d] the right to reinstate" that policy in the future and without any advance notice. See Exhibit 9.

85. While IBC's recent policy targets support from the AKF, IBC does not refuse employer contributions for employee coverage, including when such contributions derive from non-profits in the healthcare sector.

86. Many healthcare providers, such as, for example, the Jefferson Health System, the Main Line Health System, and the University of Pennsylvania Health System are non-profit organizations that would be considered to have a "financial interest" in the payment of health insurance claims under a plain reading of IBC's posted policy. Similarly, charitable organizations like the United Way receive contributions from healthcare providers.

87. Yet IBC does not refuse to accept premium support for employees, or, on information and belief, from charities like United Way that are not affiliated with a particular, disabled class of policyholders. Instead, this treatment is reserved for vulnerable, low-income ESRD patients whose coverage IBC would prefer to eliminate or avoid.

88. IBC established and posted the on-line policy and sent letters to the Individual Plaintiffs indicating that AKF grants would be rejected after the open enrollment period for purchasing private coverage on the Exchange had ended. This greatly disadvantages those who purchased coverage with the reasonable assumption that they could rely on their AKF grants to help pay for their QHPs.

89. IBC similarly has disadvantaged individuals who enrolled in Medicare in reliance on their ability to purchase IBC Medigap policies that make it possible for them to afford coverage under Medicare.

90. The Pennsylvania Insurance Code requires that a policy term be approved by the Pennsylvania Department of Insurance (or "DOI") prior to its use. See 40 P.S. § 477b.

91. On information and belief, IBC never submitted changes to its insurance contracts encompassing IBC's anti-AKF policy with the DOI with respect to either QHP or Medigap policies. On information and belief, DOI has never approved such policy terms.

92. Pennsylvania Medigap regulations also prohibit cancelation or nonrenewal of

coverage for reasons other than "nonpayment of premium or material misrepresentation," and prohibits limitations on coverage that are more restrictive than Medicare (which, as noted, accepts AKF grants to pay for Medicare Part B coverage). See 31 Pa. Code §§ 89-774(a), 89.776(a).

93. Nevertheless, the Individual Plaintiffs and hundreds of DPC's members were notified by IBC that their insurance contracts would be terminated after March 31, 2017 if they continued to use AKF grant proceeds to help pay their premiums.

94. IBC has no contractual right to terminate the insurance contracts purchased by the Individual Plaintiffs or any other ESRD patient on whose behalf it has received premium payments from third parties, including, but not limited to, the AKF.

95. No provision in IBC's insurance contracts requires premiums to be paid by a particular entity, or prohibits premiums from being paid directly or indirectly by a particular person or entity.

96. IBC's refusal to accept payments because they were either made by or funded by a third-party, including the AKF, breaches IBC's insurance contracts with the Individual Plaintiffs and other health insurance policy holders whose interests are being represented by DPC.

97. The timing of IBC's actions also constitutes bad faith and unfair dealing, as notices were given after, not before, consumers had purchased coverage from IBC, with the terminations in many cases jeopardizing their ability to obtain replacement coverage.

98. As an example, one DPC member who is not named as an Individual Plaintiff initially made his premium payments for January, February, and March 2017 in a single check funded by an AKF grant. IBC returned the check and refused to cash it, without legal basis and

in violation of his insurance contract. When he contacted IBC regarding its conduct, he was told that IBC had a new policy of not accepting premiums funded by AKF grants.

99. This DPC member was wrongly forced to find another way to pay his costly premiums to IBC for January, February, and March, 2017. In order to avoid the loss of his life-sustaining ESRD treatment, he borrowed money from his son. When his son attempted to use his credit card to pay his father's health insurance bill, IBC refused to accept that payment, demanding, instead, that the patient's son wire money to his father's account so that his father could pay his insurance premiums out of his own account. This refusal independently violates this DPC member's contract with IBC.

100. IBC refused to accept a check from AKF that was sent to pay Jane Doe 1's premiums. Instead, IBC required the AKF to send a check to Jane Doe 1 so that she could convert that check into a money order and send the money order to IBC.

101. IBC also refused to accept a check from AKF for John Doe 2's premiums. As a result, John Doe 2 lost his Medigap insurance coverage for three months.

102. IBC also refused to cash premium checks the AKF sent IBC for Jane Doe 4 and John Doe 5. As a result, Jane Doe 4 and John Doe 5 were forced to find other ways to pay their premiums.

103. The form letters IBC sent to Individual Plaintiffs and other DPC members purport to blame "significant concerns [by CMS] with certain third party payments to health insurers" for IBC's own refusal to accept insurance grants from the AKF or similar charitable foundations. See, e.g., Exhibit 8.

104. IBC's claim that its abrupt decision to investigate the source of money that ESRD patients use to pay their premiums was "based on" concerns by CMS is false and misleading.

Instead, IBC's actual motivation was to avoid the high costs of providing coverage for ESRD and to "dump" expensive ESRD patients from its insurance programs.

105. CMS' principal "concerns" have centered on premium payments made directly by "hospitals, healthcare providers and other commercial entities."

106. In hiding behind CMS for its own unilateral actions, IBC failed to inform the Individual Plaintiffs and other insureds with ESRD that two operating divisions of HHS have expressly authorized and even encouraged the AKF's payment of premiums on behalf of low income dialysis patients, and HHS has never withdrawn that guidance.

107. IBC also omitted telling the Individual Plaintiffs and other DPC members that CMS has known about and declined to prohibit charitable premium payments for decades.

