Exhibit B

COMMONWEALTH OF KENTUCKY
FRANKLIN CIRCUIT COURT
DIVISION I
CIVIL ACTION NO. 16-CI-1160

DONALD ROOF, DEPUTY LIQUIDATOR OF KENTUCKY HEALTH COOPERATIVE, INC. **PLAINTIFF**

v. **OPINION & ORDER GRANTING SUMMARY JUDGMENT**

BEAM PARTNERS, LLC, *et al.* **DEFENDANTS**

This matter is before the Court on Motions for Summary Judgment filed by Defendants Janie Miller, Joseph Smith, and the Board of Directors of the Kentucky Health Cooperative, Inc. (the "Board"). The parties appeared during Motion Hour on July 2, 2018, and the Court thereafter took the Motions under submission on the parties' briefs. Having heard the arguments of the parties, and being otherwise sufficiently advised, the Court hereby **GRANTS** the Motions for Summary Judgment, for the reasons set forth below.

BACKGROUND

I. The Affordable Care Act

The Kentucky Health Cooperative, Inc. ("KYHC") was formed in 2011 under the Affordable Care Act ("ACA"), which sought "to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S.Ct. 2480, 2485 (2015). To effectuate this goal, the ACA established Health Benefit Exchanges ("Exchanges"), or "online marketplaces where individuals can purchase health insurance and potentially obtain federal subsidies." *New Mexico Health Connections v. United States Dept. of Health and Human Servs.*, 2018 WL 1136901, at *2 (D. N.M. Feb. 28, 2018) (citation omitted). These Exchanges offered four (4) health plans: bronze, silver, gold, and platinum, with insurance companies paying sixty percent (60%) of

bronze-level members' healthcare costs and up to ninety percent (90%) for platinum-level enrollees. *Id.* In other words, bronze plans were designed for those individuals anticipating few healthcare needs and platinum plans attracted less-healthy individuals with higher healthcare costs. *Id.* To foster competition within this market, the ACA also created the Consumer Operated and Oriented Plan ("CO-OP") program, which provided loans and grants to new nonprofit health-insurance issuers so long as they offer their plans on the Exchanges. *Id.*

Though these programs worked to expand healthcare access, they also increased the risk that some insurers would incur "massive new costs," as they were required to "accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage." *Id.* (quoting *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 548 (2012)) (internal quotation marks omitted). Furthermore, "[b]ecause insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new exchanges, insurers faced significant risk if they elected to offer plans in the[] exchanges." *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1314 (Fed. Cir. 2018).

To combat this risk, the ACA created a temporary risk corridor program. In operation from 2014 to 2016, this program required profitable insurers to make payments to the United States Department of Health and Human Services ("HHS"), which in turn made payments to unprofitable insurers. *New Mexico Health Connections*, 2018 WL 1136901, at *2 (citing 42 U.S.C. § 18062); *see also Moda Health Plan, Inc.*, 892 F.3d at 1315 (explaining risk corridor program). These "risk corridor payments" therefore "permit[ted] issuers to lower [premiums] by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Moda Health Plan, Inc.*, 892 F.3d at 1315 (quoting HHS Notice of Benefit and Payment Parameters for 214, 78 Fed. Reg. 15,410, 15, 413 (Mar. 11, 2013)) (internal quotation

Entered 16-CI-01160 08/03/2018 Amy Feldman, Franklin Circuit Clerk

OPOR : 000002 of 000024

marks omitted). In other words, the payments "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuer's financial losses and gains." *New Mexico Health Connections*, 2018 WL 1136901, at *2 (quoting 2014 Final Rule, 78 Fed. Reg. at 15,411 (A.R. 000228)) (internal quotation marks omitted).

II. Kentucky Health Cooperative, Inc.

This action stems from the liquidation of KYHC, a CO-OP based in Louisville, Kentucky and offering services across the entire state. The program's stated goal was to "secur[e] access to high quality, inexpensive health insurance for the sizeable number of uninsured Kentuckians and persons working for small companies." *About Us*, KENTUCKY HEALTH COOPERATIVE, http://www.mykyhc.org/about-us.html (last visited July 31, 2018). It was self-described as "a revolutionary new model for health insurance in Kentucky." *Id.*

KYHC suffered major losses in its first years and necessarily sought risk corridor payments for 2014 and 2015. However, by that time, Congress changed directions and backtracked on its original commitments in the ACA, significantly restricting the funds available for risk corridor programs. *See Moda Health Plan, Inc.*, 892 F.3d at 1318–19. When HHS refused to make the requested payments in full, KYHC was rendered insolvent.[1] On January 15, 2016, this Court found that, if KYHC continued its operations, it would be hazardous, financially or otherwise, to the policyholders and public. As a result, the Court placed KYHC into

[1] On July 6, 2017, after the filing of the present suit, the Liquidator sued the United States in the U.S. Court of Federal Claims for payment of the risk corridor funds. This, of course, demonstrates that the Liquidator, and her legal counsel, agree with the defendants in this action that KYHC has a good faith claim to recover these funds. The Court will take judicial notice that the Liquidator has asserted claims under Section 1342 of the ACA in the amount of $142,101,334.20 against the federal government in the U.S. Court of Federal Claims. *See Nancy G. Atkins, in her capacity as Liquidator of Kentucky Health Cooperative, Inc. v. United States of America*, Fed. Ct. Cl. Case No. 17-cv-01108C.

liquidation and appointed the Commissioner of the Kentucky Department of Insurance as Liquidator and Jeff Gaither and David Hurt as Special Deputy Liquidators.

