SHEPPARD, MULLIN, RICHTER & HAMPTON LLP
A Limited Liability Partnership
Including Professional Corporations
STEVEN G. SCHORTGEN (pro hac vice to be filed)
JENNIFER K. AYERS (pro hac vice to be filed)
2200 Ross Avenue, Suite 2400
Dallas, Texas 75201
Telephone: 469.391.7400
E mail sschortgen@sheppardmullin.com
jayers@sheppardmullin.com

LAURA L. CHAPMAN, Cal. Bar No. 167249
DANIEL R. FONG, Cal. Bar No. 311985
Four Embarcadero Center, 17th Floor
San Francisco, California 94111-4109
Telephone: 415.434.9100
Facsimile: 415.434.3947
Email: lchapman@sheppardmullin.com
Email: dfong@sheppardmullin.com

Attorneys for Defendant/Counterclaimant
HealthPlan Services, Inc.

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

CALIFORNIA PHYSICIANS' SERVICE, INC., D/B/A BLUE SHIELD OF CALIFORNIA, a California nonprofit mutual corporation,

Plaintiff,

v.

HEALTHPLAN SERVICES, INC., a Florida corporation, HPH HOLDINGS CORPORATION, a Delaware corporation, HPH-TH HOLDINGS, INC., a Delaware corporation, HEALTHPLAN HOLDINGS, INC., a Delaware corporation, and JOHN DOE 1 THROUGH 10, whose true names are unknown, inclusive,,

Defendant.

HEALTHPLAN SERVICES, INC.,

Counterclaimant,

Case No. 3:18-cv-3730

DEFENDANT HEALTHPLAN SERVICES, INC.'S PARTIAL ANSWER AND COUNTERCLAIMS

DEMAND FOR JURY TRIAL

Judge: The Hon. James Donato

v.

CALIFORNIA PHYSICIANS' SERVICE, INC., D/B/A BLUE SHIELD OF CALIFORNIA,

Counter-Defendant.

Defendant HealthPlan Services, Inc. ("HPS") hereby partially answers the Complaint[1] of Plaintiff California Physicians' Service, Inc. ("Blue Shield") as follows:

PRELIMINARY STATEMENT

1. Answering paragraph 1 of the Complaint, HPS admits that this purports to be an action regarding a breach of the Business Process Outsourcing Agreement ("BPOA"). Except as so admitted, HPS denies the remaining allegations.

2. Answering paragraph 2 of the Complaint, HPS admits it was hired by Blue Shield to, among other things, perform tasks for Blue Shield's health plan subscribers related to account management and billing. Except as so admitted, HPS denies the remaining allegations.

3. Answering paragraph 3 of the Complaint, HPS denies the allegations.

4. Answering paragraph 4 of the Complaint, HPS lacks sufficient knowledge or information to form a belief as to the truth regarding Blue Shield's alleged actions, and denies the remaining allegations.

5. Answering paragraph 5 of the Complaint, HPS admits that this purports to be an action regarding an alleged breach of the Business Process Outsourcing Agreement ("BPOA") but denies the remaining allegations.

THE PARTIES

6. Answering paragraph 6 of the Complaint, HPS lacks sufficient knowledge or information to form a belief as to the truth of the allegations and on that basis denies them.

7. Answering paragraph 7 of the Complaint, HPS admits the allegations.

8. Answering paragraph 8 of the Complaint, HPS denies the allegations as to HPH Holdings Corp. and HealthPlan Holdings, Inc. because those two entities no longer exist. HPS lacks sufficient knowledge and information to form a belief as to the truth of the remaining allegations and on that basis denies them.

9. Answering paragraph 9 of the Complaint, HPS lacks sufficient knowledge or information to form a belief as to the truth of the allegations and on that basis denies them.

[1] Plaintiff's remaining claims are subject to HPS's previously filed Motion to Dismiss.

JURISDICTION AND VENUE

10. Answering paragraph 10 of the Complaint, HPS admits that this Court has subject matter jurisdiction over this action as currently pled but denies that Blue Shield is entitled to any damages or other relief.