108. In prior notices and rules dating back to 2013, CMS purported to "discourage," while not purporting to prohibit, situations where "hospitals, health care providers or commercial entities" purchased QHPs for their own patients. CMS did not, however, purport to "discourage" – let alone prohibit – third-party charities such as the AKF from helping patients purchase QHP coverage, despite being urged by the insurance lobby to do so.

HARMS TO PATIENTS CAUSED BY IBC'S ANTI-CHARITY POLICIES

109. The dire consequences faced by ESRD patients whose premiums are rejected by QHP issuers have been catalogued by CMS based on review of 600 comments from kidney disease patients. See, e.g., 81 Fed. Reg. 90211, at 90217 (Dec. 14, 2016).

110. As CMS observed (id.):

> When payments are rejected [by insurers due to premium assistance], commenters noted that individuals are typically unable to continue their coverage because of the increased financial burden. Indeed, patients may not even realize for some period that their payments, which are being paid by third parties, are even being rejected and that there coverage will be terminated . . . HHS received 600 comments

> from ESRD patients . . . that describe the adverse impact on patients . . . if those funds no longer were available. Other patients who commented described significant and unexpected disruptions in coverage such as no longer being able to afford the high cost of prescriptions and office copays, delaying receiving dialysis treatment, or no longer being able to receive treatments . . . [of] life-sustaining . . . dialysis. (Emphasis added.)

111. ESRD patients are "not required to apply for and enroll in Medicare" but may choose to do so at their option. See 81 Fed. Reg. 90213. CMS observed, however, that while ESRD patients involuntarily terminated from their Exchange plans theoretically are able to enroll in Medicare, they often face enormous practical barriers to effectuating the switch.

112. CMS has noted, for example, that ESRD patients switching from private to Medicare coverage may incur a substantial "late enrollment penalty should they decide to enroll in [Medicare] Part B," and may also face higher cost-sharing for immunosuppressant drugs. See 81 Fed. Reg. at 90216.

113. CMS also has advised that patients who lose Exchange coverage due to a failure to pay premiums outside of the limited Medicare open enrollment period may lose all coverage until the next Medicare open enrollment period. See 81 Fed. Reg. at90221. CMS noted that for patients depending upon ESRD, a mid-year loss of coverage attributable to IBC's anti-charity support policy can be fatal.

114. Medicare coverage also may be less desirable than Exchange coverage, even for patients able to navigate a mid-year switch from a QHP to Medicare.

115. Medicare – unlike a QHP – will not cover the renal patient's family members. See 81 Fed. Reg. at 90215-16. Low income Medicare recipients who do not also qualify for Medicaid also face stiff co-insurance obligations compared with QHP coverage.

116. Patients enrolled in Medicare and who have had checks returned uncashed, or have been threatened by IBC's refusal to accept charitable premium support for Medigap

coverage, similarly are placed at great risk.

117. To the extent IBC already has refused AKF or similar funding for their Medigap coverage, and to the extent IBC unilaterally reinstates its currently "suspended" policy against AKF funding as it applies to Medigap policies, DPC members are subjected to unlimited exposure to Medicare cost-sharing that many cannot afford. Those unable to secure alternative funding can lose their treatments – with potentially fatal consequences – due to the inability to pay the patient's out-of-pocket share.

118. IBC's Updated Notice on Medigap funding also places ESRD patients who are "on the list" to receive a kidney transplant in harm's way. Approximately one-third of ESRD patients are "listed" for and awaiting a possible kidney transplant.

119. Due to high costs of care – including but not limited to immunosuppressant drug therapy – associated with kidney transplants, and consideration of financial ability to pay for care in assessing the likely medical compliance of a transplant candidate, many transplant centers require candidates to have secondary coverage as a condition of receiving a transplant.

120. Due to IBC's reservation of its claimed right to reinstate its anti-charity policy for Medigap plans, transplant centers may be leery about making kidney transplants available to individuals insured by IBC who rely on charitable support to pay for Medigap.

IBC'S LEGAL OBLIGATIONS TO COVER THOSE WITH PRE-EXISTING CONDITIONS UNDER FEDERAL LAW AND PENNSYLVANIA LAW

121. In addition to breaching its contracts with the Individual Plaintiffs and other DPC members, IBC is violating multiple provisions of the ACA.

122. First, subject to narrow exclusions not applicable here, the ACA requires insurers to issue a policy to anyone willing to pay for one, as long as the insurers are doing business in that market.

123. This "guaranteed coverage" is described as follows: "Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." See 42 U.S.C. § 300gg-1.

124. The ACA also required guaranteed renewals of coverage by issuers of QHPs, and, under 42 U.S.C. §§ 300gg-2(b), 300gg-42(b), may cancel a policy only for certain enumerated bases. These relevantly include a "failure to pay" or to "timely" pay premiums. See §§300gg-2(b)(1), 300gg-42(b)(1).

125. Neither the statute nor that implementing regulations permit a cancellation of coverage where a timely payment is made on behalf of a subscriber by a third-party.

126. On the contrary, by regulation, CMS has affirmatively obligated Issuers of QHP to accept payments in the form of "checks" or other methods based on the "preference" of the enrollee. See 45 C.F.R. § 156.1240. There is no "exception" for checks paid on an enrollee's behalf by a charitable organization.

127. The ACA also prohibits an insurer from excluding an individual from participating in an insurance program (or from discriminating against an individual) based on any grounds prohibited by Section 504 of the Rehabilitation Act of 1973. See 42 U.S.C. § 18116 (the "Anti-Discrimination Provision").