III. The Present Lawsuit

Jeff Gaither filed this suit in his capacity as Special Deputy Liquidator[2] on October 28, 2016. Among the named defendants are Janie Miller, who was hired by KYHC as its Chief Executive Officer ("CEO"). She held this position from approximately September 17, 2012 through June 5, 2015. Plaintiff also sues Joseph Smith, who served as Chairman of the Permanent Board and Facilitator of the Transitional Board, both unpaid volunteer positions. He held these positions from July 2012 until approximately October 29, 2015, when this Court placed KYHC into rehabilitation. Plaintiff sues Smith in both his individual capacity and as the representative of all members of the Board of Directors. No other individual officers or directors are sued in any capacity; instead, Plaintiff attempts to sue the Board as an entity, with service of process on Smith as Chairman of the Board. Essentially, Plaintiff seeks to sue the Board, but also seeks to impose liability on one individual, Smith, for the actions of the entire Board. However, there is no allegation or proof that Smith had unilateral power to take any of the actions complained of by the Plaintiff, nor is there any allegation that Smith usurped the authority of the Board or took any unilateral action that resulted in injury to the CO-OP.

Plaintiff initially asserted claims of negligence, unjust enrichment, breach of fiduciary duty, gross negligence, and punitive damages, against Miller.[3] Similar claims were asserted against Smith and the Board for negligence, gross negligence, breach of fiduciary duties, and punitive damages. On July 31, 2017, the Court entered an Order dismissing Count 4 (Negligence

[2] Donald Roof, who now serves as Deputy Liquidator of Kentucky Health Cooperative, Inc., was substituted as the named Plaintiff by Order dated August 14, 2017.

[3] Miller's employment contract has an arbitration clause, but the Plaintiff has chosen to bypass arbitration and bring suit against Miller, thereby waiving the right to arbitration.

against Miller), Count 5 (Unjust Enrichment against Miller), Count 6 (Breach of Fiduciary Duty against Miller), Count 8 (Negligence against Board and Smith), and Count 10 (Breach of Fiduciary Duty against Board and Smith).[4]

In that same Order, the Court permitted Plaintiffs to proceed with "limited discovery on the allegations of 'gross negligence' asserted against" Miller, Smith, and the Board. *See* Order at 11. Specifically, the Court directed the parties to develop their factual basis for these claims, including the employment of a qualified actuary and other insurance consultants, reliance on advice from those entities, the process by which the rates were submitted and approved by the Department of Insurance, "and any facts that set forth the failure of the federal government to make the risk corridor and reinsurance payments that were provided for" under the ACA. *Id.* at 11–12. In addition, the Court noted that defendants should

> provide affidavits or testimony that will set forth a detailed record of facts that they alleged would support a finding of clear and convincing evidence that Ms. Miller and Mr. Smith and the Board of Directors of KYHC did not act in good faith, did not act on an informed basis, or did not act in a manner they honestly believed was in the best interest of KYHC, and that their actions or inactions, viewed through the lens of an ordinarily prudent person in a like position, amounted to gross negligence.

Id. at 12.

In accordance with the Court's Order, the parties agreed to a "Topic List" to govern upcoming depositions. The Liquidator thereafter deposed Miller and Smith, as well as corporate

[4] Plaintiff's Second Amended Complaint, filed September 6, 2017, realleges claims of simple negligence, unjust enrichment (against Miller only), and breach of fiduciary duties, which were dismissed with prejudice from the First Amended Complaint, and adds claims of breach of statutory duties. However, the Court's July 31, 2017 Order directed the parties to proceed with discovery on the issue of gross negligence only, and the Motions for Summary Judgment and their corresponding memoranda were therefore limited to the claims of gross negligence against Miller, Smith, and the Board of Directors. It is the Court's understanding, however, that the dispositive motions before the Court cover all claims not previously ruled on in the July 31, 2017 Order. To the extent some issues in the various claims asserted in the First and Second Amended Complaints are overlapping, the Court's ruling granting summary judgment also applies to the other claims of the Second Amended Complaint, as set forth in the Conclusion of this Order.

representatives of Beam Partners, LLC ("Beam"), CGI Technologies and Solutions, Inc. ("CGI"), and Milliman, Inc. ("Milliman").[5] The parties also engaged in written discovery.

Accordingly, with discovery on these issues complete, Miller, Smith, and the Board filed Motions for Summary Judgment. In their Motions, the defendants argue for the dismissal of the gross negligence and punitive damages claims, as they contend that the facts uncovered during this period of limited discovery fail to demonstrate that either party acted in a grossly negligent manner during their tenure with KYHC.