11. Answering paragraph 11 of the Complaint, HPS admits that venue is proper in this District.

FACTUAL BACKGROUND

12. Answering paragraph 12 of the Complaint, HPS generally admits that Covered California was a marketplace where health insurance plans were sold, but lacks sufficient knowledge or information to form a belief as to the truth of the remaining allegations and on that basis denies them.

13. Answering paragraph 13 of the Complaint, HPS admits the allegations.

14. Answering paragraph 14 of the Complaint, HPS lacks sufficient knowledge or information to form a belief as to the truth regarding Blue Shield's expectations and on that basis denies them, but admits the remaining allegations.

15. Answering paragraph 15 of the Complaint, HPS lacks sufficient knowledge or information to form a belief as to the truth regarding what Blue Shield foresaw as the future of the Covered California market and on that basis denies the first sentence. HPS lacks sufficient knowledge or information to form a belief as to the truth regarding the fourth sentence of paragraph 15 and on that basis denies it. HPS admits the remaining allegations.

16. Answering paragraph 16 of the Complaint, HPS denies the insinuation that HPS lacked the skills, experience, and personnel to manage Blue Shield's new customers. HPS admits that it eventually entered into a written agreement with Blue Shield. HPS also lacks sufficient knowledge or information to form a belief as to the truth regarding Blue Shield's decision-making process regarding hiring HPS and on that basis denies them and the remaining allegations.

17. Answering paragraph 17 of the Complaint, HPS admits that the BPOA contained a number of services for which HPS agreed to perform, but denies the remaining allegations.

18. Answering paragraph 18 of the Complaint, HPS denies the insinuation that HPS misrepresented its ability to perform the tasks in the BPOA or that HPS failed to meet its commitments but admits that the BPOA contains the language quoted.

19. Answering paragraph 19 of the Complaint, HPS denies the allegations.

20. Answering paragraph 20 of the Complaint, HPS denies the allegations.

21. Answering paragraph 21 of the Complaint, HPS denies the allegations.

22. Answering the first sentence of paragraph 22 of the Complaint, HPS denies the allegations. As to paragraph 22a, HPS generally admits that HPS has issued adjustments to Blue Shield customers' data, but denies the remaining allegations. As to paragraph 22b, HPS denies the allegations. As to paragraph 22c, HPS lacks sufficient knowledge and information to form a belief as to the truth of those allegations and on that basis denies them. As to paragraph 22d, HPS admits that email applications would have been rejected by HPS due to such method's non-compliance with PCI Security Standards, a standard required by Blue Shield. HPS denies the remaining allegations, including any insinuation that Blue Shield's submission of paper applications were due to any failure by HPS. As to paragraph 22e, HPS denies the allegations. As to paragraph 22f, HPS denies the allegations. As to paragraph 22g, HPS denies the allegations. HPS denies any remaining allegation in paragraph 22 save those expressly admitted.

23. Answering paragraph 23 of the Complaint, HPS lacks sufficient knowledge or information to form a belief as to the truth regarding Blue Shield's conclusions and on that basis denies them, and denies all remaining allegations.

24. Answering paragraph 24 of the Complaint, HPS admits that Blue Shield extended the BPOA from December 31, 2016 through 2017 and that Blue Shield initiated a termination of the BPOA allegedly for cause on April 28, 2017. HPS also admits that the BPOA requires HPS to assist Blue Shield post-termination with disengagement assistance, subject to the limitations set forth in the parties' contract. HPS also admits that Blue Shield's Complaint purports to seek damages. HPS denies the remaining allegations.

/ / /

/ / /

FIRST CLAIM FOR RELIEF

(Breach of Contract)

25. HPS restates and incorporate by reference each of its responses to all of the foregoing allegations as if fully set forth herein.

26. Answering paragraph 26 of the Complaint, HPS admits that Blue Shield and HPS entered into a valid contract.

27. Answering paragraph 27 of the Complaint, HPS denies the allegations.

28. Answering paragraph 28 of the Complaint, HPS denies the allegations.

29. Answering paragraph 29 of the Complaint, HPS denies the allegations.

PRAYER FOR RELIEF

30. In response to Blue Shield's Prayer for Relief, HPS denies that Blue Shield is entitled to any relief from HPS and denies the allegations contained in paragraphs (1)-(5) of the Complaints' Prayer for Relief. Finally, HPS denies each and every allegation in the Complaint regarding the breach of contract cause of action to which it has not specifically admitted, denied, or otherwise responded to in its Answer.