128. Section 504 of the Rehabilitation Act of 1973, in turn, prohibits discrimination based on disability. See 29 U.S.C. § 794. End stage renal failure which necessitates dialysis *is* a disability. See Fiscus v. Wal-Mart Stores, Inc., 385 F.3d 378, 385 (3d Cir. 2004).

129. By regulation, HHS has made clear that health insurers may no longer "impose any preexisting condition exclusion" (the "Preexisting Condition Provision") defined as "a

limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage." 45 C.F.R. §§ 147.108, 144.103.

130. Yet that is what IBC is doing through the guise of refusing to accept premium support from a charitable organization that provides financial assistance to kidney disease patients through a form of payment expressly authorized under 45 C.F.R. § 156.1240.

131. IBC is violating these ACA provisions and implementing regulations with respect to individuals suffering from ESRD.

132. IBC has refused to maintain or extend coverage to ESRD patients for unlawful reasons (i.e. because they have a disability that has led to an expensive to treat condition and because they are receiving premium assistance from a charity IBC does not like), even though these individuals have applied for and are entitled under the ACA to receive coverage as a matter of law.

133. IBC's refusal to accept premium support for ESRD patients seeking to purchase coverage from IBC also violates Pennsylvania law governing Health Plan Corporations (i.e., "Blue" plans).

134. Under the Pennsylvania Health Plan Corporations Act (the Blue Plans Act), a hospital services corporation operating as a non-profit, including IBC, is exempt from state and local taxation. See 40 Pa. C.S.A. § 6103(b). At the same time, such Blue Plans are required under the same statute to provide coverage to any member of the public who wishes to purchase coverage.

135. Indeed, the Pennsylvania Blue Plan Act expressly contemplates situations where:

> The subscriber or someone on his behalf shall pay the stated fee for professional health services in the case of given illness or injury [as a condition of] becoming entitled to treatment under the terms of the contract (emphasis added).

40 P.S.C.A. § 6326(3).

136. IBC's policy also runs afoul of Pennsylvania Insurance Department regulations relating to the sale of Medigap policies.

137. Among other things, state regulations provide that a Medigap issuer "may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation." 31 Pa. Code § 89.776(a)(1)(v)(B) (underline added).

138. IBC's policy violates this regulation by providing for cancellation of coverage despite the timely "payment" of premiums on behalf of DPC Members.

139. Under 31 Pa. Code §89.774(a), IBC may not condition the right to Medigap coverage on "limitations or exclusions . . . that are more restrictive than Medicare." IBC's policy against charitable support is, however, more restrictive than Medicare since the Medicare program accepts Part B payments from the AKF on behalf of ESRD patients.

IBC'S INVIDIOUS DISCRIMINATION AGAINST DISABLED END STAGE RENAL DISEASE PATIENTS

140. For many Americans with pre-existing disabilities, the ACA's Guaranteed Coverage, Anti-Discrimination Provisions and Community Rating provisions meant that they could finally gain viable access to the private insurance market, which is consistent with Congressional policy.

141. For IBC, however, the ACA was more nuanced. On the one hand, it created enormous opportunity for IBC by "requiring" all individuals to purchase insurance, greatly expanding IBC's potential market.

142. On the other hand, the ACA created new financial risk by enabling ESRD patients

and other costly patients IBC previously could have avoided directly or indirectly (through exorbitant fees) to purchase IBC's policies without "paying through the nose" for the privilege of obtaining commercial health coverage.

143. Quite predictably, after the ACA Exchanges became operational in 2014, individuals suffering from chronic medical conditions including ESRD began to enroll in substantial numbers in commercial insurance plans, including IBC's plans.

144. IBC has long known that many of the ESRD patients it enrolled had been receiving financial assistance to pay their premiums. IBC had openly accepted premium payments from the AKF for many years prior to 2014 on behalf of insureds who were first diagnosed with ESRD while covered by IBC policies.

145. IBC lost money on its Pennsylvania Exchange products in 2015 because it either underestimated its costs when it priced its policies or deliberately priced its policies below cost in order to gain market share.

146. IBC has the right under the ACA to withdraw completely from the Pennsylvania individual plan market. IBC did not, however, elect to withdraw from the individual market completely.

147. Instead, since IBC earns profits on the large majority of its insureds, it sought to improve the profitability of its QHPs by shedding or avoiding high-cost kidney disease patients.

148. In furtherance of that goal, IBC developed a discriminatory scheme to decrease the number of ESRD patients it insured: it stopped accepting money on behalf of disabled ESRD patients who could not pay their own premiums and relied on charitable assistance from the AKF.

149. It appears that the *only source* of premium payments IBC specifically targets in its

patient and provider communications by name is the "American Kidney Fund."

150. IBC knew from the AKF's very name, its website, its marketing materials, and IBC's years of experience knowingly accepting AKF premium payments, that the AKF is a narrowly-focused charity that provides premium assistance only to patients with ESRD – the very population IBC wants to rid itself of in order to increase its profits.

151. Thus, the AKF is a perfect "proxy" for the disability that IBC is targeting: if IBC can refuse to accept grants that poor patients use to buy coverage for ESRD treatment, then IBC can substantially reduce its costs and enhance its margins.

152. IBC attempted to mask its discriminatory conduct and intent by invoking supposed "concerns" of CMS regarding certain third-party premium payments. IBC's professed "concern" about the AKF is a pretext for its own discriminatory intent.