ANALYSIS

I. Plaintiff Had an Adequate Opportunity to Engage in Discovery.

Plaintiff first contends that additional discovery is necessary. However, a plaintiff is not entitled to take unlimited discovery prior to summary judgment but is entitled only to a full and fair opportunity to develop a factual record on any potential issues of disputed facts. *See Blankenship v. Collier*, 302 S.W.3d 665, 668 (Ky. 2010) (noting that a court should take up a summary judgment motion after reasonable opportunity for discovery); *Rich for Rich v. Kentucky Country Day, Inc.*, 793 S.W.2d 832, 838 (Ky. App. 1990) (finding thirteen months between filing of complaint and granting of summary judgment was "ample time to complete discovery"). Here, the Court finds that Plaintiff had a more than adequate opportunity to fully develop the facts supporting its gross negligence claims, especially since most if not all of the relevant facts are matters of public record. While the universe of potential topics for discovery in a case of this nature is virtually unlimited, the Court finds that the Plaintiff has had more than a full and adequate opportunity to take discovery on all material issues of fact supporting the remaining claims, and the topics for which Plaintiff seeks additional discovery are tangential at

[5] Plaintiff also filed a Motion to Compel seeking discovery on issues irrelevant to the limited issues set forth in the Court's July 31, 2017 Order. That Motion was denied by Order dated July 2, 2018.

best. Any additional discovery at this point would amount to little more than a "fishing expedition" that would unnecessarily prolong these proceedings and impose unnecessary additional costs for all concerned.

II. Plaintiff Cannot Impose Representative Liability on Defendant Smith.

As explained in more detail below, individual officers and directors may be sued in their individual capacity for their individual breaches of the duties set forth in KRS 273.229(1) and 273.215(1). The corporation may also be sued in its corporate name under KRS 273.171. In the present case, Plaintiff sues the "Officers and Board of Directors of the Kentucky Health Cooperative, Inc." and Joseph E. Smith, both individually and "in his representative capacity as Chairman of the Board of Directors." However, Plaintiff is unable to point to any legal authority that would allow this Court to impose representative liability on a single Board member for the actions (or failures to act) of the entire Board.

Instead, the actions (and inaction) of the Board at issue in this case were just that—the actions of the Board, as a whole. In fact, in his deposition, Smith explained that his job as Chair was to conduct meetings; he did not vote on any issues unless the votes were tied. *See* Smith Dep. 128–30, Jan. 24, 2018. He also explained that he could step down from his position as Chair to speak against any action that he believed was not in KYHC's best interest; however, he could not overrule the actions of the Board. *See id.* at 130–32. There is simply nothing in the record to support imposing personal liability on Smith, or any other individual Board member, for the actions of the entire Board. Accordingly, to the extent Smith is sued in his "representative capacity," he is dismissed from this suit. To the extent he is sued in his individual capacity, there is no legal authority to impose individual liability on him for the actions or inactions of the Board, and those claims fail as well.

III. The Undisputed Facts Fail to Demonstrate Intentional Misconduct, Wanton or Reckless Behavior, or Self-Dealing, and the Business Judgment Rule Therefore Protects Defendants from Liability for their Discretionary Actions.

The business judgment rule is "a presumption that in making a business decision, not involving self-interest, the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interest of the company." *Allied Ready Mix Co., Inc. v. Allen*, 994 S.W.2d 4, 8 (Ky. App. 1998) (quoting *Spiegel v. Buntrock*, 571 A.2d 767, 774 (Del. 1990)) (internal quotation marks omitted). This rule has been codified for nonprofit corporations at KRS 273.229(1) and 273.215(1). Under those statutes, officers and directors of a nonprofit corporation must discharge their discretionary authority in good faith, on an informed basis, and "[i]n a manner [they] honestly believe[] to be in the best interests of the corporation." So long as they abide by the terms of these statutes, such officers and directors are typically shielded from civil liability.

However, if an officer or director breaches or fails to perform these statutory duties, he or she may be subject to a suit for injunctive relief. *See* KRS 273.229(5)(a); 273.215(5)(a). If the failure to discharge these duties "constitutes willful misconduct or wanton or reckless disregard for human rights, safety or property," the officer's actions, or failure to act, may also be the basis for monetary damages. *See* KRS 273.229(5)(b); 273.215(5)(b). In other words, to obtain monetary damages against an officer or director, one must prove that the officer acted in a grossly negligent manner by failing to discharge his or her statutory duties. *See City of Middlesboro v. Brown*, 63 S.W.3d 179, 181 (Ky 2001) (defining gross negligence). To overcome the presumption of the business judgment rule, the challenging party must prove these

allegations by clear and convincing evidence. *See* KRS 273.229(6); 273.215(6). In such situations, punitive damages may be appropriate. *Brown*, 63 S.W.3d at 181.

To support the gross negligence claim at issue here, Plaintiff's Second Amended Complaint asserts that Smith, the Board, and Miller "willfully and recklessly ignored the obvious and foreseeable danger of setting woefully inadequate insurance premiums, and continued their willful and reckless conduct after it became known that the insurance premiums would result in KYHC's insolvency." Sec. Am. Compl. ¶¶ 59, 90. Plaintiff also alleges that these defendants "willfully and recklessly ignored the obvious and foreseeable danger posed by CGI's continuing failure to adequately process claims on behalf of KYHC's insureds." *Id.* ¶¶ 59, 91.

