IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND BRIEF IN SUPPORT

Plaintiffs Elevance Health, Inc., f/k/a Anthem Inc., along with its affiliated entities Anthem Insurance Companies, Inc., Blue Cross of California, Wellpoint Health Plans, Inc., Wellpoint Insurance Company, and Wellpoint Iowa, Inc. (collectively, "Elevance Health"), bring this Motion for Preliminary Injunction against Defendant the Centers for Medicare & Medicaid Services ("CMS"), an agency within the United States Department of Health and Human Services ("HHS").

INTRODUCTION

Star Ratings are essential to the Medicare Advantage ("MA") program and to the success of every Medicare Advantage Organization ("MAO") that participates in it for two primary reasons. First, Star Ratings directly determine plan revenue that is used to reduce premiums,

enhance benefits, and provide quality improvement programs. Second, they are designed to allow an apples-to-apples comparison of plans. For that to be true, it is essential that CMS apply the same measures and methodologies uniformly across all MA contracts so that beneficiaries, MAOs, and CMS can make, and rely on, a consistent and fair evaluation of all plans.

Elevance Health brings this action to avail itself of one of the most hoary and consequential principles of administrative law: that agencies treat like cases alike. Specifically, Elevance Health asks the Court to order no greater relief than that which this Court already granted to Clover Insurance Company ("Clover"), another similarly situated MAO, a little more than one month ago. On May 27, 2026, this Court held that 20 of the Star Ratings measure scores that CMS factored into the calculation of the Star Ratings for 2026 are unlawful or invalid. *See Clover Ins. Co. v. U.S. Dep't of Health & Human Servs.*, No. 2:25-CV-142, 2026 WL 1483515 (S.D. Ga. May 27, 2026). As a result, the Court ordered CMS to recalculate Clover's 2026 Star Rating consistent with the Court's decision. On June 10, 2026, Clover reported in a public filing with the Securities and Exchange Commission ("SEC") that "CMS informed Clover that, consistent with the Court's order, it had recalculated [and increased] Clover's 2026 Star Rating as 4.5 Stars."[1]

Elevance Health expected CMS to apply this Court's decision consistently across the industry. Indeed, when a Star Ratings lawsuit challenges systemic or methodological aspects of CMS's Star Rating calculations and CMS loses, the agency has historically recalculated Star Ratings for all MAOs across the industry consistent with the court's decision to ensure that all plans are treated equally. Doing so is essential to both the Star Ratings program and administrative law principles. That is what happened two years ago in response to two decisions in another federal

[1] Clover reiterated this fact in a subsequent SEC filing on June 18, 2026.

district court holding CMS's calculation of 2024 Star Ratings unlawful. At that time, CMS recalculated the Star Ratings for all MAOs consistent with the relief ordered by the courts in those cases and allowed MAOs the choice of keeping their original 2024 Star Ratings or selecting the recalculated rating. CMS's actions in 2024 were consistent with the usual rule of administrative law that agencies administer federal programs consistently for all. With relief identical to what was decided by the *Clover* court, the 2026 Star Rating for multiple MA contracts held by Elevance Health subsidiary health plans would see marked improvement. The financial consequences of that improvement would, in turn, allow Elevance Health to offer enhanced benefits, reduced premiums, and more quality improvement programs for its members in the 2027 plan year.

But CMS did not apply the decision in *Clover* equally to all. Rather, a little over two weeks after that decision, on June 17, CMS announced in a memorandum on its Health Plan Management System (the "June 17 HPMS memorandum") that, in response to *Clover*, it had recalculated 2027 Quality Bonus Payment ("QBP") ratings using a different methodology than this Court ordered for Clover. Specifically, CMS excluded a total of 18 measures from the 2026 Star Rating calculation for Elevance Health (and other MAOs), keeping some measures that this Court previously ordered unlawful and excluding some measures that were not at issue in *Clover*. Different terminology aside, a contract's QBP rating is derived from—and numerically equivalent to—the contract's Star Rating. *See* Gerard Mulcahy et al., Update to 2027 Quality Bonus Payment Determinations at 1, CMS (June 17, 2026), attached as Exhibit 1 to Blue Declaration. In other words, while this Court ordered CMS to recalculate Clover's Star Ratings consistent with one methodology, CMS proceeded to recalculate Star Ratings (which it referred to as the QBP ratings) for other MAOs, including Elevance Health, using a different methodology.

This is no small matter. As explained in the attached expert declaration of Tyler Marshall, an analysis of publicly known information shows that Clover received more generous treatment from CMS than that which CMS offered to other MAOs, including Elevance Health, in the June 17 HPMS memorandum. In the wake of this inconsistent treatment, Elevance Health wrote to CMS requesting that its 2026 Star Rating be recalculated by CMS consistent with the *Clover* decision. CMS refused.

Elevance Health filed this lawsuit challenging CMS's calculation of its 2026 Star Ratings on three principal grounds: First, it is arbitrary and capricious for CMS to refuse to apply the same methodology for calculating Star Ratings across all MAOs. Second, CMS's calculation of Elevance Health's 2026 Star Ratings exceeded its statutory authority with respect to the same ten measures that this Court held in *Clover* were adopted in excess of CMS's statutory authority. Third, CMS's calculation of Elevance Health's 2026 Star Ratings was improper because CMS relied on an additional ten measures that, as this Court held in *Clover*, it adopted without observance of procedure required by law (*i.e.*, without notice and comment).

The stakes here are enormous for Elevance Health, and the requirements for a preliminary injunction are satisfied.

1. ***Elevance Health is likely to succeed on the merits.*** After this Court held in *Clover* that 20 of the 2026 Star Ratings measures were unlawful or invalid, CMS responded by recalculating the Star Ratings for all MAOs but pursuant to a different methodology than the *Clover* decision would dictate. For Clover itself, it appears CMS recalculated its 2026 Star Rating "consistent with" this Court's order. At the very least, publicly known information shows CMS gave more favorable treatment to Clover than to everyone else. That is because, for everyone else, CMS excluded certain additional measures not addressed in *Clover*, while including certain other

measures that this Court held in *Clover* were invalid. To be sure, some MAOs benefited from the recalculation methodology set out in CMS's June 17 HPMS memorandum, but Elevance Health (and presumably other MAOs) did not and Elevance Health is left with its original 2026 Star Ratings and QBP ratings. Thus, some MAOs will obtain a competitive advantage for 2027 as a result of increased QBP ratings. This different treatment among similarly situated entities is quintessential arbitrary and capricious conduct. "[T]he great principle that like cases must receive like treatment is . . . black letter administrative law." *Grayscale Invs., LLC v. SEC*, 82 F.4th 1239, 1245 (D.C. Cir. 2023) (citation omitted). That ground alone is dispositive.

Equally dispositive are the same two issues on which this Court based its decision in *Clover*. For the reasons held in *Clover*, Elevance Health is likely to succeed here on the merits in showing that (i) ten measures used by CMS in calculating Elevance Health's 2026 Star Ratings should be set aside as unlawful due to the improper source of data used to determine the measures; and (ii) ten other measures factoring into Elevance Health's 2026 Star Ratings should be set aside because CMS failed to engage in the required notice-and-comment procedures before adopting them.

2. ***Absent a preliminary injunction, Elevance Health will face irreparable harm.*** Because Clover obtained a higher 2026 Star Rating as a result of its lawsuit, it will realize a higher 2027 QBP. Likewise, other MAOs that see a Star Rating improvement under the methodology set out in the June 17 HPMS memorandum will see increased 2027 QBP ratings, and corresponding increases in rebates and QBPs, as a result of CMS's response to *Clover*. Those increased QBP ratings allowed those MAOs to resubmit bids for their 2027 MA contracts, which in turn will afford them the ability to increase their benefit offerings, lower premiums, or both. Meanwhile, Elevance Health—which under the June 17 HPMS memorandum performs no better than its original 2026

Star Ratings—has, as of now, no opportunity to rebid on its 2027 contracts. Therefore, Elevance Health—which competes with Clover in Georgia, among other service areas—will be at a competitive disadvantage with respect to its ability to attract and retain members. Elevance Health thus needs relief from this Court in time to resubmit bids with the benefit of knowing it, too, will realize higher 2027 QBP ratings that will result in increased rebates and QBPs across a number of its contracts.

3. ***The balance of the equities and public interest factors favor Elevance Health.*** The entire objective of the Star Ratings system is to convey accurately a "plan's quality" using data that are "complete, accurate, reliable, and valid." 83 Fed. Reg. 16440, 16520 (Apr. 16, 2018). And as one court has described it, through the Star Ratings program, CMS grades MA contracts on a curve. *See AvMed, Inc. v. Becerra*, No. 20-3385, 2021 WL 2209406, at *15 (D.D.C. June 1, 2021). In other words, consistency across the board is fundamental to the program. And yet, as of the filing of this motion, CMS is administering at least three different methodologies for 2026 Star Ratings: (i) the original ratings and QBP rating determinations for MA contracts that do not do better under the June 17 HPMS memorandum, which were based on 45 measures (including the 20 that this Court held in *Clover* were unlawful); (ii) revised QBP ratings (for MA contracts that did better under the June 17 HPMS memorandum, which were based in part on the measures that this Court held in *Clover* were unlawful); and (iii) Clover's apparently unique rating that is "consistent with" this Court's decision in *Clover*. Including invalid or unlawful measures to calculate the Star Ratings used by the public to pick between competing MA plans goes directly against the public interest. Beneficiaries deserve accurate, lawful Star Ratings to determine the quality of various plans in which they may choose to enroll.

BACKGROUND

I. Medicare and Star Ratings

Medicare is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42 U.S.C. § 1395 *et seq*. A Medicare beneficiary may choose to enroll in Medicare Part C, known since 2003 as Medicare Advantage. The MA program allows private health insurers to contract with CMS to provide Medicare-covered benefits to enrolled beneficiaries, thereby transferring the financial risk of providing Medicare benefits from the federal government to privately run MAOs in exchange for a per-member, per-month payment. *See* 42 U.S.C. § 1395w-23. The per-member, per-month payment amount paid must be at least as high as traditional Medicare spending per enrollee. MAOs must provide members with at least the same level of benefits offered by traditional Medicare.

Congress established an annual bidding process for MAOs. *See id.* § 1395w-23(a)(1)(B). Through this process, CMS establishes yearly benchmark rates aimed to represent CMS's cost to provide traditional Medicare benefits to an average enrollee in a particular county. *See id.* Every year, MAOs must submit a bid (by the first Monday in June) that represents the estimated cost for the MAO to provide basic Medicare benefits to members for the coming year, including administrative overhead and profit. *See id.* § 1395w-24(a)(1)(A). If a bid is lower than CMS's county-level benchmark, CMS returns a portion of the savings as a "rebate," which the MAO can use to fund additional benefits or reduce premiums (or both). *See id.* § 1395w-23(a)(1)(E).