153. As set forth above, however, CMS has only "discouraged" (and not prohibited) QHP premium payments by hospitals, providers, and commercial entities who may receive higher fees from QHPs than they do from Medicare or Medicaid.

154. CMS has not "discouraged" let alone prohibited payments for commercial insurance coverage on behalf of low-income patients by § 501(c)(3) organizations, such as AKF. The AKF is not a provider and does not encourage or require a grantee to use any particular dialysis provider.

155. While referencing the "concerns" the insurance industry expressed to CMS that premium support for sicker patients could skew the "risk pool," IBC omitted telling its policyholders that the Interim Final Rule which referenced such concerns was immediately enjoined by the Texas Federal Court, and remains enjoined today. See Dialysis Patient Citizens v. Burwell, 2017 WL 365271 (E.D. Tex. Jan. 25, 2017).

156. Indeed, IBC's invocation of "federal concerns" about charity for premium support is undercut by the fact that Medicare itself accepts AKF grants for Part B coverage and by IBC's decision in April 2017 to "suspend" the application of the anti-charity policy as it applies to the supplemental Medicare policies sold by IBC.

157. Despite IBC's reference to the enjoined CMS Interim Final Rule, IBC never contacted the Individual Plaintiffs or (upon information and belief) any ESRD patient to inquire whether they had been improperly "steered" by the AKF to enroll in any particular type of insurance coverage.

158. IBC's shifting of blame to CMS is a pretext for seeking to avoid the costs of dialysis care by steering patients disabled with ESRD into the publicly-funded Medicare and Medicaid programs for its own financial benefit. This is further demonstrated by IBC's knowing acceptance of premium payments from AKF for many years, including payment on behalf of the Individual Plaintiffs, prior to the enactment of the ACA.

159. What has changed since the enactment of the ACA is that many more people with renal failure (and other expensive to treat illnesses) have become eligible for the first time and have sought to obtain private coverage for themselves and their families that formerly had been denied or discouraged due to costly medical conditions and disabilities.

160. Under the scheme adopted by Congress, ESRD patients have a choice to enroll in either private coverage or Medicare, or to purchase Medigap if they do enroll in Medicare, as a matter of legally protected, personal choice. For example, Jane Doe 1 made the choice to enroll in one of IBC's Exchange plans.

161. Facilitating the purchase of commercial coverage is in the public interest, since Congress has statutorily made private insurance "primary" to Medicare coverage for ESRD

patients, after having previously made Medicare coverage exclusive for qualifying ESRD patients.

162. It also is an extremely unusual practice – and one ripe for abuse – for any company, let alone a State-supported health insurer of last resort, to inquire about and attempt to regulate the source of the money customers might use to buy its products.

163. IBC is a clear outlier in the business community in adopting such an atypical practice, which is further evidence of its discriminatory motive.

164. On information and belief, IBC does not investigate the source of premium payments of all its insureds to make sure that premiums are not funded by family, friends, churches, employers, other charities, or any other conceivable licit or illicit source. Instead, IBC reserves this discriminatory treatment exclusively for individuals requiring treatment for ESRD.

165. IBC carried this offensive practice to an extreme by refusing to accept payment on behalf of at least one of its insureds from the insured's own son.

COUNT I – BREACH OF CONTRACT
INDIVIDUAL PLAINTIFFS v. IBC

166. Plaintiffs incorporate the allegations contained in paragraphs 1-165 above as if fully set forth herein.

167. The Individual Plaintiffs have health insurance contracts for 2017 with IBC that cover treatment for ESRD.

168. The Individual Plaintiffs pay (and have paid) their policy premiums using grant proceeds from the AKF.

169. The Individual Plaintiffs' insurance contracts do not permit IBC to refuse to accept premium payments funded by a particular source – particularly a lawful source such as a 501(c)(3) organization like the AKF.

170. IBC refused to accept the Individual Plaintiffs 2017 premium payments in the form of AKF grants, thereby breaching its insurance contract with the Individual Plaintiffs.

171. John Doe 2 actually lost his insurance for a period of time because of IBC's wrongful conduct.

172. IBC told the Individual Plaintiffs that if they did not pay their premiums without assistance from the AKF, their insurance would be terminated.

173. The Individual Plaintiffs contracts with IBC runs for a one-year term –subject to renewal – ending December 31, 2017.

174. IBC has no contractual right to terminate the Individual Plaintiffs' contracts, and no contractual right to refuse to accept premium payments funded by AKF grant proceeds.

175. IBC's breaches of contract have caused financial damage to the Individual Plaintiffs, in an amount to be proven at trial.

176. Jane Doe 1, John Doe 2 and Jane Doe 4 receive dialysis three times a week at a clinic. John Doe 5 receives peritoneal dialysis at his home daily. Absent this treatment, which they cannot afford without insurance coverage, they will die.

177. The Individual Plaintiffs will therefore suffer irreparable harm as a result of IBC's AKF Policy, are therefore entitled to an injunction prohibiting IBC from refusing to accept third-party premium assistance.

WHEREFORE, the Individual Plaintiffs respectfully request that judgment be entered in their favor, and against IBC and QCC Insurance Company in an amount to be proven at trial, and that IBC and QCC be enjoined from continuing to engage in their improper conduct, and further request that they be awarded interest, costs, attorneys' fees, and such other relief as the Court finds to be just and equitable.

COUNT II – BREACH OF CONTRACT – DECLARATORY JUDGMENT
DPC AND THE INDIVIDUAL PLAINTIFFS v. IBC

178. Plaintiffs incorporate the allegations contained in paragraphs 1-179 above as if fully set forth herein.

179. The Individual Plaintiffs have health insurance contracts for 2017 with IBC that cover treatment for their ESRD and other medical services.