These conclusory allegations lack any specific facts showing bad faith or intentional misconduct on behalf of Smith and the Board. The Second Amended Complaint does not allege that these defendants personally enriched themselves at the expense of KYHC or the public in any way, or that anyone involved in KHYC's management engaged in any dishonest or unethical conduct. Thus, the Court's July 31, 2017 Order directed Plaintiff to develop the factual basis for the gross negligence claims. With discovery on this issue now complete, Plaintiff makes the following factual allegations:

- *The Board's decision to hire Defendant Janie Miller as KYHC's CEO*: According to Plaintiff, Smith knew that Miller lacked experience running a health insurance company and that her prior experiences in government were clearly not comparable.
- *KYHC's decision to hire Milliman*: Prior to KYHC's hiring of Milliman to set rates, Milliman prepared a feasibility study to inform the Center for Medicare & Medicaid Services' ("CMS's") decision to approve and fund KYHC, and payment

for the study was contingent on acceptance by CMS. Plaintiff argues that Miller knew this but failed to question Milliman's financial interest. Plaintiff also argues that Miller and the Board failed to seek outside assistance in the hiring process.

- *KYHC's decision to hire CGI*: KYHC hired CGI as a business process outsourcing ("BPO") vendor. In this role, CGI assumed and performed many of KYHC's core operations (claims processing, payments, enrollment, etc.). According to Plaintiff, Miller did not participate in the selection process, and the Board failed to investigate concerns about CGI's lack of experience with KYHC's claims software. Instead, Plaintiff argues, the decision to hire CGI was based entirely on the recommendations of Miller and Beam.
- *KYHC's concerns with CGI's performance*: Shortly after open enrollment began in October 2013, "serious problems developed" because CGI transferred inaccurate information from Kentucky's Health Exchange. By December, Plaintiff argues, the Board had "real concerns with CGI's performance" and the problems worsened in January; however, the Board took no action. Plaintiff also argues that Miller knew that a Louisiana Co-op fired CGI for similar problems, but chose not to share this with the Board and eventually pushed the Board to stay with CGI, which relied on Miller's recommendation without obtaining an outside opinion.
- *Initial rate development*: After approving the initial rates, the Board submitted the information to the Department of Insurance ("DOI"). The Board then realized that Milliman had failed to factor certain costs into its calculations; however,

according to Plaintiff, the Board failed to investigate and instead relied on Milliman's assurances that the oversight would not affect these rates.

- *2015 rate development*: The Board approved Milliman's suggested increase in rates, but Plaintiff argues that it did so without meeting with Milliman to discuss its methodology. Furthermore, the Board lacked the actuarial expertise necessary to review the recommendation and Miller knew that neither the Board nor Milliman had accurate enrollment or claims data.
- *The Board's lack of action as losses continued*: Plaintiff claims that it had become clear by 2014 that CGI's job performance was worsening and KYHC was unable to pay claims; however, the Board took no action other than encouraging its staff to fix the problem. Plaintiff also claims that Miller was aware of monthly losses but did not inform Board, and instead relied on the risk corridor payments.[6] Miller discussed with the Board whether the platinum plan (in which insurers paid approximately ninety percent (90%) of patient costs) should be dropped, but could not advise Board and recommended retaining the plan; the Board agreed. Lastly, Plaintiff points to a discussion between Smith and Miller in 2014 in which Smith raised concerns over KYHC's financial trouble and Miller told him that it would improve in 2015. The Board's only action was to request more funding; it did not engage another actuarial firm to review Milliman's work or get a second opinion.
- *The Corrective Action Plan*: In January 2015, the Department of Insurance ("DOI") placed KYHC into a Corrective Action Plan. Plaintiff contends that the Board took no action, relying exclusively on Miller to implement the Plan.

[6] However, Miller stated in her deposition that she understood the risk corridor payments were temporary.

- *The preparation of 2016 rates*: According to Plaintiff, in 2015, Smith questioned for the first time whether the rates set by Milliman were too low. In her deposition, Miller conceded that they were too low, though she referenced various other factors, like that all companies had somewhat low rates and that KYHC received ninety percent (90%) of Kentucky's high-risk population. Plaintiff also notes that Miller cautioned the Board that the DOI might reject its rate filing if Milliman's rates were not accepted. Ultimately, the rates were accepted without discussion of raising the rates and without bringing in an expert to review Milliman's work.

Relying on these factual assertions, Plaintiff now argues that these defendants acted in a grossly negligent manner because (1) their reliance on Milliman to set rates was unwarranted and improper; (2) they permitted KYHC to continue offering a health plan that it could not afford; and (3) they failed to act or otherwise made uniformed decisions regarding CGI. In addition, Plaintiff claims that Miller's desire to obtain a bonus contributed to her grossly negligent conduct. Simply put, Plaintiffs contend that these defendants failed to act on an informed basis and their failure to abide by their statutory duties "constitutes willful misconduct or wanton or reckless disregard for human rights, safety or property" under KRS 273.215(5) and 273.229(5).

a. Defendants' Reliance on Milliman Was Not "Unwarranted" under KRS 273.215 and KRS 273.229.