The Medicare "Star Ratings" program is not a simple report card on an MA contract. The program is CMS's primary tool aimed at measuring and publicizing the quality of care provided by MAOs—and the primary mechanism through which Congress created financial incentives for MAOs to compete on quality. CMS established its Star Ratings system in 2007. Congress codified

the Star Ratings system in 2010, identifying § 1395w-22(e) as the exclusive source of data for quality rating calculations and omitting the clause previously granting the Secretary discretion to consider other measures. *See id.* § 1395w-23(o)(4)(A).

The objective of the Star Ratings system is to convey accurately a "plan's quality" using data that are "complete, accurate, reliable, and valid." 83 Fed. Reg. at 16520. *See also Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 5-8 (D.D.C. 2024); *Scan Health Plan v. Dep't of Health & Human Servs.*, No. 23-CV-03910, 2024 WL 2815789, at *1 (D.D.C. June 3, 2024). Furthermore, "Star Ratings are a curved grading system[.]" *AvMed, Inc.*, 2021 WL 2209406, at *15. A Star Rating synthesizes a range of quality data about each contract into a summary rating of 1 to 5 Stars, including half-Stars. CMS calculates a contract's overall Star Rating through a multi-step process. First, CMS scores the contract on each applicable "measure"—a discrete performance criterion measuring some aspect of quality—on a scale of 1 to 5. Second, CMS applies a predetermined weight to each measure score. Third, CMS aggregates the weighted measure scores into a single overall Star Rating. Because the overall Star Rating is a weighted average, a contract's score on any individual measure—particularly a high-weight measure—can tip the overall rating above or below a critical threshold. Star Ratings are made public and assist beneficiaries in identifying contract quality when choosing an MA or MA-Part D plan. *See* 83 Fed. Reg. at 16,520. The Star Rating rebate and QBP mechanism works as follows. For each MA contract, CMS establishes a county-level payment benchmark—a maximum amount CMS will pay per member per month for coverage in that county. A plan submits a bid representing its estimated cost of providing the standard Medicare benefit package to an enrollee of average health. If a plan's bid is below the benchmark, the difference between the bid and the benchmark is called the "rebate." *See* Blue Decl. ¶ 8.

CMS does not pay the full rebate to the plan; instead, it returns a percentage of the rebate to the plan, and that percentage is determined by the plan's Star Rating. CMS returns 50% of the rebate amount for plans rated below 3.5 Stars, 65% for plans rated at 3.5 or 4.0 Stars, and 70% for plans rated at 4.5 Stars or above. Under 42 U.S.C. § 1395w-23(o), CMS pays a QBP to MAOs whose contracts achieve a Star Rating of 4.0 or above. The QBP takes the form of an increased benchmark—the maximum per-member amount CMS will pay for the contract—which in turn allows the MAO to offer enhanced supplemental benefits and lower premiums. The combined effect of the higher benchmark and the higher rebate percentage means that a plan crossing the 4.0-Star threshold receives substantially more per member per month than a plan rated just below that threshold—even if the two plans submitted identical bids. Plans use QBP rebate amounts to provide supplemental benefits to enrollees, reduce cost-sharing, or reduce premiums. *See* Blue Decl. ¶ 9.

II. ***Clover*** **decision and June 17 HPMS memorandum**

On May 27, 2026, this Court set aside CMS's 2026 Star Rating for Clover and ordered CMS to recalculate Clover's rating. *See generally Clover Ins. Co.*, 2026 WL 1483515. The Court held that 42 U.S.C. § 1395w-23(o)(4)(A) requires that Star Ratings shall be determined based on data collected under § 1395w-22(e), and CMS may not base its Star Ratings on data derived from other sources. *Id.* at *10. The Court concluded CMS unlawfully included ten measures[2] in Clover's

[2] The ten unlawfully included measures are: Medication Adherence for Diabetes Medications (D08); Medication Adherence for Hypertension (RAS antagonists) (D09); Medication Adherence for Cholesterol (Statins) (D10); Call Center – Foreign Language Interpreter and TTY Availability (C33); Call Center – Foreign Language Interpreter and TTY Availability (D01); Reviewing Appeals Decisions (C32); Rating of a Drug Plan (D05); Getting Needed Prescription Drugs (D06); MTM Program Completion Rate for CMR(D11); and Statin Use in Persons with Diabetes (D12).

2026 Star Rating because those measures, which Clover specifically challenged, were not based on data derived from an appropriate data source. *Id.* at *14 (holding that "the plain text of 42 U.S.C. § 1395w-23(o)(4)(A), when read alongside surrounding statutory provisions in the Medicare Act, supports the conclusion that CMS may *only* base its quality rating calculations on measures using data collected under Section 1395w-22(e)"). Additionally, the Court held that ten other measures[3] were invalid because CMS did not promulgate the governing measure specifications through notice-and-comment rulemaking as required by 42 U.S.C. § 1395hh(a)(2). *Id.* at *25.

As a result, Clover's 2026 Star Rating was set aside. CMS was ordered to recalculate Clover's rating consistent with the Court's order. *Id.* The *Clover* order had an immediate effect. Within weeks, CMS informed Clover that it had recalculated Clover's 2026 Star Rating for its PPO MA contract (H5141)—which covers 97% of Clover's members—to 4.5 Stars for Contract Year ("CY") 2027. Clover Health Invs., Corp., Current Report (Form 8-K) (June 10, 2026).[4] CMS instructed Clover to submit alternate bids using the updated Star Rating. *Id.*

Meanwhile, in response to *Clover*, CMS announced for every other MAO its intent to voluntarily recalculate 2027 QBP ratings. *See* Blue Dec., Exh. 1, Mulcahy et al., Update to 2027 Quality Bonus Payment Determinations. But the methodology announced by CMS in its memorandum is not consistent with the holding in *Clover*. Instead, the June 17 HPMS memorandum methodology removes certain additional measures not addressed in *Clover*, while

---

[3] The ten invalid measures are: Improving or Maintaining Mental Health (C05); Reducing the Risk of Falling (C15); Getting Needed Care (C22); Rating of Health Care Quality (C25); Care Coordination (C27); Improving Bladder Control (C16); Annual Flu Vaccine (C03); Improving or Maintaining Physical Health (C04); Getting Appointments and Care Quickly (C23); and Customer Service (C24).

[4] https://www.sec.gov/Archives/edgar/data/1801170/000180117026000137/clov-20260609.htm.

including certain other measures that this Court held in *Clover* had been improperly adopted as part of the Star Rating calculation for 2026. *See generally id.* MAOs may opt into the recalculation if it results in a higher QBP rating; contracts that would receive a lower rating under the recalculation retain their original rating and are held harmless. *See id.*

Critically, publicly available information appears to confirm that CMS recalculated Clover's 2026 Star Rating based on a methodology different from that set out in the June 17 HPMS memorandum. As explained in the attached expert declaration of Tyler Marshall of the Berkeley Research Group, it is extremely unlikely that Clover could have obtained a 4.5 Star Rating based on the methodology of the June 17 HPMS memorandum. Marshall Decl. ¶ 20. As Mr. Marshall explains, "under the recalculation methodology described in CMS's HPMS memo, the Overall Star Rating for [the Clover contract] only reaches 4.0 Stars." *Id.* In other words, the public record appears to confirm that CMS extended to Clover more favorable terms than it extended to other MAOs, including Elevance. Thus, as Mr. Marshall explains, "[t]his likely results in 2026 Overall Star Ratings being calculated for MAOs under at least three distinct methodologies, *i.e.*, one methodology for Clover, another for MAOs that are recalculated under the HPMS Memo, and still another for those MAOs that retain their original 2026 Star Ratings." *Id.* ¶ 21.

III. The injury and irreparable harm to Elevance Health

MAOs that receive increased QBP ratings obtain increased revenue for 2027 and "a contract has greater economic flexibility to offer additional benefits or lower premiums, thus making it more competitive and attractive to health insurance consumers[.]" Chervenska Decl. ¶¶ 6-7; *see also* Kurdziel Decl. ¶ 7. If Elevance Health does not receive the relief it seeks here, it will lose its ability to fully compete in the marketplace. The ramifications of having a competitive disadvantage "including decreased enrollment, diminished market position, weakened provider

negotiations, and diminished brand recognition among beneficiaries, are not readily quantifiable or compensable in dollars after the fact." Kurdziel Decl. ¶ 11; *see also* Marshall Decl. ¶ 27 (pointing out that the disparate methodologies for calculating (or recalculating) 2026 Star Ratings "creates an unlevel playing field that could undermine the competitiveness of the bidding process").

Under the *Clover* holding, Elevance Health would be entitled to receive approximately $115 million in increased rebate payments and QBPs, attributable to five contracts. *See* Haskins Decl. ¶ 6(f). These additional payments would allow Elevance Health to provide improved benefits, including potentially lower premiums to its members. *See* Chervenska Decl. ¶¶ 6-7; Kurdziel Decl. ¶ 7. Further, "an understated Star Rating can affect not only the benefits available to members, but also the provider partners who participate in risk-based arrangements[.]" *See* Kurdziel Decl. ¶ 14.

The bidding process is extremely complex and, if Elevance Health is provided with an opportunity to resubmit its bids for 2027, that is a multi-faceted process, and "CMS would first need to recalculate the applicable Star Ratings" and complete multiple additional steps outside Elevance Health's control before Elevance Health can finalize a new 2027 bid. Chervenska Decl. ¶ 9. Time is of the essence here, and, to avoid irreparable harm, Elevance Health needs a decision to be rendered on or around August 14, 2026. This date is operationally important. A decision by that date "would still leave only a limited period for CMS action, actuarial certification, bid resubmission, and downstream implementation before the 2027 enrollment cycle" begins. *Id.*; *see also* Blue Decl. ¶ 28.

STANDARD

"[T]he purpose of a preliminary injunction is 'to preserve the court's ability to render a meaningful decision on the merits.'" *United States v. Stinson*, 661 F. App'x 945, 952 (11th Cir. 2016) (quoting *Canal Auth. of State of Fla. v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974)). A preliminary injunction is appropriate where a movant can demonstrate (1) it has a "substantial likelihood of success on the merits," (2) it "will suffer an irreparable injury unless the injunction is granted," (3) "the harm from the threatened injury outweighs the harm the injunction would cause the opposing party," and (4) "the injunction would not be adverse to the public interest." *Gonzalez v. Governor of Ga.*, 978 F.3d 1266, 1271 (11th Cir. 2020); *see also Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Because the opposing party in this case is the government, the third and fourth elements merge, and the harm to the government is analyzed as part of the public interest. *See Nken v. Holder*, 556 U.S. 418, 435 (2009); *Swain v. Junior*, 958 F.3d 1081, 1091 (11th Cir. 2020).