AFFIRMATIVE AND OTHER DEFENSES

FIRST AFFIRMATIVE DEFENSE

(Failure to State a Claim)

31. Blue Shield's cause of action fails to state a claim for which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

(Assumption of Risk)

32. HPS repeats and realleges its factual assertions set forth above.

33. Blue Shield knowingly assumed the risks associated with working with a potentially flawed system such as Covered California and the risks associated with not aligning its own FACETS system and data with commercial standards.

THIRD AFFIRMATIVE DEFENSE

(Failure to Mitigate)

34. HPS repeats and realleges its factual assertions set forth above.

35. Blue Shield's damages were sustained, in whole or in part, by Blue Shield's failure to correct its data transmission methods and business processes despite knowing the consequences of not doing so.

FOURTH AFFIRMATIVE DEFENSE

(Laches and Statutes of Limitations)

36. HPS repeats and realleges its factual assertions set forth above.

37. Blue Shield's cause of action is barred by the doctrine of laches and the statute of limitations.

FIFTH AFFIRMATIVE DEFENSE

(Prevention of Performance)

38. HPS repeats and realleges its factual assertions set forth above.

39. Blue Shield's damages were sustained in whole or in part by the failure of Blue Shield to timely provide accurate data to HPS such that HPS could in turn timely update its own database.

40. Blue Shield's damages were sustained in whole or in part by express requests from Blue Shield to perform the very acts about which Blue Shield now complains.

SIXTH AFFIRMATIVE DEFENSE

(Duplicative Claims)

41. HPS repeats and realleges its factual assertions set forth above.

42. Here, Blue Shield seeks recovery for a breach of contract claim that is duplicative of its breach of the implied covenant of good faith and fair dealing, which is not permitted under California law.

SEVENTH AFFIRMATIVE DEFENSE

(Lack of Capacity)

43. HPS repeats and realleges its factual assertions set forth above.

44. Under Delaware law, merged entities lack the capacity to be sued post-merger.

45. Defendants HealthPlan Holdings, Inc. and HPH Holdings, Corp. both merged with HPS prior to the filing of the Complaint.

EIGHTH AFFIRMATIVE DEFENSE

(Breach of Contract by Plaintiff)

46. HPS repeats and realleges its factual assertions set forth above.

47. Blue Shield's cause of action is barred due to its own failure to perform some or all of the conditions precedent to further obligations by HPS and/or by its prior material breach of contract.

48. See Counterclaim below.

NINTH AFFIRMATIVE DEFENSE

(No Causation)

49. HPS repeats and realleges its factual assertions set forth above.

50. Blue Shield's cause of action is barred due to the failure of Blue Shield to demonstrate that any incurred damages were caused by HPS's conduct, as opposed to Blue Shield's own acts and omissions, including, but not limited to, as set forth herein in HPS's Counterclaim.

TENTH AFFIRMATIVE DEFENSE

(Frustration of Purpose)

51. HPS repeats and realleges its factual assertions set forth above.

52. Blue Shield's cause of action is barred due to Blue Shield's and Covered California's actions which frustrated the purpose for which Blue Shield entered into the BPOA and frustrated HPS's performance thereunder.

ELEVENTH AFFIRMATIVE DEFENSE

(Estoppel)

53. HPS repeats and realleges its factual assertions set forth above.

54. Blue Shield's cause of action is barred, in whole or in part, by the doctrine of estoppel, which bars recovery when a party, by its language or conduct, leads another to do what he would not otherwise have done.

55. Blue Shield, by its language and conduct, encouraged HPS to continue to rely on the information and data provided by Blue Shield and/or Covered California. HPS reasonably relied on that information to its detriment.

TWELFTH AFFIRMATIVE DEFENSE

(Unjust Enrichment)

56. HPS repeats and realleges its factual assertions set forth above.

57. Blue Shield's cause of action is barred, in whole or in part, because Blue Shield would be unjustly enriched if it were allowed to recovery any damages or other relief sought.