As noted above, KRS 273.229(1) and KRS 273.215(1) require that officers and directors discharge their discretionary authority "on an informed basis." They are considered to act on an informed basis so long as they rely on "information, opinions, reports, or statements, including financial statements and other financial data" that are prepared or presented by an officer or

employee of the corporation "whom the [officer or director] honestly believes to be reliable and competent in the matters presented" or "[l]egal counsel, public accountants, or other persons as to matters the [officer or director] honestly believes are within the person's professional or expert competence." KRS 273.229(3); KRS 273.215(3). However, an officer or director "shall not be considered to act in good faith" if he or she relies on another's opinion despite having knowledge that makes reliance "unwarranted" under Subsection 3. *See* KRS 273.229(4); KRS 273.215(4). Thus, if the officer or director knows that the entity providing the information is unreliable, incompetent, or acting outside the scope of its professional or expert competence, that officer or director has failed to act on an informed basis.

Here, Plaintiff argues that the defendants' reliance on Milliman was unwarranted because Milliman conducted its feasibility study on a contingency basis, failed to factor certain costs into the initial rates, and set rates too low. However, the facts produced in discovery do not indicate that Miller or any other officer or director had specific knowledge that Milliman was an unreliable or incompetent actuarial consultant or was otherwise acting outside the scope of its professional competence. Instead, Milliman, a reputable actuary,[7] was selected to calculate rates for a new and unpredictable health insurance market, with no precedent to guide it. It is therefore not surprising that payment for Milliman's feasibility study would be contingent on CMS's approval and funding of KYHC. The uncertainty of the market also helps explain Milliman's initial failure to factor certain costs into its calculations and the low rate settings. Most importantly, the DOI, as the state agency with regulatory responsibility to oversee the setting of health insurance rates under KRS Chapter 304, ultimately approved Milliman's recommended rates. Thus, the officers and directors of KYHC had no reason to believe that KYHC's failings

[7] Milliman is self-described as "one of the world's largest providers of actuarial and related products and services." *Who We Are*, MILLIMAN, http://www.milliman.com/about/ (last accessed August 2, 2018).

were due to Milliman's incompetence rather than the unique and uncertain nature of the market in which tens of thousands of formerly uninsured individuals were obtaining health insurance for the first time.

In short, Miller and the Board relied on the opinion of Milliman, a nationally recognized, established actuary, to provide guidance on rate-setting. The record does not indicate that Miller or any member of the Board of Directors held any specific knowledge that Milliman was unreliable, incompetent, or acting outside the scope of its expertise. Accordingly, these defendants acted on an informed basis under KRS 273.229(3) and 273.215(3).

b. Defendants Made Informed Decisions in a Unique and Unpredictable Market.

In addition to its arguments regarding Milliman, Plaintiff argues that these defendants acted in a grossly negligent manner by permitting KYHC to continue offering a health plan (the platinum plan) that it could not afford, and by failing to act or making uniformed decisions regarding CGI. For example, Plaintiff points to the hiring of CGI despite concerns about its lack of experience with certain software and the failure to replace CGI or take other action, such as obtaining a second opinion, as CGI's performance declined.

When considering whether these defendants made informed choices, the Court must consider the highly unique nature of KYHC. The program's stated purpose was to provide high quality, inexpensive health insurance for many uninsured Kentuckians and employees of small companies. The public service nature of the programs brought significant risks, as this unique market had no precedent or health insurance rate or payment history to rely on when calculating rates. As noted above, this lack of precedent presented a significant challenge to Milliman, who struggled to set adequate rates and factor in certain costs. Reliance on those suggested rates,

Entered 16-CI-01160 08/03/2018 Amy Feldman, Franklin Circuit Clerk

OPOR : 000014 of 000024

however, was not unreasonable given the unpredictable nature of the market. Simply put, the very lack of any established model for enrolling hundreds of thousands of people into these programs in such a short period of time supports a finding that the "standard of care" that prevailed in the marketplace was in a state of flux.

Furthermore, it should be noted that Milliman's suggested rates were continuously approved by the DOI, the very government agency whose commissioner, in her statutory capacity as Liquidator, is now alleging that the DOI-approved rates were "grossly inadequate." However, the filed rate doctrine supports KYHC's reliance on the DOI-approved rates. That doctrine "prohibits a ratepayer from recovering damages measured by comparing the filed rate and the rate that might have been approved absent the conduct in issue." *Commonwealth ex rel. Chandler v. Anthem Insurance Co., Inc.*, 8 S.W.3d 48, 52 (Ky. App. 1999) (quoting *Sun City Taxpayers' Assoc. v. Citizens Utilities Co.,* 847 F.Supp. 281, 288 (1994)) (internal quotation marks omitted). It therefore "preserve[s] the authority of the legislatively created agency to set reasonable and uniform rates and to insure that those rates are enforced, thereby preventing price discrimination." *Id.* (quoting *Sun City*, 847 F.Supp. at 288) (internal quotation marks omitted). Though arguably not directly applicable in the present matter, the doctrine does support the defendants' reliance on the rates, recommended by Milliman and ultimately approved by DOI. The DOI was authorized to set reasonable and uniform rates, and it was not unreasonable for KYHC to rely on those approved rates, particularly given the lack of other guiding precedent.