ARGUMENT

Here, each element supports the grant of preliminary injunctive relief in favor of Elevance Health. First, Elevance Health is likely to succeed on the merits, both because CMS has treated similarly situated MAOs (specifically, Elevance Health and Clover) differently, and, in any event, because the same 20 measures that this Court held in *Clover* were unlawfully or improperly adopted were used to calculate Elevance Health's 2026 Star Ratings. Second, Elevance Health faces a substantial threat of immediate and irreparable harm if this Court does not enter a preliminary injunction because it will lose MA contract market share, both in the Southeast and nationwide, due to its inability to compete in the marketplace on equal terms as other MAOs that receive the benefit of higher recalculated 2027 QBP ratings, and corresponding increased QBPs

and rebates. Finally, the balance of the equities and the public interest favors Elevance Health. In comparison to the competitive harm Elevance Health is facing, Defendants would bear only the burden of following the law (which this Court already decided in *Clover*) and applying the same Star Rating calculation methodology even-handedly. Lawful, equal treatment of MAOs serves the public interest, in particular, the consumers of MA health insurance.

Because each element is satisfied, this Court should grant the preliminary injunction. In the alternative, if the Court considers the *Clover* case, it should similarly find an injunction is a proper remedy.

I. Elevance Health is likely to succeed on the merits.

Whether a party is substantially likely to succeed on the merits is "generally the most important" element in determining whether to grant a preliminary injunction. *Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1223, 1232 (11th Cir. 2005). "A substantial likelihood of success on the merits requires a showing of only *likely* or probable, rather than *certain*, success." *Id.* Elevance Health is likely to succeed on all three of its claims for relief.

A. Elevance Health is likely to succeed in showing that CMS is not treating similarly situated MAOs similarly.

Elevance Health is likely to succeed in showing that CMS treated Elevance Health differently than it treated Clover without a reasoned basis for doing so. Like Clover, Elevance Health holds MA contracts with CMS that compete for membership based on quality. And, in fact, Elevance Health's largest contract competes in Georgia with the contract at issue in *Clover*. Blue Decl. ¶ 26 ("In Georgia, Elevance's contract H4036 is in direct competition for enrollees with the MA plans offered by . . . Clover."). The Star Ratings program is intended to create a level playing field between MAOs to allow the public to compare Medicare plans' performance based on the

same set of specified measures. *See, e.g.*, *Humana Inc. v. U.S. Dep't of Health & Human Servs.*, 806 F. Supp. 3d 642, 649 (N.D. Tex. 2025). This is especially important because "Star Ratings are a curved grading system[.]" *AvMed, Inc.*, 2021 WL 2209406, at *15. CMS may not, through its actions or inaction, deprive MAOs of the level playing field—doing so distorts the entire system.

As the D.C. Circuit has explained, "dissimilar treatment of evidently identical cases" is "the quintessence of arbitrariness and caprice." *Grayscale Invs.*, 82 F.4th at 1245 (quoting *Colo. Interstate Gas Co. v. FERC*, 850 F.2d 769, 774 (D.C. Cir. 1988)). Prior to filing this lawsuit, Elevance Health contacted CMS to request that CMS recalculate its 2027 QBP rating consistent with the *Clover* decision. Blue Decl. ¶ 12 & Ex. 2. Elevance Health explained in its letter that the June 17 HPMS memorandum did not give it any benefit and thus left behind Elevance Health (and other MAOs) that would benefit from revised and higher 2027 QBP ratings "based on the same set of measures that the *Clover* court afforded to Clover." *See id.* CMS, by written response, refused that request, ignoring the holding in *Clover* and pointing back to its June 17 HPMS memorandum as Elevance Health's only alternative to its original Star Ratings. *See id.* ¶ 12 & Ex. 4.

In *Grayscale*, the D.C. Circuit vacated the SEC's denial of Grayscale's product, a bitcoin futures fund, as arbitrary and capricious because the SEC failed to explain why it had denied Grayscale's proposed product but approved two materially similar products. *Grayscale Invs.*, 82 F.4th at 1242. The court explained, when a party "plausibly alleges it has received inconsistent treatment under the same rule or standard," a court must determine whether the agency "has offered a reasonable and coherent explanation for the seemingly inconsistent results." *Id.* at 1245 (citation omitted). The SEC offered none. The SEC's reasons for approving the comparable products "seem[ed] to apply equally to Grayscale," yet it denied Grayscale's product. *Id.* at 1251. Because the agency failed to provide "reasonable and coherent explanation for the[se] seemingly

inconsistent results," the court held the denial was arbitrary and capricious. *Id.* (quoting *Balt. Gas & Elec. Co. v. FERC*, 954 F.3d 279, 286 (D.C. Cir. 2020)).

For the same reason, CMS's disparate treatment of Elevance Health is arbitrary and capricious. This Court has itself passed upon the well-established principle of administrative law that an agency must treat similar cases in a similar manner unless it can provide a legitimate reason for failing to do so. *See Georgia v. Wheeler*, 418 F. Supp. 3d 1336, 1379 (S.D. Ga. 2019) (Wood, J.). As this Court pointed out in *Wheeler*, when it struck down an agency rule implementing the federal Clean Water Act extending a farming exemption to one category of regulated waters while withholding it from a similarly situated category and providing no reasoned basis for the different treatment, "[a] long line of precedent has established that an agency action is considered arbitrary when the agency has offered insufficient reasons for treating similar cases differently," *Id.* at 1379-80 (quoting *Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng'rs*, 833 F.3d 1274, 1289 (11th Cir. 2016)), or has failed to explain its reasoning at all, *id.* at 1380.

Here, CMS has done just that. CMS treats two similarly situated entities—Elevance Health and Clover—differently. In so doing, CMS offered no explanation for the difference. Furthermore, the difference in treatment benefits one entity, Clover, while harming the other, Elevance Health. Elevance Health and Clover are similarly situated in every material respect. Elevance Health is an MAO subject to the same rules and regulations as Clover, competing in the same markets for the same customers, and harmed by the same measures that the Court in *Clover* held were unlawfully adopted. In fact, Elevance Health's largest contract competes in Georgia with the very contract at issue in *Clover*, *see* Blue Decl. ¶ 26, making the harm direct and concrete. Here, CMS has now erected three different methodologies for determining 2027 QBP ratings to plans that are subject to the same statute, same regulatory framework, and the same unlawful measures. Clover's June

10 8-K shows it received a recalculated 2026 Star Rating consistent with this Court's decision, and the supporting declaration of Tyler Marshall demonstrates that the methodology CMS applied in recalculating Clover's 2026 Star Rating was more generous to Clover than that which CMS extended to other MAOs under the June 17 HPMS memorandum. Marshall Decl. ¶¶ 20-21.

There is no reasonable explanation for why Elevance Health is not entitled to have its Star Rating recalculated on the same terms that this Court held in *Clover*. Surely the disparate treatment cannot be explained by the fact that Clover obtained a judgment. What matters is that, in response to that judgment, CMS recalculated Clover's 2026 Star Rating pursuant to one methodology, while offering to recalculate other MAO ratings pursuant to a different methodology, and leaving any MAO that did not benefit from its non-*Clover* methodology with its original 2026 Star Rating. To take a program premised on scoring plans based on a level playing field and splinter it into three different cohorts based on three distinct scoring methodologies is textbook arbitrary and capricious conduct, cutting directly against the oft-recognized rule that "[r]egulated parties are entitled to know what an agency's rules require and to assume that administration of the rules will be reasonably predictable and coherent across cases." *Balt. Gas*, 954 F.3d at 286.

That CMS appreciates it cannot treat MAOs differently in how the Star Ratings are calculated even where litigation by an MAO is what initially upsets the status quo is demonstrated by CMS's own past conduct in just this type of situation. Two years ago, in a nearly identical posture following defeats in two Star Ratings cases,[5] CMS recalculated the 2024 Star Ratings for all MAOs. There was no argument then that the treatment given to the prevailing plaintiffs should or could lawfully be bifurcated from the treatment given to everyone else. CMS published a very

[5] *See Elevance Health*, 736 F. Supp. 3d 1; *Scan Health Plan*, 2024 WL 2815789.

similar HPMS memorandum at the time, explaining that it was recalculating all scores because of the court decisions.[6] What was evident in 2024 remains evident in 2026: an agency cannot—for whatever reason—treat similarly situated regulated entities differently without articulating a legitimate reason for doing so.

Elevance Health is likely to succeed on its claim that CMS was arbitrary and capricious for CMS's refusal to recalculate its 2026 Star Ratings consistent with the *Clover* decision.

B. For the very reasons already ruled upon in *Clover*, Elevance Health is likely to succeed in showing its 2026 Star Ratings should be set aside.

Even if CMS could justify treating Elevance Health differently in the calculation of its 2026 Star Ratings than CMS treated Clover, Elevance Health is still likely to prevail on the merits of its claim. This is because the fundamental flaws in how Elevance Health's 2026 Star Ratings were calculated are identical to those already addressed by this Court in the *Clover* case. In *Clover*, this Court identified two bases for rejecting the 20 measures targeted by Clover: 10 were deemed unlawful because they were based on data sources that the Medicare Act does not authorize CMS to consider; and another 10 were deemed procedurally improper because they were required to be, but were not, adopted through notice-and-comment rulemaking. *Clover Ins. Co.*, 2026 WL 1483515, at *10, *25.

The types of measures CMS may consider in its Star Rating analysis are statutorily mandated in 42 U.S.C. § 1395w-23(o)(4)(A): "[t]he quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w-22(e) of this title)." The permissible data sources for § 1395w-22(e)'s quality improvement program data are HEDIS, HOS, or CAHPS. *See* 69 Fed. Reg. 46866-01,

[6] *See* https://www.cms.gov/files/document/updateto2025qualitybonuspaymentdeterminations.pdf.

46,886 (Aug. 3, 2004) (identifying HEDIS, HOS, and CAHPS as the required measurement systems within the quality improvement program); *see also Clover Ins. Co.*, 2026 WL 1483515, at *8 n.8.