58. By way of example, Blue Shield's system of calculating write-offs over-states the amounts actually written off and includes write-offs initiated by Blue Shield at its direction and unrelated to any HPS conduct. Recovering for these write-offs would permit Blue Shield to recover sums that it either did not actually lose or were the result of a business decision unrelated to any HPS conduct.

THIRTEENTH AFFIRMATIVE DEFENSE

(Waiver)

59. HPS repeats and realleges its factual assertions set forth above.

60. Blue Shield's cause of action is barred, in whole or in part, under the doctrine of waiver.

FOURTEENTH AFFIRMATIVE DEFENSE

(Contractual Limitation on Alleged Damages)

61. HPS repeats and realleges its factual assertions set forth above.

62. All damages Plaintiff claims, to the extent any exist, are limited in amount by the parties' Agreements, including, but not limited to, BPOA § 30.

HPS'S COUNTERCLAIMS

Counter-Claimant HealthPlan Services, Inc. ("HPS"), by and through counsel, hereby files these Counterclaims against Counter-Defendant California Physician's Service, Inc. ("Blue Shield") and alleges the following:

JURISDICTION AND VENUE

1. This Court has subject matter jurisdiction over these counter-claims pursuant to 28 U.S.C. § 1332(a)(1) because the amount in controversy exceeds $75,000 and there is complete diversity of citizenship. HPS is a citizen of the state of Florida, and Blue Shield is a citizen of the state of California.

2. Blue Shield is subject to the personal jurisdiction of this Court and venue is proper in this District under 28 U.S.C. §1391(b) because Blue Shield resides and conducts business in this District.

3. Additionally, Blue Shield previously and purposefully availed itself to this Court's jurisdiction in the associated case number in which this Counterclaim is brought.

THE PARTIES

4. HPS is one of the largest providers of benefits administration and technology services to the health insurance industry. HPS is a Florida corporation with its principal place of business in Tampa, Florida.

5. Blue Shield is one of the largest health insurance providers in the state of California, with millions of enrolled members. Blue Shield is a California nonprofit mutual benefit corporation with its principal place of business in San Francisco, California.

FACTUAL BACKGROUND

Contracting with HPS

6. The state of California created its own health benefit exchange, Covered California, in 2010 to carry out the Affordable Care Act's mandate requiring all individuals to either purchase health insurance or pay an individual mandate penalty.

7. To facilitate the massive influx of Californians who would now be required by law to purchase health insurance, Covered California permitted multiple health insurance companies, including Blue Shield, to sell their insurance plans on the Covered California exchange.

8. Prior to the October 2013 initial enrollment period, there arose skepticism as to whether this massive expansion of health insurance coverage could be smoothly implemented, with several large health insurers, such as UnitedHealth Group, Inc. and Cigna, declining to offer their plans on Covered California.

9. During this period leading up to Covered California's launch, Blue Shield was working with Trizetto, a healthcare IT business, on a major project to move Blue Shield's administrative services to its FACETS platform, which would act as a comprehensive system to handle Blue Shield's enrollment, billing, and claims adjudication.

10. Blue Shield anticipated that its FACETS platform would not be fully operational by the time of Covered California's first enrollment period in October 2013 and shared the concern that Covered California may experience a number of logistical issues during its initial roll-out phase.

11. Therefore, Blue Shield chose to outsource its administrative services to HPS.

12. On July 10, 2013, HPS and Blue Shield entered into the Amended and Restated Business Process Outsourcing Agreement ("BPOA") prior to the launch of Covered California.

13. Under the BPOA, HPS agreed to facilitate Blue Shield's entry onto the Covered California exchange and to launch Blue Shield's non-Covered California ACA compliant plans. These services included set-up of Blue Shield on HPS's platform, integrating with Covered California, Blue Shield, and Blue Shield's electronic brokers, validating and processing member enrollment requests, and managing customer premium billing and payment processing.