The Court also notes that Congress created the risk corridor program for the very purpose of alleviating the many risks associated with this market, and it was therefore not unreasonable that KYHC relied upon these payments to get them through the risky navigation of uncharted

territory, namely, setting rates for thousands of previously uninsured citizens.[8] Congress then did a complete "about face" and changed the rules by eliminating much of the funding for risk corridor payments, paying KYHC and many other CO-OPs a fraction of their requested payments. In fact, as a result of the risk corridor program's failure, only four (4) of the country's original (23) CO-OPs still operate, offering plans in only five (5) states. *See* Louise Norris, *CO-OP health plans: patients' interests first*, (July 25, 2018), https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/#states. Thus, the failure of KYHC is not demonstrative of gross negligence or incompetence of these defendants or the other CO-OPS throughout the country that failed; instead, it serves to highlight the necessity of the risk corridor payments in such a high-risk market.

In sum, the actions (or inactions) of Miller, Smith, and the Board must be considered in the context of a unique and unpredictable health insurance market in its infancy. With no precedent to guide them through this high-risk enterprise, these defendants reasonably relied on the work of Milliman, CGI, and others. Though the program struggled financially, it was not unreasonable that the officers and directors of KYHC interpreted this as a natural consequence of the market's volatile development, to be alleviated in the first few years by the risk corridor payments and then to stabilize over time. Through no fault of KYHC, however, Congress drastically reduced the risk corridor payments, forcing KYHC into insolvency. While the Court

[8] Publicly available data demonstrates that from 2013 to 2016, approximately 351,749 previously-uninsured individuals obtained insurance, and the portion of uninsured individuals in Kentucky fell from 16.3 percent to 7.2 percent. *See Key Facts about the Uninsured Population*, THE HENRY J. KAISER FAMILY FOUNDATION (Nov. 2017), http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population. The record in this case does not disclose how much of this improvement in health insurance coverage is due to the low rates set by KYHC. Nevertheless, the Court may take judicial notice that the consequence of KYHC's setting of the rates so low was that more people obtained health insurance coverage, even if they paid too little for it. The likely alternative was that many of these individuals would have gone uninsured if they were forced to pay higher market-based rates, which would have worked against the goals of the ACA and imposed enormous costs on the health care system through untreated illness and health care in emergency rooms.

recognizes that KYHC aggressively set low rates with the goal of bringing more people into the insurance market, there is no evidence that the rates were set in bad faith. The fact that these rates were approved by DOI is dispositive and precludes any claim for gross negligence in the setting of the rates. Given these unique circumstances, the Court cannot find that these defendants acted intentionally, wantonly, or recklessly, and their discretionary actions are therefore protected by the business judgment rule, as codified at KRS 273.229(1) and 273.215(1).

c. The Undisputed Facts Do Not Provide Sufficient Evidence of Self-Dealing by Miller.

Under the business judgment rule, the Court presumes that an officer acted on an informed basis, in good faith, and with an honest belief that the action taken was in the best interest of the corporation, so long as the officer's decision was not influenced by self-interest. *Allied Ready Mix Co., Inc*, 994 S.W.2d at 8 (citation omitted). In the present case, Plaintiff points to Miller's acceptance of a $50,000 bonus to argue that Miller's actions as CEO were clouded by her desire to obtain this bonus. The bonus, as written into Miller's employment agreement, was contingent on the achievement of certain "Bonus Milestones." She achieved the necessary milestones and received the bonus in 2014.[9] Plaintiff now argues that Miller "made the Bonus Milestones her focus." Pl.'s Resp. in Opp. 19. As a result, Plaintiff argues, she rushed the Board through the hiring process and later refused to consider replacing CGI as BPO in the hopes that she would satisfy the Bonus Milestones.

[9] It is worth noting that Miller accepted her bonus in 2014, and Congress restricted appropriations for risk corridor payments by enacting the Consolidated and Further Continuing Appropriations Act on December 16, 2014. Thus, it is unclear but possible that Miller received her bonus prior to learning that KYHC would not be receiving its risk corridor payments in full.

However, the record remains void of any facts that would overcome the presumption that Miller's decisions were made in good faith and with an honest belief that she acted in the best interest of KYHC. Though her actions ultimately satisfied the various Bonus Milestones, one can presume that the achievement of these objectives benefitted—or at least were intended to benefit—the corporation. Otherwise, KYHC would have no reason to incentivize Miller to accomplish the Bonus Milestones. In fact, as Miller explained in her deposition, the CO-OPs had to submit the Milestones to CMS for approval in order to receive start-up funding, "and that was [CMS's] method of oversight to assure that [CO-OPs] were, in fact, doing what they needed to do to draw down the federal funds." Miller Dep. 116: 7–16, Jan. 17, 2018. Having received approval from CMS, KYHC then contracted with Miller for the very purpose of achieving these goals and therefore clearly hoped that she would do so. Miller, in turn, focused on satisfying the terms of that contractual agreement. As she explained, "In general a [CO-OP] had to be completing its milestones in a timely fashion or run at the risk that CMS could delay providing start-up funds to the [CO-OP], so meeting the milestones was important to the development of the [CO-OP]." Miller Dep. 239: 14–18.