180. Hundreds of DPC's members have health insurance contracts for 2017 with IBC that cover treatment for their ESRD and for other covered medical services.

181. These contracts run for a one year term, most of which extend through December 31, 2017. Under the ACA, individuals enrolled in QHPs purchased through the Exchange also are legally entitled to guaranteed renewals of their QHP coverage (or comparable coverage).

182. Individual Plaintiffs pay (and have paid) their policy premiums using grant proceeds from the AKF.

183. Hundreds of DPC's members pay their policy premiums using grant proceeds from the AKF.

184. IBC's insurance contracts for the Individual Plaintiffs and DPC members do not limit the source of premium payments by Pennsylvania citizens, nor permit IBC to refuse premium payments from a particular source, including the AKF.

185. IBC has told the Individual Plaintiffs and hundreds of DPC's members that, as of March 1, 2017, it is refusing to accept premium payments funded by AKF grant proceeds, thereby repudiating and anticipatorily breaching its contracts.

186. Despite the fact that the Individual Plaintiffs' contracts and the contracts of hundreds of DPC's members with IBC run for a one-year term ending December 31, 2017 – subject to automatic renewal under law – IBC has instructed the Individual Plaintiffs and

hundreds of DPC's members that IBC is unilaterally terminating their insurance coverage as of April 1, 2017.

187. IBC has been absolute and unequivocal in its refusal to perform its contractual obligations to the Individual Plaintiffs and hundreds of DPC's members beginning April 1, 2017.

188. The Individual Plaintiffs and hundreds of DPC's members rely on IBC insurance to pay for dialysis several times a week.

189. Without dialysis, the Individual Plaintiffs and hundreds of DPC's members are placed at risk of losing health insurance coverage and access to life sustaining dialysis, as graphically explained by CMS.

190. The Individual Plaintiffs and DPC are entitled to a declaratory judgment that IBC's prospective refusal to accept third-party premium assistance breaches IBC's contracts.

191. The Individual Plaintiffs and DPC are entitled to an injunction prohibiting IBC from refusing to accept third-party premium assistance.

WHEREFORE, DPC and the Individual Plaintiffs respectfully request that judgment be entered in their favor, and against IBC and QCC Insurance Company, and that the Court declare that IBC and QCC are contractually bound to provide coverage in exchange for paid premiums, regardless of whether the premiums are funded by AKF, and that DPC and the Individual Plaintiffs, further, be awarded costs, attorneys' fees, and such other relief as the Court finds to be just and equitable.

COUNT III –VIOLATION OF ACA GUARANTEED ISSUANCE, RENEWABILITY AND TERMINATION REQUIREMENTS

192. Plaintiffs incorporate the allegations contained in paragraphs 1-191 above as if fully set forth herein.

193. The ACA amended the Public Health Service Act to require QHP issuers to

guarantee coverage of willing purchasers of individual coverage for qualified individual (also referred to as "guaranteed issue") through State or Federal Exchanges. See ACA § 1302, 42 U.S.C. § 300gg-4. See also 45 C.F.R. § 147.102.

194. For those with QHPs purchased through the Exchange, the ACA amended the Public Health Service Act to require guaranteed renewals of the same or comparable coverage at the conclusion of the coverage period. See 42 U.S.C. 300gg-2. See also 45 C.F.R. § 147.106.

195. The ACA also amended the Public Health Service Act to require that issuers continue coverage in force and effect at the option of the policyholder and to strictly enumerate and limit the circumstances under which existing coverage may be cancelled. See 42 U.S.C. §§ 300gg-2(a), 300gg-42(a). See also 45 C.F.R. §§ 155.430, 156.270.

196. The ACA relevantly permits discontinuation (termination) of coverage for such things as "fraud," moving out-of-the area, and "nonpayment of premiums or contributions." The latter is defined as a "failure to pay" or to "timely" pay premiums or premium contributions "in accordance with the terms of the health insurance coverage." 42 U.S.C. §§ 300gg-2(b)(1)(2), 300gg-42(b)(1)(2). See also 45 C.F.R. §§ 155.430(b)(2), 147.106(b).

197. The exclusive statutory grounds for discontinuing coverage do not permit termination based on timely payments of the requisite premiums on behalf of the subscriber by a third-party charity.

198. 42 U.S.C. § 300gg-2(a) and 42 U.S.C. § 300gg-42(b) both contain rights conferring language by specifying that unless a discontinuance of coverage is for a reason "as provided in this section" an "individual" has the right to require the issuer to "continue in force for such coverage at the option of the individual." In contrast, there is no enforcement scheme or other provision of law that reflects congressional intent to preclude a private right of action.

199. Individual Plaintiffs and other DPC members who reside in Pennsylvania are eligible to purchase QHPs, as confirmed by the fact that such individuals acquired QHP coverage before IBC threatened to terminate coverage absent direct payment using the members' personal funds.

200. Premiums or contributions were paid by the AKF for QHP coverage on behalf of Individual Plaintiffs and other DPC members in the requisite amounts required under their health insurance coverage.

201. IBC's discontinuation of QHP coverage for Individual Plaintiffs and other DPC members who use AKF grants to pay for such coverage violates their rights to guaranteed coverage and the continuation of their health insurance coverage in violation of the ACA.

202. In its implementing rules concerning the form of payment, CMS has specified that, "[a]t a minimum," QHP issuers

> In the individual market, [must] accept paper checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their referred payment method.