Problems with Covered California

14. The fears about Covered California's readiness came to fruition as Covered California's website experienced multiple crashes and glitches when it attempted to go live in October 2013. The October 2014 "Covered California Open Enrollment 2013-2014 Lesson Learned" confirms Counterclaim-Defendant's technology challenges and discloses that "[t]hrough

a combination of factors, there were delays in the electronic transmission and receipt of information between Covered California and the health plans, making it sometimes difficult for consumers to confirm their enrollment with the health plan they chose." Those delays were attributable to Counterclaim-Defendant and its lack of preparation and oversight.

15. For the entire first month of open enrollment, the HPS systems did not receive member enrollment records from Covered California.

16. Additionally, although Covered California released a Companion Guide detailing the technical specifications of data to be transferred from the exchange to the insurer, Covered California's actual file transfers did not follow those specifications. This resulted in a number of enrollment requests failing to properly read into HPS's system and error rates rising to roughly 35% due to Blue Shield's acts and omissions.

17. Throughout 2014 and 2015, HPS was forced to work on modifying the HPS system to accommodate these unexpected new data formats and data quality challenges from Covered California and Blue Shield.

18. In late 2015, during the policy renewal process, Covered California again sent HPS inaccurate and non-conforming data, which had the effect of reversing customers' account receivables.

19. Despite the number of complications raised by Covered California's flawed roll-out, HPS successfully addressed every Corrective Action issue raised by Blue Shield.

20. This ability to flexibly adapt to the flurry of problems caused by Covered California was recognized by Blue Shield in its Quarterly Business Reviews, which acknowledged the quality of work done by HPS.

21. Blue Shield reinforced this recognition of HPS's work by renewing the BPOA for the 2017 plan year after the BPOA's initial term expired in 2016 and further extended HPS's administrative responsibilities through the critical 2018 open enrollment period, during which Blue Shield expected high growth. This is despite Blue Shield's current allegation that HPS was somehow in breach of contract well before this renewal and expansion of responsibilities.

Issues with Blue Shield's Data Transmissions

22. Despite selecting HPS for billing and payment services, Blue Shield notified HPS that Blue Shield would be employing a shadow billing process whereby it would duplicate all Individual ACA (On-Exchange and Off-Exchange) records onto Blue Shield's FACETS platform.

23. HPS warned Blue Shield of the problems such duplications would cause, including the need to continually perform reconciliations to ensure the records of HPS and Blue Shield's FACETS platforms matched. Blue Shield failed to heed this warning.

24. However, by doing this shadow billing, it made it easier for Blue Shield to transition all of HPS's administrative services for Blue Shield's ACA members to its own FACETS platform despite its contract with HPS.

25. In 2017, Blue Shield sought to terminate the BPOA in bad faith. On information and belief, Blue Shield did so with the intention of moving its administrative services in-house using its FACETS platform while fabricating allegations of supposed "breach" to justify its act.

26. As a consequence of having these two separate platforms when working with HPS, Blue Shield routinely sent files and data to HPS that were untimely, inaccurate, and/or not up-to-date. Blue Shield failed to deliver or to cause to be delivered data to HPS in accordance with the parties' agreement. Blue Shield's failures proximately caused damage to HPS as set forth herein.

27. This plan to eventually transition over to FACETS also explains Blue Shield's lack of attention to and haphazard approach to the data it provided HPS under the Parties' agreement.

28. For example, at one point, Blue Shield admitted that there were 17,163 cases where the termination dates in FACETS differed from the termination date that HPS had on record in the data Blue Shield provided. In numerous cases, Blue Shield failed to notify HPS when a dependent was added to an insurance plan or when members changed their tier of insurance coverage.

29. HPS expended substantial money and personnel to perform reconciliations and account for Blue Shield's gross data inaccuracies, unreasonable and deficient business processes and contractual deficiencies.

30. Additionally, for California customers who applied for insurance directly through Blue Shield as opposed to through Covered California (*i.e.*, "off-exchange" customers), Blue Shield assumed responsibility to provide such member data to HPS directly.

31. At the outset, Blue Shield inexplicably chose to not convey the off-exchange member data to HPS in Electronic Data Interchange 834 files, as is typically done for health plan enrollment data.