Further, Congress explains, "[n]o rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1)." 42 U.S.C. § 1395hh(a)(2). In *Clover*, this Court held that Star Ratings measures specifications are "statement[s] of policy" that govern the payment for services because they serve as a "deciding principle" for those payments. *Clover Ins. Co.*, 2026 WL 1483515, at *22, *24. This means that the notice-and-comment requirement is triggered to revise the Star Ratings measure specifications. As such, the Court found ten measures unlawful because they were based on improper data sources and another ten measures invalid because they were not promulgated through the notice-and-comment period. *Id.* at *10, *25.

Elevance Health asks for relief from those same 20 measures, because those same measures factored into its 2026 Star Ratings. Because this Court has already passed judgment on these same two issues, Elevance Health is likely to succeed on these arguments.

II. Elevance Health will be irreparably harmed absent preliminary injunctive relief.

The test for irreparable harm absent a preliminary injunction is "whether there is any adequate remedy at law for the injury in question." *Sierra Club v. Martin*, 71 F. Supp. 2d 1268, 1327 (N.D. Ga. 1996). An injury is irreparable if it cannot be undone through monetary remedies. *See Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283,

1285 (11th Cir. 1990). Here, what would be irreparable absent a preliminary injunction is Elevance Health's ability to offer competitive plans for CY 2027.

Elevance Health stands to be irreparably harmed in the absence of a preliminary injunction due to the nature of the MA contracting calendar. An MAO that receives an increased rebate or a QBP as a result of a higher QBP rating has greater flexibility to offer additional benefits in its plan(s), lower premiums, and implement quality improvement programs—all for the benefit of its members. *See* Marshall Decl. ¶¶ 26-28. These benefits make an MAO more competitive in the MA health insurance marketplace. But timing is paramount. Each year, to receive an MA contract with CMS, a plan must submit a bid that includes its estimated cost for covering certain benefits to an average enrollee for the upcoming year. Blue Decl. ¶ 5; Chervenska Decl. ¶¶ 4-5. For CY 2027, Elevance Health submitted its bids to CMS by June 1, 2026—the statutory deadline. Blue Decl. ¶ 5. Those bids include extensive supporting documentation, including information about the benefits and cost-sharing the plan will cover and a detailed financial breakdown of how the plan arrived at its bid amount, with actuarial basis and support for the calculations. *Id.* ¶ 6; Chervenska Decl. ¶ 4. For CY 2027, as in any year, Elevance Health designed its benefits and set its premiums to be as competitive as possible against other MAOs by analyzing competitor MAOs' existing benefit offerings and publicly available Star Ratings. Kurdziel Decl. ¶ 5. "These data points about competitor benefits offerings factor heavily into how an MAO structures its own benefits. . . . Elevance designed its benefits, set its premiums, and calibrated its cost-sharing against that known background." *Id.* This allowed Elevance Health to make educated calculations of others' QBPs and ability to provide or cut benefits based on the QBPs. *Id.*

Competing MAOs that benefitted from the June 17 HPMS memorandum Star Ratings recalculation methodology redesigned and resubmitted bids that will provide better benefits and

likely lower premiums to beneficiaries. *Id.* ¶ 7. "[C]ompetitors whose recalculated QBP ratings produced a QBP or rebate increase are now in the process of redesigning and resubmitting bids that will fund richer supplemental benefits, lower premiums, and reduced cost-sharing than those competitors originally intended to offer." *Id.* Because Elevance Health did not benefit from the June 17 HPMS memorandum methodology, and because CMS has refused to recalculate Elevance Health's 2026 Star Ratings consistent with the *Clover* decision, Elevance Health is at a competitive disadvantage. MAOs that took advantage of the June 17 HPMS memorandum to recalculate their 2027 QBP ratings will be positioned to offer better benefits and lower premiums during the upcoming Annual Enrollment Period. *Id.*; *see also* Marshall Decl. ¶¶ 26, 28. Courts in this Circuit consistently recognize competitive harm as irreparable and thus as a basis to grant preliminary injunctive relief. *See, e.g.*, *United Parcel Serv., Inc. v. Mercado*, 799 F. Supp. 3d 1281, 1295 (N.D. Ga. 2025) ("loss of competitive edge" irreparable); *Bee Warehouse, LLC v. Blazer*, 671 F. Supp. 3d 1347, 1362 (N.D. Ala. 2023) ("loss of market position" irreparable); *C.B. Fleet Co. v. Unico Holdings, Inc.*, 510 F. Supp. 2d 1078, 1083 (S.D. Fla. 2007) ("loss of market share is more than sufficient to establish irreparable harm").

To avoid being irreparably harmed, *i.e.*, to avoid losing the window to rebid on its CY 2027 contracts with more generous benefits offerings, Elevance Health needs relief on or around August 14—after that, the window of opportunity for Elevance Health to increase its benefit offerings to be competitive for CY 2027 will close. Blue Decl. ¶ 28; Chervenska Decl. ¶¶ 9-10. Once contracts are finalized and MAOs market their CY 2027 benefits to members and prospective enrollees, there is no going back. Blue Decl. ¶ 19 ("The bid is a key legal and financial foundation of Elevance's 2027 operations. . . . Once the bid is submitted and certified by CMS, the benefit package for the coming year is, as a practical matter, fixed."). Enrollment choices lock

beneficiaries into their selected plan for the entire plan year absent qualifying special enrollment circumstances, which are limited. Kurdziel Decl. ¶¶ 10-11 ("[The Annual Enrollment Period] is the annual period during which most Medicare beneficiaries make enrollment decisions."). If Elevance Health enters the enrollment period with inferior benefits, because it bid from a lower benchmark driven by non-recalculated Star Ratings, Elevance Health is likely to lose enrollees, and fail to attract new ones, to competitors who are offering richer, more attractive benefits. *Id.* Those enrollment losses cannot be reversed mid-year. *Id.* ¶ 10.

III. The balance of the equities and the public interest favor Elevance Health.

When the opposing party is the government, harm to the government is analyzed as part of the public interest. *See Nken*, 556 U.S. at 435; *Swain*, 958 F.3d at 1091. This analysis asks, "whether any significant 'public consequences' would result from issuing the preliminary injunction." *Gayle v. Meade*, 614 F. Supp. 3d 1175, 1206 (S.D. Fla. 2020) (quoting *Winter*, 555 U.S. at 24). "There is generally no public interest in the perpetuation of unlawful agency action." *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016).

Here, the balance of the equities and the public interest clearly favors Elevance Health. Defendants will not suffer any harm should CMS be required to recalculate Elevance Health's 2026 Star Ratings consistent with the decision of this Court in Clover. On the other hand, Elevance Health will suffer significant competitive harm and be unable to offer additional benefits and lower premiums to its members if its 2026 Star Ratings are not recalculated consistent with *Clover*.

Not only will Elevance Health suffer competitive harm by the new tripartite Star Ratings ecosystem CMS has created, Medicare beneficiaries stand to lose confidence in the system. Star Ratings are intended to provide information to beneficiaries related to an MA plan's quality. Including invalid or unlawful measures in the information used by the public to choose between

MA plans goes directly against the public interest. Beneficiaries deserve—and have a compelling interest in—accurate, lawful Star Ratings to determine the quality of various plans. If one contract's rating excludes 20 unlawful measures from its calculations, while the ratings of other contracts (like Elevance Health's) continue to be based on those unlawful measures, and the ratings of yet a third category of contracts (subject to the June 17 HPMS memorandum) include some but not all of those unlawful measures, the public is deprived of a transparent, accurate, and reliable reflection of the plans' quality.

Those provider partners with whom Elevance Health has shared-risk arrangements will similarly be harmed without the requested relief. The additional revenue and improved benefit offerings impact provider partners because those "benefits and reduced member cost sharing can support provider relationships, member access, care coordination, and the overall economics of shared-risk arrangements." Kurdziel Decl. ¶ 14.

Further, the public has a compelling interest in consistent application of rules and regulations; CMS's action in treating MAOs differently goes against that interest. The inconsistent Star Ratings recalculation between MAOs and refusal to offer the choice to opt into the 2026 Star Rating recalculation methodology provided to Clover leads to favoring one MAO over others. "[D]issimilar treatment of evidently identical cases" is "the quintessence of arbitrariness and caprice." *Grayscale Invs.*, 82 F.4th at 1245 (quoting *Colo. Interstate Gas Co.*, 850 F.2d at 774). Favoring one or more MAOs above others is against the public interest and favors issuing the preliminary injunction requested herein.

CONCLUSION

For the foregoing reasons, Elevance Health respectfully requests that this Court preliminarily enjoin Defendants from refusing to recalculate Elevance Health's 2026 Star Ratings

consistent with this Court's holding in *Clover*. The requested injunction does not seek to alter the Star Ratings of any other MAO. Elevance Health asks only that Defendants be required to do something this Court has already once ordered with respect to another MAO: to recalculate Elevance Health's 2026 Star Ratings consistent with this Court's holding in *Clover* that the same 20 challenged measures were unlawfully adopted and should not have been relied upon.

Respectfully submitted this 7th day of July, 2026.

/s/ *Benjamin H. Brewton*
Benjamin H. Brewton
Georgia Bar No. 002530
bbrewton@balch.com
Jena C. Lombard
Georgia Bar No. 213734
jlombard@balch.com
Balch & Bingham LLP
801 Broad Street, Suite 800
Augusta, Georgia 30901
Telephone: (706) 842-3711
Facsimile: (866) 258-8984

James L. Hollis
Georgia Bar No. 930998
jhollis@balch.com
Balch & Bingham, LLP
30 Ivan Allen Jr. Blvd. NW, Suite 700
Atlanta, Georgia 30308
Telephone: (404) 962-3585
Facsimile: (866) 332-8969

Daniel W. Wolff (*pro hac vice* forthcoming)
DWolff@crowell.com
D.C. Bar No. 486733
Crowell & Moring LLP
600 Fifth Street NW
Washington, DC 20001
Telephone: (202) 624-2621

Steven D. Hamilton (*pro hac vice* forthcoming)
StevenHamilton@crowell.com
Illinois Bar No. 6289663
Crowell & Moring LLP
300 N. LaSalle Drive, Suite 2500
Chicago, IL 60654
Telephone: (312) 379-7615

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system and service will be perfected upon the following as indicated below this 7th day of July, 2026:

US Attorney, Southern District of Georgia
22 Barnard Street, Suite 300
Savannah, GA 31401
USAGAS.Webmaster@usdoj.gov
bradford.patrick@usdoj.gov
(via personal service and email)

/s/ *Benjamin H. Brewton*
Counsel for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

DECLARATION OF ANNIE KURDZIEL

I, Annie Kurdziel, declare as follows:

1. I am the Vice President, Chief Product Officer, Government Health Benefits for Elevance Health, Inc. ("Elevance"). I submit this declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case.