45 C.F.R. § 156.1240. This regulation both facially covers AKF payments for qualified individuals, and evidences federal intent that payment method options are to be applied expansively, not preclusively.

203. The ACA's restrictions on circumstances in which individual coverage may be terminated are designed to protect the rights of individual policy-holders, and there is no congressional evidence of an intent to preclude private enforcement of these provisions of the ACA.

204. IBC's refusal to maintain or extend coverage when a check or other prescribed form of payment is presented on behalf of Individual Plaintiffs or other DPC members violates

the ACA and federal implementing regulations.

WHEREFORE, DPC and the Individual Plaintiffs respectfully request that judgment be entered in their favor, and against IBC and QCC Insurance Company, and that the Court declare that IBC and QCC are contractually bound to provide coverage in exchange for paid premiums, regardless of whether the premiums are funded by AKF, and that DPC and the Individual Plaintiffs, further, be awarded costs, attorneys' fees, and such other relief as the Court finds to be just and equitable.

COUNT IV – VIOLATION OF SECTION 1557 OF THE AFFORDABLE CARE ACT, 42 U.S.C. § 18116, INTENTIONAL DISCRIMINATION ALL PLAINTIFFS v. IBC

205. Plaintiffs incorporate the allegations contained in paragraphs 1-204 above as if fully set forth herein.

206. IBC widely accepts premium support and contributions towards coverage for non-ESRD patients including, for example, in the form of contributions from employers who sponsor ERISA plans. IBC also broadly accepts premium subsidies from the IRS for about 84% of all persons who purchase QHPs through the Exchange.

207. On information and belief, IBC also accepts premium support and contributions towards coverage for non-ESRD patients in the form of contributions from charities and foundations other than the AKF.

208. IBC is, however, targeting premium and cost-sharing support for ESRD patients as a means of intentionally discriminating against and "dumping" expensive patients with ESRD based on their medical condition.

209. IBC's actions violate Section 1557 of the ACA, 42 U.S.C. § 18116, and related regulations. Section 1557 provides in relevant part:

> Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited by . . . section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance. . . The enforcement mechanisms provided for and available under such . . . section 504 . . . shall apply for purposes of violations of this subsection.

42 U.S.C. § 18116 (emphasis added).

210. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, prohibits discrimination based upon disability. A "disability" under section 504 is "a physical or mental impairment that substantially limits one or more major life activities." 29 U.S.C. § 794(a); 29 U.S.C. § 705(20)(B); 42 U.S.C. § 12102(1)(A).

211. The Individual Plaintiffs and hundreds of DPC's members each suffer from ESRD. That disease substantially limits major life activities and constitutes a disability. ESRD prevents the natural ability to eliminate bodily waste. Processing and eliminating waste from the blood qualifies as a major life activity because, in its absence, death results. ESRD also substantially limits one's ability to work – which is also a major life activity – in light of the length and frequency of dialysis sessions, and their impact on a patient's energy and schedule.

212. ESRD has been held to be a disability in the Third Circuit. See, e.g., Fiscus v. Wal-Mart Stores, Inc., 385 F.3d 378, 385 (3d Cir. 2004).

213. IBC is, and its insurance policies are, a "health program or activity, any part of which is receiving Federal financial assistance" under 42 U.S.C. § 18116.

214. The insurance plans at issue are covered "health programs" under 45 C.F.R. 92.4.

215. IBC receives federal financial assistance. Among other things, IBC offers federally-subsidized plans on marketplace Exchanges, and sells Medicare Advantage plans

issued under Medicare Part C and Part D for which it is federally reimbursed. See also https://www.opm.gov/our-inspector-general/reports/2014/audit-of-independence-blue-cross-philadelphia-pennsylvania-1a-10-55-14-027.pdf.

216. Jane Doe 1 and hundreds of DPC's members purchased their plans from IBC on the Federal Exchange. IBC receives tax credits to pay for all or part of the premiums for approximately 84% of QHPs purchased through the Exchange.

217. IBC is intentionally discriminating against the Individual Plaintiffs and hundreds of DPC's members based solely on their ESRD disability in violation of 42 U.S.C. § 18116, 29 U.S.C. § 794 and 45 C.F.R. 92.207.

218. IBC's intentional discrimination against those disabled by ESRD is exacerbated by the fact that ESRD disproportionately strikes the African-American community. See http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0048407; https://www.usrds.org/2010/pdf/v2_02.pdf?zoom_highlight=disparities#search=%22disparities%22.

219. Federal regulations provide that an issuer shall not:

> Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability.

45 C.F.R. 92.207(1) (emphasis added).

220. Despite its pretext of CMS concerns, IBC is unilaterally cancelling, or threatening abruptly to cancel the insurance coverage of the Individual Plaintiffs and hundreds of DPC's members on the basis of their disability.

221. IBC's policies also impose additional costs and other burdens on the Individual Plaintiffs and hundreds of other vulnerable DPC members. Among other things, the deprivation

of coverage will cause these individuals and their families to lose health coverage for co-morbidities of ESRD and all other related and unrelated covered medical services.

222. Individual Plaintiffs and hundreds of DPC's members, unlike many other IBC plan subscribers, have been limited by IBC as to the resources they can use to make premium payments, on the basis of their disability and the cost of covering their medical care.

223. 42 U.S.C. § 300gg-4 provides that "a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on . . . (1) Health status; (2) Medical condition (including both physical and mental illnesses); (3) Claims experience; (4) Receipt of health care; (5) Medical history. . .; (8) Disability."