In addition, the Court notes that Plaintiff largely mischaracterizes much of Miller's deposition. For example, while Miller acknowledged that the hiring decision "was a tight time frame," she does not state that she "rushed the Board through hiring Milliman because she wanted to satisfy a Bonus Milestone." Pl.'s Resp. in Opp. 19. Instead, she explains that the Milestones "were coming fast and furious and the—at some point in time someone was going to have to step to the plate and say, we're not going to be able to meet this milestone." Miller Dep. 251: 1–4. At the possibility of missing a deadline, Miller noted that she "didn't want the board

to think I was shirking in my obligations" and it was not "in [her] psyche to . . . miss milestones." *Id.* at 251: 10–17.

At most, these statements demonstrate Miller's desire to achieve the Milestones that the Board had approved, and without more, the Court cannot infer that Miller acted in bad faith or declined to act in the corporation's best interest. It is undisputed that the Milestones were legitimate performance goals written into her contract to provide extra incentive to achieve worthwhile goals for the organization. The record in this case leaves no doubt that the Milestones were made part of the employment contract because the Board reasonably concluded that such performance standards were beneficial to the mission of the CO-OP, namely, promoting public health by extending health insurance options to a vast population of citizens who were previously uninsured or underinsured.

While it is easy to second guess those decisions in retrospect, this record offers absolutely no basis to conclude that the Milestones or contract with Miller were not good faith efforts to accomplish the goals spelled out in the ACA. Stated another way, the fact that Miller received a financial benefit from satisfying the Bonus Milestones, without more, is insufficient to demonstrate self-interest. There is simply no evidence in the record that personal financial gain—to the detriment of the corporation—was Miller's goal in achieving the Bonus Milestones. Thus, Plaintiff fails to overcome the business judgment rule's presumption.

This Court does note that the awarding of the $50,000 bonus to Miller raises legitimate concerns; however, the Court must conclude based on this record that the awarding of a contractual bonus was a matter within the discretion of the Board. While this Court may have exercised that discretion differently, it has no legal authority to second guess the Board in the circumstances presented in this record. Again, the record is devoid of any evidence of

Entered 16-CI-01160 08/03/2018 Amy Feldman, Franklin Circuit Clerk

dishonesty, misrepresentation, or misconduct that would form the basis to void the Board's decision. The Court also notes that the Liquidator had the option of addressing these issues in arbitration and waived that option in favor of going directly to court. The Court is now bound to defer to the business judgment of the Board absent some showing of bad faith or misconduct.

IV. KRS 411.200 Also Shields Smith for Actions Taken in Good Faith and Within the Scope of his Official Functions and Duties.

KRS 411.200 provides that

> [a]ny person who serves as a director, officer, volunteer or trustee of a nonprofit organization qualified as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986, as from time to time amended, and who is not compensated for such services on a salary or prorated equivalent basis, shall be immune from civil liability for any act or omission resulting in damage or injury occurring on or after July 15, 1988, if such person was acting in good faith and within the scope of his official functions and duties, unless such damage or injury was caused by the willful or wanton misconduct of such person.

In the present case, Smith served on the Board of Directors of KYHC, a 501(c)(29) nonprofit organization. Unlike Miller, he and the other members of the KYHC Board served as volunteers to launch this non-profit enterprise under the ACA for the purpose of extending healthcare coverage to a large segment of previously-uninsured Kentucky citizens. They received absolutely no compensation for this public service. Furthermore, there is no allegation that Smith or any Board member used their positions to financially benefit themselves in any way. There is no allegation of misconduct, self-dealing, conflicts of interest, financial impropriety, or any other form of malfeasance. Rather, the Liquidator stakes his claim on the allegation that the rates set by the KYHC were so unreasonably low that they guaranteed failure in the insurance marketplace. However, these low rates were ultimately approved by the DOI. In addition, while KYHC encountered significant problems with the administration of claims by CGI, there is not one shred of evidence that the hiring of the contractor was not done in "good faith and within the

scope of his official functions and duties." In sum, the undisputed facts do not indicate that any alleged damages resulted from his willful or wanton misconduct; instead, the actions at issue here were taken in good faith and within the scope of Smith's official functions and duties as Chair of the Board. Accordingly, he is shielded from civil liability by both the business judgment rule, as codified at KRS 273.215, and KRS 411.200.

Furthermore, in assessing the potential liability of a volunteer like Smith, the Court also finds it is appropriate to interpret and apply the statutory immunity required by KRS 411.200 in a manner that reflects the similar and longstanding qualified immunity of public officials and agencies. As the Kentucky Supreme Court has noted, such "immunity entitles its possessor to be free 'from the burdens of defending the action, not merely . . . from liability.'" *Breathitt Cnty. Bd. of Educ. v. Prater*, 292 S.W.3d 883, 886 (Ky. 2009) (quoting *Rowan Co. v. Sloas*, 201 S.W.3d 469, 474 (Ky. 2006)); *see also Mitchell v. Forsyth*, 472 U.S. 511, 525–26 (1985). This case provides a classic example of a defendant, Smith, who volunteered to perform a public service without compensation and has now been brought into court to defend his actions under the threat of personal liability. He has been subjected to all of the costs, inconvenience, time demands, and stress of defending a claim brought by agents of the state who have virtually unlimited resources to pursue litigation. Yet there is not a shred of evidence of any dishonesty, misconduct, self-dealing, financial impropriety, or other malfeasance on the part of Smith. The Liquidator's only claim against Smith is poor business judgment arising out of a new, untested, quasi-public enterprise[10] established under federal law to extend health insurance coverage to

[10] The CO-OP is a private, nonprofit health insurance carrier. However, it was designed to provide a public service, namely, to be an insurer of last resort under the ACA and to guarantee that all individuals, regardless of health, had an opportunity to obtain adequate coverage. It is also uniquely funded. Instead of dividing profits among shareholders, the CO-OPs, once profitable, reinvest their profits into the plan to allow for lower premiums and better coverage. *See* Louise Norris, *CO-OP health plans: patients' interests first*, (July 25, 2018), https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/#states. In addition, the

thousands of previously uninsured individuals, a start-up non-profit enterprise for which there was no known model prior to the enactment of the ACA. In these circumstances, the record is devoid of any basis to impose personal liability against Smith, and all claims against him must be dismissed.