2. Part of my Chief Product Officer responsibilities in the role include leading the Medicare Product team that partners with actuary and the business leadership to shape the benefit choices for the Annual Enrollment Period ("AEP") for the bid. I am involved in the coordinated development, evaluation, and execution of Elevance's Medicare Advantage product strategy, including the design of benefit structures, product offerings, market positioning, and related capabilities that support Elevance's Medicare Advantage portfolio. That work is conducted in

coordination with actuarial, finance, compliance, operations, regional leadership, sales, distribution, marketing, clinical, and other cross-functional teams. In that role, I help guide the development of Elevance's Medicare Advantage offerings for each annual bid and enrollment cycle, including the assessment of market needs, competitive dynamics, member experience considerations, regulatory requirements, benefit design, and operational readiness. I work closely with the functions that support the bid, benefit-design, pricing, approval, implementation, and go-to-market processes described in this declaration. Through my role, I am familiar with the Medicare Advantage bid process, the Star Ratings, rebate and Quality Bonus Payment ("QBP") framework, CMS requirements affecting product and benefit design, and the operational calendar that governs the transition from bid submission through approval, implementation, and AEP. My team also includes the Product Leader for the Group Retiree business.

3. I am making these statements based on my personal knowledge and professional experience and judgment.

4. The purpose of my declaration is twofold: First, I want to explain the competitive disadvantage the memorandum issued by CMS on June 17, 2026 creates for Elevance. Second, I want to explain the additional level of benefits Elevance could offer through its MA contracts at issue in its complaint if it were to obtain the relief it seeks (as explained by Mr. Haskins) in time to revise its bids for the 2027 Calendar Year ("CY") (as explained by Mr. Blue).

Why CMS's June 17 memo creates a competitive disadvantage.

5. When Elevance submitted its original CY 2027 bid in advance of the June 1, 2026, deadline, it did so against a particular competitive landscape in which all other plans in its service area were also operating from their original Star Ratings. All Medicare Advantage Organizations ("MAOs") rely on a level playing field in preparing bids. Although Elevance (as with any MAO)

has no direct insight into the particular benefits competitor plans offer in their annual bids, there is certain competitive intelligence that any MAO has about its competitors, including its existing benefit offerings and its Star Ratings. The Star Ratings are insightful because they allow other MAOs to make educated assessments of the rebates and QBPs that competitors will receive, and thus of a competitor's ability to offer greater benefits or, conversely, need to stay even with the prior year or even cut benefits. These data points about competitor benefits offerings factor heavily into how an MAO structures its own benefits. For CY 2027, as in any year, Elevance designed its benefits, set its premiums, and calibrated its cost-sharing against that known background.

6. That landscape no longer exists; it has been upended by the *Clover* decision and CMS's own decision, in response to *Clover*, to issue the June 17 HPMS memorandum. If CMS had recalculated Elevance's Star Rating for the identified contracts consistent with the holding in *Clover*, Elevance would see higher Star Ratings for 2026 for five of its contracts and, as a result, greater 2027 QBPs and rebates. Under the June 17 HPMS memorandum, Elevance realizes no increased 2027 QBP ratings but understands that other MA organizations will benefit from CMS recalculation and are submitting requests for their 2027 bids to be redone. That by itself causes a distortion of the landscape by which competing plans would have submitted their CY 2027 bids. Contract H8849 for example, competes for membership with that plaintiff's contract, but obviously as of June 1, when Elevance submitted its CY 2027 bids, it was not factoring that plaintiff's now recalculated 2026 Star Rating into its bidding logic; rather, it was factoring that plaintiff's original Star Rating into its bidding logic.

7. In its June 17 HPMS memorandum, CMS does not offer other MA contracts the right to recalculate their own 2026 Star Ratings based on the *Clover* decision. Rather, CMS fashioned a brand-new modification to the status quo—recalculating ratings under a whole new

formulation of measures. Mr. Haskins explains why the June 17 HPMS memorandum does not offer any benefit to Elevance. What I want to explain is how the opportunity that memo provides to other MAOs that do see a benefit from the recalculation to rebid on CY 2027 prejudices Elevance. Specifically, competitors whose recalculated QBP ratings produced a QBP or rebate increase are now in the process of redesigning and resubmitting bids that will fund richer supplemental benefits, lower premiums, and reduced cost-sharing than those competitors originally intended to offer. Elevance cannot do the same. It is therefore entering the 2027 Annual Enrollment Period at a structural disadvantage relative to competitors whose benefit offerings it could not have anticipated.

8. The magnitude of this disadvantage is a function of the rebate differential that competitors will enjoy relative to their original bids. Even a fraction-of-a-star increase can translate into a meaningfully higher QBP rating and, accordingly, a larger rebate pool available to fund supplemental benefits. Competitors who receive a higher benchmark by virtue of the June 17 HPMS memorandum's corrective recalculation can redirect those additional rebate dollars toward dental, vision, hearing, fitness, and over-the-counter benefits that Elevance's budget cannot support, because the Plan's benefit design was locked in at the June 1, 2026 deadline.

9. In a market where beneficiaries routinely select plans based on supplemental benefit offerings, and where premium and cost-sharing differentials of even modest magnitude drive enrollment decisions, the benefit gap created by competitors' rebids is not a marginal concern.

10. The competitive harm is structural and cannot be remedied after the fact. AEP is the annual period during which most Medicare beneficiaries make enrollment decisions. Enrollment choices made during the AEP lock-in beneficiaries into their selected plan for the entire

subsequent plan year absent qualifying special enrollment circumstances, which are limited. If Elevance enters the AEP with inferior benefits, because it bid from a lower benchmark driven by an uncorrected Star Rating, Elevance is likely to lose enrollees to competitors who are offering richer, more attractive benefits. In addition, the impact of this case includes our Group Retiree contract H4036. Although H4036 does not sell exclusively during AEP, given the nature of the Group Retiree sales cycle, a change in the contract's Star Rating affects how we assess the product's financial position, benefit design, pricing, renewal strategy, customer communications, and operational readiness. In the group retiree market, employer and plan-sponsor customers make renewal and purchasing decisions based on a combination of pricing, benefits, service capabilities, quality performance, member experience, and Star Ratings. As a result, an incorrect Star Rating can affect Elevance's ability to offer competitive renewal terms, maintain existing group retiree relationships, and communicate accurately with plan sponsors and retirees regarding the quality and value of the product. Once those renewal decisions and communications have occurred, the harm is difficult to reverse, because plan sponsors and retirees generally cannot restart the renewal, implementation, and communication process mid-year.

11. The injuries described above, including decreased enrollment, diminished market position, weakened provider negotiations, and diminished brand recognition among beneficiaries, are not readily quantifiable or compensable in dollars after the fact. The harm is not simply a matter of lost revenue for a single year. It is a structural distortion of the competitive landscape that will compound year over year, affecting Elevance's long-term market position in ways that no post hoc damages award can restore.

The additional benefits Elevance could offer if it obtains the relief it seeks.

12. If Elevance were to obtain the relief it seeks and obtain it in time to modify its existing CY 2027 bids and meet its obligations before the start of open enrollment, Elevance could offer a multitude of additional benefits, after we have met the requirement to pass the respective tests and adjust Part C and Part D benefits including backing out targeted reductions or enhancing benefits as needed. The product impact of a corrected Star Rating and resulting rebate and/or QBP increase would be evaluated at the plan benefit package ("PBP") level, not only at the contract level. The specific product actions available for a particular contract would depend on the PBPs affected, the amount of additional revenue available for each PBP, and the amount of change needed for each PBP to satisfy applicable CMS bid requirements, including Total Beneficiary Cost ("TBC") and high-margin testing. Depending on the TBC level, each PBP may have a different path to satisfying those requirements, and Elevance would not necessarily apply the same benefit changes across all PBPs or contracts.

13. For PBPs affected by high-margin testing, the product actions would depend on the nature of the PBP and the applicable financial arrangement. For non-risk plans, Elevance would generally evaluate adjustments to A/B benefits, Part D benefits, and supplemental benefits as needed to satisfy the applicable target. For risk plans, Elevance would generally evaluate whether to reverse targeted reductions to A/B benefits and then consider Part D and supplemental benefit enhancements as needed to meet the applicable target. In some circumstances, timing or procedural constraints could limit the ability to make Part D changes before rebate reallocation, in which case Elevance may need to focus on Part C benefit adjustments. There are several examples of the types of benefits that Elevance could consider enhancing if the affected contracts received the corrected Star Rating and associated rebate and/or QBP revenue. For our plans in California, Texas, and Arizona, depending on the affected PBP and the applicable bid tests, we would consider

investments in benefits such as reduced Medicare Part A and Part B cost sharing, enhanced Part D benefits, dental benefits, vision benefits, hearing benefits, over-the-counter allowances, transportation benefits, grocery or utility supports where permitted, and other supplemental benefits designed to improve affordability, access, and member experience. The specific benefits considered would vary by contract and PBP, because each PBP may have different test results, revenue impacts and competitive needs.

14. These investments would not affect Elevance Health alone. For PBPs in which Elevance has shared-risk arrangements with provider partners, additional revenue and improved benefit positioning would also be favorable to those provider constituents. Improved benefits and reduced member cost sharing can support provider relationships, member access, care coordination, and the overall economics of shared-risk arrangements. As a result, an understated Star Rating can affect not only the benefits available to members, but also the provider partners who participate in risk-based arrangements connected to those PBPs. For Contract H4036, which primarily serves Elevance's Group Retiree clients, additional rebate revenue would support further investment in member engagement and quality-related programs. Those investments could include incentives or outreach designed to encourage members to complete preventive and quality-related activities, such as A1C screenings, cancer screenings, annual wellness visits, medication adherence activities, health risk assessments, and other care-gap closure initiatives. These programs are important to member health, quality performance, and the value proposition Elevance offers to employer and plan-sponsor customers in the group retiree market.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 7th day of July, 2026.

Annie Kurdziel

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

DECLARATION OF JAMES HASKINS

I, James Haskins, declare as follows:

1. I am the Director, Advanced Analytics for Elevance Health, Inc. ("Elevance"). I submit this declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case. The statements contained herein are based on my own personal knowledge and professional experience.

2. I serve as Director of Advanced Analytics for Medicare Stars and CAHPS, leading analytics strategy, forecasting, performance monitoring, and analytic support for Elevance Health's Medicare Star Ratings program. A core function of my role is supporting the full Star Ratings cycle from an analytics perspective including Plan Preview 1 and 2 data validation, as well as verifying the accuracy of yearly published Star Ratings on Medicare Plan Finder.