224. IBC violated this provision by establishing rules of eligibility based on medical history (receipt of dialysis) and disability (ESRD).

225. Individual Plaintiffs and hundreds of DPC's members have been injured by IBC's violations of 42 U.S.C. § 18116 and the implementing regulations cited above.

226. IBC's unlawful discrimination will irreparably harm the Individual Plaintiffs and hundreds of DPC's members because they will not be able to pay for necessary medical care, without which they will be placed at risk of death and their family members will be deprived of health insurance coverage.

227. Individual Plaintiffs and hundreds of DPC's members have no adequate remedy at law for IBC's violation of their rights.

228. Declaratory and injunctive relief are required to delineate the rights of the Individual Plaintiffs' and hundreds of DPC's members under 42 U.S.C. § 18116 and related statutes and regulations, to remedy IBC's violation of 42 U.S.C. § 18116, and to secure IBC's

compliance with the anti-discrimination provisions of the ACA and related regulations.

WHEREFORE, DPC and the Individual Plaintiffs respectfully request that judgment be entered in their favor and against IBC and QCC Insurance Company in an amount to be proven at trial, that IBC and QCC be enjoined from continuing to engage in their improper conduct, and that DPC and the Individual Plaintiffs be awarded interest, costs, attorneys' fees, and such other relief as the Court finds to be just and equitable.

COUNT V - VIOLATION OF SECTION 1557 OF THE AFFORDABLE CARE ACT, 42 U.S.C. § 18116, DISPARATE IMPACT ALL PLAINTIFFS v. IBC

229. Plaintiffs incorporate the allegations contained in paragraphs 1-228 above as if fully set forth herein.

230. IBC's refusal to accept premium payments from the AKF is unlawfully discriminatory, even if IBC did not act with discriminatory intent, because it has a disparate impact on individuals disabled by ESRD.

231. AKF grants are awarded only to individuals with ESRD, meaning 100% of those impacted by IBC's policy are "disabled" under the law of this Circuit.

232. Conversely, IBC's newly announced charitable support policy has no impact on individuals who are not disabled.

233. As a result of IBC's policy, the Individual Plaintiffs and hundreds of DPC's members are being and will be denied meaningful access to, excluded from participation in, and denied the benefits of a health program in violation of 42 U.S.C. § 18116 and federal implementing regulations.

234. The disparate impact of IBC's discrimination against those disabled by ESRD is exacerbated by the fact that ESRD disproportionately strikes the African-American community. See http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0048407;

https://www.usrds.org/2010/pdf/v2_02.pdf?zoom_highlight=disparities#search=%22disparities%22.

235. IBC should be ordered to maintain the status quo ante and continue to accept AKF grants on behalf of ESRD patients, as IBC has for many years. This is a "reasonable accommodation" under IBC's insurance programs, and will allow the Individual Plaintiffs and hundreds of DPC's members' meaningful access to IBC's health insurance.

236. Plaintiffs have been aggrieved by IBC's violation of 42 U.S.C. § 18116 and have no adequate remedy at law for the IBC's violation of their rights.

237. IBC's unlawful discrimination will irreparably harm the Individual Plaintiffs and hundreds of DPC's members because they will not be able to pay for necessary medical care, without which they will die.

238. Declaratory and injunctive relief are required to delineate Plaintiffs' rights under 42 U.S.C. § 18116 and related statutes and regulations, to remedy IBC's violation of 42 U.S.C. § 18116, and to secure IBC's compliance with the anti-discrimination provisions of the ACA and related regulations.

WHEREFORE, DPC and the Individual Plaintiffs respectfully request that judgment be entered in their favor, and against IBC and QCC Insurance Company in an amount to be proven at trial, and that IBC and QCC be enjoined from continuing to refuse charitable support for ESRD patients from the AKF or other third-party charities, and that DPC and the Individual Plaintiffs be awarded interest, costs, attorneys' fees, and such other relief as the Court finds to be just and equitable.

COUNT VI – VIOLATION OF THE PENNSYLVANIA UNFAIR TRADE PRACTICES ACT AND PENNSYLVANIA'S CONSUMER PROTECTION LAW
ALL PLAINTIFFS v. IBC

239. Plaintiffs incorporate the allegations contained in paragraphs 1-238 above as if

fully set forth herein.

240. Pennsylvania's Consumer Protection Law declares unlawful "unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce," 73 P.S. § 201-3, including both certain specifically enumerated practices and "any other fraudulent or deceptive conduct which creates a likelihood of confusion or of misunderstanding." 73 P.S. § 201-2(4)(xxi).

241. Violations of other Pennsylvania statutes and regulations are actionable under the Consumer Protection Law.

242. The Pennsylvania Unfair Insurance Practices Act, 40 P.S. § 1171.1 et seq., deems certain enumerated practices in the insurance industry to be unfair or deceptive. These include:

> Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

40 P.S. § 1171.1(a)(7) (emphasis supplied).

243. IBC's refusal to accept payment on behalf of low-income dialysis patients while accepting the same amount of payment by higher-income dialysis patients constitutes both discrimination in a "term[] or condition" of the policy and discrimination "in any other manner whatever" within the meaning of 40 P.S. § 1171.1(a)(7). It is therefore an unfair or deceptive practice violative of the Unfair Insurance Practices Act.

244. Through 31 Pa. Code §§ 89.776, 89.790 and other regulations, the Pennsylvania Insurance Department regulates Medicare Supplemental Insurance, or Medigap plans, through its administration of the Commonwealth's insurance laws and regulation of the insurance industry.