CONCLUSION

For the reasons set forth above, the Court hereby **GRANTS** Joseph Smith and the Board's Motion for Summary Judgment on Counts 10 (Gross Negligence) and 22 (Punitive Damages) of the Second Amended Complaint and **GRANTS** Janie Miller's Motion for Summary Judgment on Counts 7 (Gross Negligence) and 22 (Punitive Damages) of the Second Amended Complaint. These Counts are hereby **DISMISSED WITH PREJUDICE**.

The Court also incorporates by reference its prior Order entered July 31, 2017, granting summary judgment and dismissing with prejudice the First Amended Complaints' claims of simple negligence and breach of fiduciary duties against defendants Miller, Smith, and the Board. That Order similarly held that the business judgment rule protected Smith and Miller from such claims. Accordingly, the following claims against Smith (including the attempt to assert claims against the Board by naming Smith in a "representative" capacity) and Miller are also **DISMISSED WITH PREJUDICE**: Negligence against Miller (Count 4); Breach of Fiduciary Duty against Miller (Count 6); Negligence against Smith and the Board (Count 9); and Breach of Fiduciary Duty against Smith and the Board (Count 11).

In addition, although the parties' arguments were limited to the claims of gross negligence, the Court finds that the analysis set forth in this Order is directly applicable to the Breach of Statutory Duties claim against Miller (Count 8), and Breach of Statutory Duties claim

federal government plays a unique role in providing loans and grants to insurers, as well as additional funding through risk corridor payments. Thus, KYHC is best described as a quasi-public entity.

against Smith and the Board (Count 12). Those claims allege violations of KRS 273.229 (against Miller) and KRS 273.215 (against Smith and the Board), the same statutes discussed in this Order. Applying the same analysis, these claims must also be **DISMISSED WITH PREJUDICE**.

Furthermore, the Court's July 31, 2017 Order dismissed *without* prejudice the Unjust Enrichment claim against Miller (Count 5); however, that Order expressly stated that the claim was dismissed without prejudice "to the right of the plaintiff to assert a claim for breach of contract if facts were developed in discovery that would support a claim that Ms. Miller was not contractually entitled to the bonus payment." Order at 9. Plaintiff's Second Amended Complaint realleges the Unjust Enrichment claim, without alleging newly-discovered facts that would support a breach of contract claim. Accordingly, the Unjust Enrichment claim against Miller (Count 5) is now hereby **DISMISSED WITH PREJUDICE.**

This is a final and appealable judgment, and pursuant to CR 54.02 this Court finds that the issues presented regarding defendants Miller, Smith, and the Board are separate and distinct from the remaining issues in this statutory action for the liquidation of the KYHC, and accordingly, there is no just cause to delay the entry of this final judgment in favor of Miller, Smith, and the Board, dismissing all claims against the individual defendants, as well as the Liquidator's attempt to impose liability on the Board by naming Smith in his "representative" capacity.

So **ORDERED** this the 3rd day of August, 2018.

/s/ HON. PHILLIP J. SHEPHERD
electronically signed
8/3/2018 3:54:38 PM

PHILLIP J. SHEPHERD, JUDGE
Franklin Circuit Court, Division I

DISTRIBUTION:

Hon. Paul C. Harnice
Hon. Sarah J. Bishop
201 West Main St., Suite A
P.O. Box 5130
Frankfort, KY 40601

Hon. Stewart C. Burch
114 West Clinton St.
Frankfort, KY 40601

Hon. Perry M. Bentley
Hon. Lucy A. VanMeter
Hon. Connor B. Egan
300 West Vine St., Suite 2100
Lexington, KY 40507

Hon. Darryl W. Durham
Hon. B. Keith Saksefski
471 West Main Street, Suite 400
Louisville, KY 40202

Hon. Douglas L. McSwain
250 West Main St., Suite 1600
Lexington, KY 40507

Hon. Matthew Nickel
2000 McKinney Ave., Suite 1900
Dallas TX 75201

Hon. Justine Margolis
Hon. Catharine Luo
Hon. Justin Kattan
1221 Avenue of Americas, 26th Floor
New York, NY 10020

Hon. Philip W. Collier
400 West Market St., Suite 1800
Louisville, KY 40202-3352

Hon. Luke Morgan
201 East Main St., Suite 900
Lexington, KY 40507

Hon. Margaret H. Warner
500 North Capitol St., NW
Washington, DC 20001

Entered 16-CI-01160 08/03/2018 Amy Feldman, Franklin Circuit Clerk