3. As an extension of ensuring the accuracy of published Star Ratings as well as validation of rebate and Quality Bonus Payment ("QBP") status for all Elevance contracts. The validation activities are conducted using the Improvement and Star Ratings calculation excel files CMS provides to compliance, which are then shared with the Stars and CAHPS analytics team.

4. The purpose of my declaration is to explain the differential in rebate and QBP revenue that Elevance is projected to receive for 2027 based on its existing 2026 Star Ratings, and the QBP and rebate revenue that Elevance *would* be projected to receive for 2027 if CMS applied to Elevance 2026 Star Rating measures consistent with the decision by the U.S. District Court for the Southern District of Georgia in a lawsuit brought by Clover Insurance Company ("Clover") against CMS (the "Clover Litigation").

5. It is my understanding that the court in the Clover Litigation concluded that certain Star Ratings measures were not properly utilized by CMS and that Clover's 2026 Star Ratings scores for a certain Clover-held contract should be recalculated by excluding the following measures from Clover's Star Ratings: D01, D05, D06, D08, D09, D10, D11, D12, C03, C04, C05, C15, C16, C22, C23, C24, C25, C27, C32, C33 (the "Clover Measures").

6. If CMS had recalculated the Star Rating for Elevance's contracts by excluding the Clover Measures, the following contracts held by the identified Elevance affiliates would receive a higher 2026 Star Rating and realize higher 2027 rebate and QBP calculation: H0544, H0907, H1423, H4036, and H8849. The details for those contracts are as follows:

a. Contract H0544, held by Blue Cross of California, has a membership of 50,087 and serves enrollees in California. Its 2026 Star Rating was 3.0. If the Star Rating for H0544 were recalculated by excluding the Clover Measures, its Star Rating would be 3.5. In turn, its rebate for 2027 would increase by approximately $9,600,000.

b. Contract H0907, held by Wellpoint Iowa, Inc., has a membership of 4,275 and serves enrollees in Iowa. Its 2026 Star Rating was 3.0. If the Star Rating for H0907 were recalculated by excluding the Clover Measures, its Star Rating would be 3.5. In turn, its rebate for 2027 would increase by approximately $2,700,000.

c. Contract H1423, held by Wellpoint Health Plans, Inc., has a membership of 3,886 and serves enrollees in Arizona. Its 2026 Star Rating was 3.0. If the Star Rating were recalculated by excluding the Clover Measures, its rating would be 3.5 Stars. In turn, its rebate for 2027 would increase by approximately $790,000.

d. Contract H4036, held by Anthem Insurance Companies, Inc., has a membership of 365,764 and serves enrollees in Ohio, Wisconsin, Kentucky, and Georgia. Its 2026 Star Rating was 4.0. If the Star Rating were recalculated by excluding the Clover Measures, its rating would be 4.5 Stars. In turn, its rebate and QBP for 2027 would increase by approximately $65,800,000.

e. Contract H8849, held by Wellpoint Insurance Company, has a membership of 54,306 and serves enrollees in Texas. Its 2026 Star Rating was 3.5. If the Star Rating were recalculated by excluding the Clover Measures, its rating would be 4.0 Stars. In turn, its rebate and QBP for 2027 would increase by approximately $36,500,000.

f. In total, if CMS applied the outcome in Clover to the Elevance contracts, Elevance has five contracts that would see increased rebates and QBPs for 2027, together amounting to more than $115 million.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 7 day of July, 2026.

James Haskins

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

DECLARATION OF JAROD BLUE

I, Jarod Blue, declare as follows:

1. I am the Medicare Chief Growth Officer for Elevance Health, Inc. ("Elevance"). I submit this declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case. I am making these statements based on my personal knowledge and professional experience and judgment regarding the MA program's operational calendar.

2. As Medicare Chief Growth Officer, I am involved in the coordinated development and execution of Elevance's Medicare Advantage growth efforts, including the sales, distribution, marketing, and platform capabilities that support those efforts. That work is conducted in coordination with regional leadership, marketing partners, and other cross-functional teams. In that role, I help prepare Elevance's Medicare Advantage offerings for each annual enrollment cycle

and work closely with the actuarial, finance, product, compliance, and operations functions that support the bid, benefit-design, and go-to-market processes described in this declaration. Through my role, I am familiar with the MA bid process, the Star Ratings and Quality Bonus Payment ("QBP") framework, and the operational calendar that governs the transition from bid submission to the Annual Enrollment Period ("AEP"). The statements in this declaration are based on my personal knowledge, my review of relevant Elevance business records and information made available to me in the course of my duties, and my professional experience and judgment.

3. The Centers for Medicare & Medicaid Services ("CMS"), an agency within the U.S. Department of Health and Human Services, administers the Medicare Advantage program. Generally speaking, Medicare Advantage offers the benefits of the federal Medicare health insurance program under the management of a private insurance company, known as a Medicare Advantage ("MA") organization, or MAO.

4. Elevance is one of the largest MAOs in the country, offering Medicare Advantage plans through its health-plan subsidiaries that contract directly with CMS. The MA contracts identified in the complaint are held by certain of those subsidiaries, each of which is licensed to offer Medicare Advantage products in its respective service area.

5. By way of brief background, each year an MAO must submit a bid to CMS that represents, among other things, its estimated cost for covering Medicare-defined standard benefits to an average enrollee for the upcoming year. Initial bids were submitted to CMS by June 1, 2026 for Contract Year 2027. The AEP for calendar year 2027 will commence on October 15, 2026.

6. As addressed in greater detail in a separate declaration by my colleague, Veronika Chervenska, these bids require extensive supporting documentation, including information about

the benefits and cost sharing that the plan will cover and a detailed financial breakdown of how the plan arrived at its bid amount, with the actuarial basis and support for the calculations.

7. MA contracts are rated by CMS annually on a five-star basis. Originally, the primary purpose of this so-called Star Ratings program was to provide consumers with a measure of comparison between plans available in their service areas. But since the implementation of the Affordable Care Act ("ACA"), the Star Ratings program has also been central to an MAO's finances because Congress tied rebates and an annual QBP to an MA contract's Star Rating. (This only applies to MA contracts offering benefits under Medicare Part C, or both Parts C and D. It does not apply to contracts that offer benefits only under Part D, which governs Medicare Prescription Drug Plans.)

8. For each MA contract, CMS establishes a county-level payment benchmark—a maximum amount CMS will pay per member per month for coverage in that county. A plan submits a bid representing its estimated cost of providing the standard Medicare benefit package to an enrollee of average health. If a plan's bid is below the benchmark, the difference between the bid and the benchmark is called the "rebate."

9. CMS does not pay the full rebate to the plan; instead, it returns a percentage of the rebate to the plan, and that percentage is determined by the plan's Star Rating. CMS generally returns 50% of the rebate amount for plans rated below 3.5 Stars, 65% for plans rated at 3.5 or 4.0 Stars, and 70% for plans rated at 4.5 Stars or above. Separately, plans rated at or above 4.0 Stars also receive an additional benefit in the form of a QBP, whereby CMS increases the benchmark itself by 5 percentage points before calculating the rebate, meaning the pool from which the rebate is drawn is larger to begin with. The combined effect of the higher benchmark and the higher rebate percentage means that a plan crossing the 4.0-Star threshold receives substantially more per

member per month than a plan rated just below that threshold—even if the two plans submitted identical bids. Plans use rebate and QBP amounts to provide supplemental benefits to enrollees, reduce cost-sharing, or reduce premiums.

10. CMS also publishes regulations governing the determination of the Star Ratings, including at 42 C.F.R. § 422.162 *et seq.* and 42 C.F.R. § 423.182 *et seq.*

11. On June 17, 2026, CMS issued a memorandum on its Health Plan Management System ("HPMS")—the "June 17 HPMS memorandum"—announcing that it would voluntarily recalculate 2027 QBP ratings for certain MA contracts in light of a court decision (*Clover Insurance Co. v. Department of Health and Human Services*) which ruled that CMS had improperly adopted 20 "measure" scores that factored into an MA contract's overall 2026 Star Rating. A true and correct copy of this memorandum is attached hereto as Exhibit 1. Elevance's understanding from a June 10 filing with the Securities and Exchange Commission by the plaintiff in *Clover* is that CMS recalculated that plaintiff's 2026 Star Rating by removing those 20 measures from the score. The methodology CMS announced in its June 17 HPMS memorandum for recalculating 2027 QBP ratings did not track the *Clover* decision in key respects.

12. On June 24, 2026, Jennifer Jarrell, Elevance Vice President, Member Star Performance and Member Experience, sent CMS a letter to the CMS Star Ratings Mailbox at PartCandDStarRatings@cms.hhs.gov. This letter requested that CMS expand upon the options set forth in the HPMS memorandum and requested that CMS offer MAOs the option of having their 2027 QBP ratings recalculated based on the same set of measures that the *Clover* court afforded to Clover, in addition to the two existing options set forth in the HPMS memorandum. A true and correct copy of this letter is attached hereto as Exhibit 2. On June 25, 2026, CMS sent an email to Ms. Jarrell confirming receipt of the letter from Elevance. A true and correct copy of this email is

attached hereto as Exhibit 3. Then, on June 26, 2026, CMS again sent an email to Ms. Jarrell, from the Part C and D Star Ratings Mailbox, responding to Elevance's letter of June 24th, declining to provide Elevance's requested relief and stating that "[y]our request to change the terms of the hold harmless is not consistent with the HPMS memo attached and released on June 17th. In that memo, we stated 'We recalculated the 2027 QBP ratings for MA organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data.' We held all contracts harmless if the recalculated QBP rating resulted in a lower rating." A true and correct copy of this email is attached hereto as Exhibit 4.

13. I have been asked to explain, from an operational standpoint, how Elevance would likely be injured in the absence of obtaining immediate relief as requested in our preliminary injunction motion, *i.e.*, a recalculated Star Rating on the same terms as ordered for the MA contract in *Clover*. This relief is important because an MA contract's Star Rating dictates its rebates and/or QBPs for the following calendar year. A higher rating means a higher rebate and/or QBP, and more budgeted revenue for the following year.

14. Based on that higher budget, a contract has greater economic flexibility to offer additional benefits or lower premiums, thus making it more competitive and attractive to health insurance consumers considering Medicare Advantage for health insurance coverage. As explained in more detail in Ms. Chervenska's declaration, an MA contract factors the expected Star rating into its pricing calculations when preparing and submitting its bid to CMS for the following year.