32. Remarkably, Blue Shield initially began sending off-exchange member applications containing member credit card and financial data to HPS via email. HPS advised Blue Shield that such a method violated Payment Card Industry ("PCI") Data Security Standards and shut down the email address used to send these applications. Shockingly, Blue Shield continued to attempt to send applications via this method instead of the PCI Compliant fax server process established. Notably, Section 7.7 of the BPOA requires that HPS adhere to all Payment Card Association Rules and to be PCI-certified.

33. From 2013 to 2014, Blue Shield sent off-exchange member applications to HPS in paper format. Starting from 2014, Blue Shield eventually transitioned to sending membership applications to HPS via XML files (a type of electronic data file) and customer maintenance requests via Microsoft Excel sheets.

34. Therefore, because of Blue Shield's highly unconventional methods of data generation and transfer, HPS was reliant upon Blue Shield's providing off-exchange member applications and membership status changes on a timely and accurate basis. Because this data came directly from Blue Shield, HPS had no way of verifying the accuracy of the data provided.

35. Unsurprisingly, Blue Shield's failure to utilize integrated uniform methods of data transmission resulted in off-exchange member data being conveyed to HPS in an *ad hoc*, unreliable and untimely fashion.

36. Blue Shield's highly unusual data maintenance and transmission methods and business processes resulted in customer-facing errors that were directly attributable to Blue Shield's conduct – for example, customers receiving inaccurate invoices and/or incorrect refund amounts.

37. HPS attempted to mitigate these issues caused by Blue Shield's transmission of inaccurate data by performing continual audits of refunds. Similarly, Blue Shield reviewed and approved all refunds that exceeded $2,500.

38. Because of these data discrepancies, Blue Shield often (and unfairly) asked HPS to write-off premiums. For example, Blue Shield would request that HPS write-off deficiency balances where the customer refused to pay extra for overbilled invoices, *e.g.*, when a customer was charged for a more expensive plan due to HPS not receiving timely notice of the change in plan. Likewise, Blue Shield would request that HPS write-off premiums as a sign of goodwill for customers who complained to the California Department of Managed Healthcare regarding their accounts. Even more outrageously, Blue Shield would request that HPS write-off unpaid premium balances that were older than two months, even where the delay was attributable to Blue Shield's own conduct and the aged receivable was through no fault of HPS.

39. Because Blue Shield delayed in resolving delinquency issues, Blue Shield would backdate transactions for terminated customers, which meant that HPS was required to continually bill customers who had terminated.

40. Blue Shield further requested that HPS continue billing customers who were delinquent in their payments but who had an adjustment made to their account within the past 60 days. While Blue Shield would perform its internal investigation of whether the customer was merely refusing to pay based on incorrect invoicing, HPS was prohibited from sending the customer account through the delinquency process and was forced to manually process a write-off transaction for the continuing uncollected premiums.

41. Despite needing to perform this additional work as a result of Blue Shield's failure to timely provide accurate member information to HPS, Blue Shield refused to pay HPS for these unforeseen additional costs despite HPS's request for payment.

Payment Dispute Over Overage Costs

42. In late 2014, HPS approached Blue Shield regarding the disproportionately increasing costs of servicing Blue Shield's customers. HPS noted that this cost increase was due

to factors such as data errors being fed to HPS from Blue Shield, increased troubleshooting required as a result of Covered California's bugs, and Blue Shield's conduct.

43. To account for these unexpected costs, HPS proposed that Blue Shield increase the Per Member Per Month ("PMPM") rate. Per the BPOA, HPS required Blue Shield's written authorization for changes in charges.

44. Blue Shield refused to consider the proposal, arguing that any cost adjustments would only be addressed when it came time for the BPOA to be renewed. Per BPOA § 4.1, the BPOA would expire on December 31, 2016.

45. This meant that for three years, Blue Shield refused to address any adjustment to the PMPM rate despite HPS being forced to expend substantial costs for additional work caused by either Covered California, Blue Shield, or its partners. In addition to breach of contract, Blue Shield's conduct also constituted a breach of the implied covenant of good faith and fair dealing.