245. 31 Pa. Code § 89.776(1)(v)(B) provides that the issuer of a Medicare supplement

policy "may not cancel or renew the policy for a reason other than non-payment of premium or material misrepresentation."

246. 31 Pa. Code § 89.790 provides that an issuer of a Medicare supplement policy may not "[d]eny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (e) that is offered and is available for issuance to new enrollees by the issuer," "[d]iscriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care or medical condition," or "[i]mpose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy."

247. IBC's refusal to accept premium payments on behalf of low-income dialysis patients while accepting payment by higher-income dialysis patients violates Pennsylvania's insurance law and is therefore a violation of the Consumer Protection Law and the Unfair Insurance Practices Act.

248. IBC's discrimination under the Unfair Insurance Practices Act is also a violation of the Consumer Protection Law, since both the Consumer Protection Law and the Unfair Insurance Practices Act prohibit "unfair methods of competition and unfair or deceptive acts or practices," and such methods and acts or practices occurring in the insurance industry violate the Consumer Protection Law as well as the Unfair Insurance Practices Act. See Pekular v. Eich, 355 Pa. Super. 276, 286-87 (1986).

249. Plaintiffs are entitled to injunctive relief to enforce their rights under the Unfair Insurance Practices Act and the Consumer Protection Law.

WHEREFORE, DPC and the Individual Plaintiffs respectfully request that judgment be entered in their favor and against IBC and QCC Insurance Company in an amount to be proven at trial, and further request that IBC and QCC be enjoined from refusing to accept

charitable premium support from the AKF and other third party charities and foundations, and that DPC and the Individual Plaintiffs be awarded interest, costs, attorneys' fees, and such other relief as the Court finds to be just and equitable.

COUNT VII – IBC'S VIOLATION OF THE PENNSYLVANIA HEALTH PLAN CORPORATION ACT
ALL PLAINTIFFS v. IBC

250. Plaintiffs incorporate the allegations contained in paragraphs 1-249 above as if fully set forth herein.

251. As a non-profit "Blue" plan, IBC is subject to the Pennsylvania Health Plan Corporations Act (also commonly known as the Blue Plans Act), 40 P.S. §§6101 et seq., 6301, et seq., which, in turn, subjects IBC to the Health Care Insurance Individual Accessibility Act, 40 P.S. 981-1, et seq. See 40 P.S. § 981-3.

252. As a non-profit Blue Plan, IBC is subject to benefits and burdens under state law.

253. The benefits realized by IBC as a non-profit Blue plan include an exemption from state and local taxes. See 40 Pa. C.S. §§ 6103(b), 6307(b).

254. The burdens of this status include serving as an "insurer of last resort," subject to the requirement to provide coverage to any citizen of Pennsylvania in exchange for payment for such coverage. See 40 P.S. §§ 981-3, 981-4; Ciamaichelo v. Independence Blue Cross, 589 Pa. 415 (2006).

255. IBC's obligation to make coverage available to any Pennsylvania citizen who wishes to purchase coverage is not conditioned on that persons paying for coverage with his or her personal assets, nor does the Blue Plans Act entitle IBC to refuse premiums from a § 501(c)(3) organization, including but not limited to the AKF, that volunteers to purchase coverage for a Pennsylvania citizen.

256. On the contrary, it is a Pennsylvania legislative policy that "adequate professional

health services," which include renal dialysis are "essential" and should be provided under the Blue Plans Act, "to persons of low income who are unable to purchase such services for themselves." 40 Pa. C.S. § 6303.

257. Rather than authorizing Blue plans to refuse premium support on behalf of low income citizens, the legislature has specifically endorsed, as a contractual condition of coverage, payment of the stated fee or fees for professional services by "the subscriber or someone on his behalf." 40 Pa. C.S. § 6326(3).

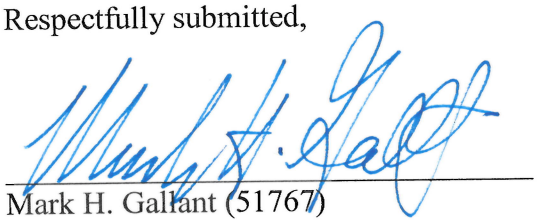
258. IBC's statutory obligation to provide coverage to willing purchasers is intended especially for the benefit of Plaintiffs and other Pennsylvania citizens that choose to purchase coverage from IBC at rates authorized or approved by the Department of Insurance.

259. Plaintiffs' are entitled to enforce the provisions of the Blue Plans Act entitling them to purchase coverage from IBC under the test set forth in Schappell v. Motorists Mut. Ins. Co., 594 Pa. 94, 103, 934 A.2d 1184, 1189 (2007). See also Doe v. Franklin Cty., 139 A.3d 296, 311 (Pa. Commw. Ct. 2016).

WHEREFORE, DPC and the Individual Plaintiffs respectfully request that judgment be entered in their favor and against IBC and QCC Insurance Company in an amount to be proven at trial, that IBC and QCC be enjoined from continuing to engage in their improper conduct, and that DPC and the Individual Plaintiffs be awarded interest, costs, attorneys' fees,

and such other relief as the Court finds to be just and equitable.

Respectfully submitted,



Dated: May 12, 2017

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VERIFICATION

I, Hrant Jamgochian, chief executive officer of Dialysis Patent Citizens, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing complaint is true and correct, to the best of my knowledge, information and belief.

Executed on May 12, 2017.

Hrant Jamgochian