15. If CMS were to recalculate the 2026 Star Ratings for Elevance's MA contracts identified in the complaint on terms consistent with the holding in *Clover*, its Star Ratings would

improve and result in substantially higher 2027 rebates and QBPs. The anticipated financial impact Elevance would expect to realize is addressed by my colleague James Haskins in his separate declaration. As I explain further below, and even assuming Elevance undertakes substantial preparatory work in advance at its own risk and expense, Elevance's opportunity to resubmit bids for its CY 2027 contracts on the basis of corrected ratings would, as a practical matter, be at substantial risk of becoming infeasible if the requested relief is not obtained by on or around August 14, 2026.

16. Pursuant to the statutory deadline (the first Monday in June of each year) and the usual annual cadence of MA contracting, bids for CY 2027 were submitted to CMS by June 1, 2026. Under the June 17 HPMS memorandum, however, MA contracts that realize an increase in their 2027 QBP ratings positively impacting their benchmark or rebate amount were given a time-limited opportunity to resubmit their CY 2027 bids. MA contracts that do not see a positive impact based on the recalculation offered by CMS would remain subject to their original Star Rating and resulting 2027 QBP rating, and cannot resubmit CY 2027 contract bids, even though the federal court ruled in *Clover* that certain "measure" scores that factored into CMS's calculation of the 2026 Star Ratings were improperly or unlawfully used by CMS.

17. Elevance will not realize a positive impact on its 2027 QBP rating under the methodology set out in the June 17 HPMS memorandum. Accordingly, it was not afforded a rebid opportunity for CY 2027. In contrast, had Elevance been given the ability to recalculate its 2027 QBP rating under the reasoning set out in *Clover*, it would realize higher Star Ratings for the contracts named in the lawsuit and, based on the separate declaration of James Haskins, would realize more than $115 million in increased 2027 rebates and QBPs. That is additional revenue that Elevance could budget for CY 2027 and thus put toward lower premiums and more generous

benefits. But time is of the essence for Elevance to be able to factor that additional revenue into its CY 2027 bids.

18. The number of moving parts hinge off of the bidding process. The MA bid cycle is deeply integrated into a cascade of statutory, regulatory, and operational obligations involving CMS, Elevance, its contracted vendors, its actuaries, and CMS contracting processes.

19. The bid is a key legal and financial foundation of Elevance's 2027 operations for its Medicare Advantage line of business. Once the bid is submitted and certified by CMS, the benefit package for the coming year is, as a practical matter, fixed. CMS then uses those bids to certify benefit packages, review them for compliance with statutory and regulatory standards, and ultimately publish plan information to beneficiaries and on the Medicare Plan Finder, a website that allows consumers to shop for MA plans available in their area. Outside the limited circumstances CMS itself authorizes—such as the rebid opportunity described in the June 17 HPMS memorandum—the MA program's standard annual cycle does not contemplate a plan unilaterally re-opening, amending, or resubmitting a bid after the bid submission window has closed.

20. The AEP is the annual period from October 15 until December 7 when a Medicare beneficiary can enroll into a Medicare Part C or D plan, renew their existing Medicare Part C or D plan, or change into another Medicare plan. Plans may begin marketing the upcoming plan year on October 1, though beneficiaries cannot make enrollment elections until the AEP opens on October 15. The chosen Medicare Part C or D plan coverage begins on January 1st. The AEP is the most consequential event in the Medicare Advantage program calendar.

21. CMS typically publishes updated plan information, including premiums, cost-sharing, and supplemental benefits, on the Medicare Plan Finder website and in related CMS data

files in early October, shortly before the AEP opens on October 15. This publication is based on the finalized, certified bids. Beneficiaries and their advisors, including State Health Insurance Assistance Programs ("SHIP") counselors, consult Medicare Plan Finder in making enrollment decisions. A plan's benefit design as reflected in the Medicare Plan Finder is a consulted reference for the 2027 enrollment season.

22. Under CMS marketing regulations, CMS review timelines vary by material type. Certain File & Use materials may be used shortly after filing, while CMS model or standardized materials may be subject to an approximately 10-day review period and other marketing materials may be subject to an approximately 45-day review period. While some materials may therefore clear relatively quickly, the practical constraint is the full end-to-end sequence that follows a finalized bid. Annual Notice of Change ("ANOC") documents—the annual disclosures mailed to all existing enrollees describing changes in benefits, costs, and coverage for the coming year—must be mailed to enrollees by September 30 of each year, the deadline established under 42 C.F.R. § 422.111(a)(2). Evidence of Coverage ("EOC") documents must accompany or closely follow the ANOC. These documents are derived directly from the finalized benefit package, which in turn is derived from the finalized bid. If Elevance's benefit package changes as a result of a corrected QBP rating and rebid, the ANOC and EOC must reflect those changes. Preparing these documents, drafting, compliance review, CMS filing, and printing and mailing to potentially hundreds of thousands of enrollees, takes a minimum of 3 weeks.

23. For MA plans offering prescription drug coverage (MA-PD plans), the formulary, the list of covered drugs and their tier placement, which directly determines the cost-sharing enrollees face is an integral component of the bid and is subject to its own CMS review and approval process. Formulary changes triggered by a revised bid must be reviewed and approved

by CMS's formulary analysts before they can be implemented. CMS's formulary review cycle runs on a distinct but overlapping timeline with the overall bid review process and must be completed before plan information is published on Medicare Plan Finder.

24. Relatedly, the benefits a plan expects to offer inform its broader operational and contracting planning for the year, including arrangements that are generally set in advance of the enrollment season. In my professional judgment, the later a corrected rating arrives in the cycle, the less able Elevance is to reflect it across the planning that is already underway.

25. MA plans depend heavily on licensed insurance agents and brokers to educate beneficiaries and facilitate enrollment during the AEP. If Elevance's benefit package changes as a result of a corrected QBP rating and rebid, Elevance would need time to update broker-facing materials, training content, talking points, and distribution communications so that agents and brokers can accurately describe the revised benefits, premiums, cost-sharing, service areas, and other plan information. Those broker-readiness activities must occur after the benefit package is finalized and before October 1, when plans may begin marketing the upcoming plan year and when brokers begin helping current members review ANOC benefit changes and prospects compare plan options for the upcoming enrollment cycle.

26. In Georgia, Elevance's contract H4036 is in direct competition for enrollees with the MA plans offered by the plaintiff MAO in *Clover*. H4036 improves from a QBP rating of 4 to 4.5 Stars for 2027 using the *Clover* measure set but has no improvement based on the options outlined in the HPMS memorandum.

27. The AEP is Elevance's highest-volume operational period of the year. Staffing levels in Elevance's enrollment, member services, and call center operations are planned based on projected enrollment volume, which is in turn based on anticipated benefit competitiveness.

Elevance needs sufficient time to adjust its infrastructure to accommodate the enrollment volume it would anticipate attracting if it is able to offer more generous benefits.

28. Given the above, in my professional judgment, Elevance would need to obtain relief from this Court in the form of an order directing CMS to recalculate Elevance's 2026 Star Ratings consistent with the *Clover* decision by on or around August 14, 2026, in order for there to be sufficient time for all the moving pieces discussed here to fall into place and for revised MA contracts to be ready for 2027 enrollment.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 7 day of July, 2026

Jarod Blue

EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

DATE: June 17, 2026

TO: Medicare Advantage Organizations

FROM: Gerard Mulcahy
Director, Medicare Drug & Health Plan Contract Administration Group, Center for Medicare

Vanessa S. Duran
Director, Medicare Drug Benefit and C & D Data Group, Center for Medicare

Jennifer Lazio
Director, Parts C & D Actuarial Group, Office of the Actuary

Shruti Rajan
Acting Director, Medicare Plan Payment Group, Center for Medicare

SUBJECT: Update to 2027 Quality Bonus Payment Determinations

In light of a recent court decision,[1] CMS is voluntarily recalculating the 2027 Quality Bonus Payment (QBP) ratings for certain Medicare Advantage (MA) contracts. We assigned MA contracts the recalculated rating only if it was higher than the previously assigned QBP rating. If a contract's recalculation results in a lower rating than the previously assigned rating, CMS will not update the contract's 2027 QBP rating; it will be held harmless in this recalculation. CMS is not announcing any policy or position here regarding the calculation of the 2027 Star Ratings, which will be issued in October 2026, nor the 2028 QBP ratings.

We recalculated the 2027 QBP ratings for MA organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data. We removed all the Part D measures and the following Part C measures: Special Needs Plan Care Management, Complaints about the Health Plan, Members Choosing to Leave the Plan, Plan Makes Timely Decisions about Appeals, Reviewing Appeals Decisions, and Call Center – Foreign Language Interpreter and TTY Availability.

[1] The decision in *Clover Insurance Company v. Department of Health & Human Services*, Civ. A. No. 25-142 (S.D. Ga.) was issued on May 27, 2026. CMS's decision to recalculate 2027 Quality Bonus Payment ratings as described herein has no bearing on CMS's potential exercise of its right to appeal this decision.

MA organizations can view their recalculated 2027 QBP ratings in the Health Plan Management System (HPMS).

- To access the recalculated 2027 QBP ratings data, select Quality and Performance in the navigation bar and then Performance Metrics > Reports > Costs. Select MA QBP Rating as the "Report Type." Contracts should ensure that 2027 is selected as the "Contract Year" and then click "Create Report" to view their QBP ratings.

Contracts will be informed when updated Total Beneficiary Cost (TBC) data are available.

MA contracts with increases in their 2027 QBP ratings as described above (i.e., only contracts that have an increase in their QBP ratings that has an impact on their benchmark or rebate amount) will have a time-limited opportunity to resubmit their Contract Year (CY) 2027 bids, including bid pricing tools (BPTs), plan benefit packages (PBPs), and formularies. As a reminder, QBP ratings are calculated at the contract level, so all PBPs underlying a contract will be assigned the associated QBP rating.

Although bid resubmission is permitted for affected entities, it is not required. Your organization maintains the option to proceed with its original 2027 QBP rating and the corresponding final bid submitted to CMS on or before the June 1, 2026 deadline. If you opt out of the resubmission, please be advised that the original bid will be reviewed for compliance with all bid standards and requirements, and the original 2027 QBP rating will be used for payments for enrollees with functioning graft status and for Employer Group Waiver Plans (EGWP) under the contract.