46. However, in exchange for performance of additional implementation work, Blue Shield eventually agreed (1) that it would forgo any reconciliation of PMPM fees due to the definition of "effective members" from January 2014 through May of 2015, and (2) that it would make two $500,000 payments to HPS upon HPS's completing certain milestones, such as making adjustments to the platform and fixing unexpected complications. HPS satisfied all conditions associated with these payments.

47. Upon completion of HPS' first milestone, Blue Shield made its payment of $500,000.

48. However, after HPS fulfilled its second milestone, Blue Shield refused, without cause or justification, to pay the remaining $500,000.

Payment Dispute Over Member Count

49. Under the BPOA, Blue Shield was required to pay HPS for PMPM Charges based on the number of "Effective Members," members listed in BSC's membership files, in any given month that were eligible for benefits.

50. HPS approached Blue Shield with its concern that almost 30% of Blue Shield's California customers submitted to HPS's system ultimately did not pay their initial premium, thus

making them ineligible for benefits and resulting in Blue Shield not compensating HPS as required under the parties' Agreement. In other words, Blue Shield paid HPS roughly 70% of the amount owed under the Agreement.

51. Because these customers never submitted their initial premium, their names would not show up on Blue Shield's member files as enrolled and eligible members. Thus, HPS performed the initial onboarding work, such as validation, transaction processing, reconciliation and sending out notices, for all of these customers without receiving payment for such work as required under the parties' Agreements.

52. Recognizing the disconnect between the BPOA and reality, HPS proposed changing the definition of PMPM Charges to include work for all customers submitted to HPS but who did not pay their initial premium.

53. Blue Shield agreed to this change in definition of "members."

54. Based on that agreement, HPS began billing Blue Shield using this new definition of "members." Blue Shield continued to make payments on these invoices that were based on this new definition.

55. In May 2015, Blue Shield requested that HPS revert to invoicing PMPM Charges based on Effective Members, rather than the revised member definition agreed to previously.

56. HPS declined to change its billing practices, noting that Blue Shield had agreed to the definition change (largely to account for Blue Shield's own business practices) and that such a change was necessary to account for the actual work done by HPS for Blue Shield.

57. In breach of the party's agreements, Blue Shield proceeded to self-report member counts and to pay subsequent HPS invoices only for the number of members Blue Shield had in its enrollment database. This resulted in Blue Shield substantially underpaying its billed invoices in breach of contract. Moreover, on information and belief, Blue Shield's behavior was purposeful and willful and expressly designed to under-report numbers to reduce HPS's contractually required payments

58. Further, HPS discovered through a member count comparison that Blue Shield was not counting off-exchange members who purchased stand-alone specialty products (dental/vision)

and thus HPS was not being paid for these members. This too was in breach of contract. Moreover, on information and belief, Blue Shield's behavior was purposeful and willful and expressly designed to under-report numbers to reduce HPS's contractually required payments.

59. Blue Shield eventually acknowledged its conduct and following its analysis for the period June 2015 through September 2017, reported that 983,736 member months were not counted resulting in an amount owed HPS of in excess of $1,250,000. HPS demanded these amounts and Blue Shield refused payment, in further breach of contract.

Failure to Provide Aggregate Forecasts

60. Per BPOA, Schedule C, § 3.3(c), Blue Shield was obligated to provide HPS monthly with "an aggregate rolling volume forecast of Effective Members and Calls for the following three (3) calendar months."

61. In the event that the actual number of Effective Members in a given month was less than eighty percent of the forecast for that month, HPS would be entitled to calculate its PMPM Charges based upon eighty percent of the forecast of Effective Members, provided that HPS met its Quality Service Levels that month. BPOA, Schedule C, § 3.3(e)(i).

62. Blue Shield failed to provide the required monthly aggregate rolling volume forecasts.

63. This meant that HPS was deprived of the opportunity to receive payments based on the method outlined in Schedule C, § 3.3(e)(i).

FIRST CLAIM FOR RELIEF

(BREACH OF CONTRACT)

64. HPS incorporates herein the allegations set forth above in paragraphs 1-63.

65. HPS and Blue Shield entered into a valid contract.

66. HPS performed its contractual obligations to Blue Shield. To the extent any of HPS's obligations might have not been performed, such absence of performance was excused or was caused by Blue Shield's acts and omissions, including Blue Shield's prior breaches of contract.

67. Blue Shield breached the BPOA by failing to provide HPS with monthly aggregate rolling volume forecasts of Effective Members and Calls, as required by BPOA, Schedule C, § 3.3(c).

68. Blue Shield's breach of contract has caused HPS to incur significant damages to be proven at trial.

69. Additionally, Blue Shield agreed to pay HPS two separate payments of $500,000 each in exchange for completion of additional work.

70. HPS performed its obligations by completing both milestones. To the extent any of HPS' obligations in this agreement might not have been performed, such absence of performance was excused or was caused by Blue Shield's acts and omissions, including prior breaches of contract..

71. Blue Shield breached this contract by paying the first $500,000 payment upon completion of the first milestone but then failing to pay HPS for completing the second milestone.

72. This breach of contract has caused HPS to incur additional damages of least $500,000.

SECOND CLAIM FOR RELIEF

(BREACH OF THE COVENANT

OF GOOD FAITH AND FAIR DEALING)

73. HPS incorporates herein the allegations set forth above in paragraphs 1-72.

74. HPS and Blue Shield entered into a valid contract, the BPOA.

75. The covenant of good faith and fair dealing is both implied by law into the BPOA and expressly provided for in BPOA, § 32.24 ("Each party, in its respective dealings with the other Party under or in connection with this Agreement, will act reasonably and in good faith.").

76. HPS fully performed its obligations to Blue Shield under the BPOA. To the extent any of HPS's obligations might have not been performed, such absence of performance was excused.

77. Blue Shield unfairly interfered with HPS' right to receive the benefits of the contract by refusing in bad faith to negotiate adjustments to the PMPM rate prior to the BPOA's

termination despite the addition of unexpected overage costs, refusing in bad faith to negotiate regarding a change in definition of "members" for purposes of PMPM Charges, and continuing to provide untimely and inaccurate data knowing this would impede HPS's ability to fulfill its contractual responsibilities.

78. HPS was harmed by Blue Shield's conduct in an amount to be proven at trial.

THIRD CLAIM FOR RELIEF

(Declaratory Judgment)

79. HPS incorporates herein the allegations set forth above in paragraphs 1-72.

80. An actual controversy exists between HPS and Blue Shield regarding the basis of Blue Shield's termination of the BPOA. HPS disagrees with Blue Shield's categorization of its termination of the BPOA as one "for cause," and believes that Blue Shield's termination is actually one for convenience, per BPOA § 26.1.4 and § 26.2.

81. Because a termination for convenience would entitle HPS to termination fees, per BPOA Schedule C, a judicial declaration is necessary and proper at this time so that HPS may determine its right to such fees. Such a declaration would conserve judicial and parties' resources by avoiding the need for a separate legal action to enforce HPS's entitlement to the aforesaid termination fees.

PRAYER FOR RELIEF

WHEREFORE, Counterclaimant HPS prays for the following relief:

1. An award to HPS of damages in an amount to be proven at trial;

2. For a judicial declaration that Blue Shield's termination of the BPOA was a "termination for convenience" as defined by the BPOA;

3. Costs of suit;

4. An order for such other and further relief as the Court may deem just and appropriate.

Dated: August 13, 2018 SHEPPARD, MULLIN, RICHTER & HAMPTON LLP

By */s/ Laura L. Chapman*
LAURA L. CHAPMAN
STEVEN G. SCHORTGEN
JENNIFER K. AYERS
DANIEL R. FONG

Attorneys for Counterclaimant/Defendant
HealthPlan Services, Inc.

DEMAND FOR JURY TRIAL

Counterclaimant HealthPlan Services, Inc. hereby demands a jury trial on all issues triable as of right to a jury pursuant to FED. R. CIV. P. 38(b) and Civil L.R. 3-6(a).

Dated: August 13, 2018 SHEPPARD, MULLIN, RICHTER & HAMPTON LLP

By */s/ Laura L. Chapman*
LAURA L. CHAPMAN
STEVEN G. SCHORTGEN
JENNIFER K. AYERS
DANIEL R. FONG

Attorneys for Counterclaimant/Defendant
HealthPlan Services, Inc.