CY 2027 bid submissions must match the QBP rating and associated rebate status in HPMS. For HPMS to reflect your organization's preference for using its recalculated 2027 QBP rating (if applicable) or its original 2027 QBP rating, CMS needs notice to update HPMS accordingly for bid review and evaluation. Your organization must notify CMS of either your intention to resubmit a bid or your intention to opt out of resubmission no later than June 22, 2026, at 11:59 PM Pacific Daylight Time. Please send this information to the Part C & D Star Ratings mailbox (PartCandDStarRatings@cms.hhs.gov) using the following subject line: 2027 Bid Resubmission Decision Contract(s) HXXXX. Failure to submit your intention by COB June 22, 2026, will be treated as notice of intent to opt out of bid resubmission. After June 22, 2026, CMS will update the 2027 QBP ratings in HPMS as needed for consistency with the QBP ratings used in the final bids. For contracts that opt out of bid resubmission, their 2027 QBP rating will be updated to reflect the QBP rating used in their original bid submission.

In an effort to minimize disruption to the overall formulary review process, including for those MA contracts without changes to their 2027 QBP ratings, affected contracts that would like to make changes to one or more formularies associated with their contracts must contact PartDFormularies@cms.hhs.gov by June 22, 2026 using the following subject line: 2027 QBP Formulary Changes Request FID(s) 27XXX, to confirm next steps. For CMS to effectively and efficiently complete the bid review process consistent with its statutory obligations, CY 2027 bid resubmissions must be submitted no later than June 29, 2026, including the updated supporting documentation. CMS will open the gates in HPMS on June 25, 2026 for affected contracts to resubmit bids to reflect the change in their QBP rating. MA organizations, including Part D sponsors, should continue to respond to staged BPT, PBP, and formulary review

communications. The actuarial certification for any CY 2027 bid resubmissions must be completed by July 1, 2026.

If you intend to resubmit your bid, this is a reminder that all MA organizations are required to submit their best accurate and complete bid(s) no later than Monday, June 29, 2026, at 11:59 PM Pacific Daylight Time. For information regarding bid submission requirements and evaluation, please refer to the April 22, 2026 HPMS memorandum "Final Contract Year (CY) 2027 Standards for Part C Benefits, Bid Review and Evaluation", as well as the February 6, 2026 HPMS memorandum "Contract Year (CY) 2027 Final Part D Bidding Instructions".

Any organization proceeding with bid resubmission in accordance with this process is required to submit a bid that complies with issued bid guidance, including but not limited to: Part D Cost Sharing thresholds, Part C Service Category Cost Sharing, PMPM Actuarial Equivalent Cost Sharing, TBC, and/or Optional Supplemental Benefit requirements and evaluation standards.

Questions regarding your QBP rating should be sent to: PartCandDStarRatings@cms.hhs.gov. Questions regarding the TBC information that will be posted in HPMS should be sent to: actuarial-bids@cms.hhs.gov. Questions related to the TBC policy should be submitted to: https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/. Questions related to Part D benefits should be submitted to: PartDBenefits@cms.hhs.gov. Questions related to formularies should be sent to: PartDFormularies@cms.hhs.gov.

For impacted contracts that notify CMS of their intent to proceed with bid resubmission based on the recalculated rating, we will be updating the overall rating displayed in HPMS and Medicare Plan Finder for QBP eligibility purposes to match the recalculated 2027 QBP rating in the coming weeks.

EXHIBIT 2

June 24, 2026

Via Email: PartCandDStarRatings@cms.hhs.gov

Gerard Mulcahy
Director, Medicare Drug & Health Plan Contract Administration Group
Vanessa S. Duran
Director, Medicare Drug Benefit and C & D Data Group
Jennifer Lazio
Director, Parts C & D Actuarial Group
Shruti Rajan
Acting Director, Medicare Plan Payment Group

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Objection to CMS's June 17, 2026 HPMS Memorandum Regarding Updated 2027 Quality Bonus Payment Calculations

Dear Mr. Mulcahy, Ms. Duran, Ms. Lazio, Ms. Rajan:

Elevance Health, Inc. ("Elevance Health") writes to request additional action by CMS in furtherance of the goals set forth in CMS's June 17, 2026, Health Plan Management System (HPMS) memorandum entitled "Update to 2027 Quality Bonus Payment Determinations" (the "HPMS memorandum"). While Elevance Health recognizes that CMS undertook the recalculation outlined in the HPMS memorandum in response to the decision in *Clover Insurance Company v. Department of Health & Human Services*, Civ. A. No. 25-142 (S.D. Ga.), issued on May 27, 2026, CMS did not actually act consistent with the *Clover* decision when it issued the HPMS memorandum. Rather, CMS removed *some* measures from the Quality Bonus Payment ("QBP") determination for 2026 Star ratings but did not remove all measures that the *Clover* court found to be invalid. At the same time, CMS removed other measures not addressed by the *Clover* court. Furthermore, the options offered in the HPMS memorandum are not sufficient to produce equitable results for the Medicare Advantage Organizations ("MAOs") that contract with CMS.

I. CMS is obligated to administer the Star Ratings program even-handedly.

CMS is required under foundational principles of administrative law to treat the MAOs that contract with CMS fairly and even-handedly. *See Grayscale Investments, LLC v. Securities and Exchange Commission*, 82 F. 4th 1239, 1245 (D.C. Cir. 2023). The approach taken in CMS's June 17 HPMS memorandum does not satisfy this standard. In that HPMS memorandum, CMS states that it is voluntarily recalculating the 2027 QBP ratings "in light of a recent court decision." However, it does not appear that CMS in fact offered MAOs the same treatment it afforded to Clover Insurance Company (Clover).

Based on a June 9 Securities and Exchange Commission filing by Clover, it appears Clover received the benefit of the court's order for the contract at issue in its case. Given the nature of the Star Ratings program, that sets a new benchmark for all other MAOs. But instead of offering all other MAOs the "better of" either their original 2026 Star Rating and resulting 2027 QBP or a recalculation based on the *Clover* court's decision, CMS crafts for "MA contracts with increases in their 2027 QBP ratings" an entirely novel option to resubmit bids. CMS's novel approach is based on (i) the retention of a number of measures that were invalidated by the *Clover* court; and (ii) the removal of a number of other measures used to calculate the 2026 Part C and Part D Star Ratings, including several measures from the Star Ratings calculation that were not at issue in the *Clover* lawsuit. In the HPMS memorandum, CMS does not provide any explanation or justification for how it selected the measures it removes from the offered recalculation, including why it did not remove some of the measures invalidated by the court in *Clover*, or why it removed other measures that were not at issue in *Clover*.

While some MAOs may find that CMS's recalculation leaves them in a materially improved position from their status quo, it leaves Elevance Health in a materially worse position relative to both Clover and to competitors that benefit from the recalculation. In other words, through its memorandum, CMS creates winners and losers without a principled justification for doing so. Agency action that confers selective benefit on some regulated parties while leaving others disadvantaged, without a coherent and uniform basis for the distinction, is arbitrary and capricious. *See Westar Energy v. Federal Energy Regulatory Com'n*, 43 F. 3d 1239, 1241 (D.C. Cir. 2007) (noting that "[a] fundamental norm of administrative procedure requires an agency to treat like cases alike. If the agency makes an exception in one case, then it must either make an exception in a similar case point to a relevant distinction between the two cases.")

II. Requested Relief

Elevance Health respectfully requests that CMS expand upon the options set forth in the HPMS memorandum. Namely, Elevance Health requests that CMS offer MAOs the option of having their 2027 QBP ratings recalculated based on the same set of measures that the *Clover* court afforded to Clover, in addition to the two existing options set forth in the HPMS memorandum. This approach would preserve optionality for the MAOs to allow them to determine which approach best coincides with their business needs while not providing any one MAO with a significant competitive advantage over others as a result of the way their 2027 QBP ratings are calculated.

Elevance Health respectfully requests a response to this request by 5:00 Eastern Time on Friday, June 26, 2026, and reserves all rights with respect to the matters described herein.

Respectfully submitted,

Jennifer Jarrell
Vice President, Star Performance
Elevance Health

EXHIBIT 3

From: CMS PartC&DStarRatings
To: Jarrell, Jennifer N.
Cc: CMS PartC&DStarRatings
Subject: RE: Elevance Health - Regarding Updated 2027 Quality Bonus Payment Calculations
Date: Thursday, June 25, 2026 6:40:37 AM
Attachments: image002.png
image003.png

Confirming receipt.

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

From: Jarrell, Jennifer N. <jennifer.jarrell@elevancehealth.com>
Sent: Wednesday, June 24, 2026 6:22 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: Elevance Health - Regarding Updated 2027 Quality Bonus Payment Calculations

Star Ratings Team:

Please find enclosed a letter from Elevance Health in response to CMS's June 17, 2026, HPMS memorandum regarding updated 2027 quality bonus payment calculations. We kindly request a reply confirming receipt of this submission.

Respectfully,

Jennifer Jarrell
Vice President, Medicare Star Performance and Member Experience
M: 757-971-3150
Hanover, MD Office
elevancehealth.com

EXHIBIT 4

From: CMS PartC&DStarRatings
To: Jarrell, Jennifer N.
Cc: CMS PartC&DStarRatings
Subject: RE: Elevance Health - Regarding Updated 2027 Quality Bonus Payment Calculations
Date: Friday, June 26, 2026 4:26:26 PM
Attachments: image001.png
image002.png
HPMS Memo Updated QBPs.pdf

Your request to change the terms of the hold harmless is not consistent with the HPMS memo attached and released on June 17th. In that memo, we stated " We recalculated the 2027 QBP ratings for MA organizations only using data collected under 42 U.S.C. 1395w-22(e) as of November 1, 2003, specifically Part C measures using Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) data." We held all contracts harmless if the recalculated QBP rating resulted in a lower rating.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, June 25, 2026 6:40 AM
To: Jarrell, Jennifer N. <jennifer.jarrell@elevancehealth.com>
Cc: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Elevance Health - Regarding Updated 2027 Quality Bonus Payment Calculations

Confirming receipt.

Part C & D Star Ratings Team
Medicare Drug Benefit and C&D Data Group (MDBG)
PartCandDStarRatings@cms.hhs.gov

From: Jarrell, Jennifer N. <jennifer.jarrell@elevancehealth.com>
Sent: Wednesday, June 24, 2026 6:22 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: Elevance Health - Regarding Updated 2027 Quality Bonus Payment Calculations

Star Ratings Team:

Please find enclosed a letter from Elevance Health in response to CMS's June 17, 2026, HPMS memorandum regarding updated 2027 quality bonus payment calculations. We kindly request a reply confirming receipt of this submission.

Respectfully,

Jennifer Jarrell
Vice President, Medicare Star Performance and Member Experience
M: 757-971-3150
Hanover, MD Office
elevancehealth.com

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., et al. Plaintiffs, v. **DEPARTMENT OF HEALTH AND HUMAN SERVICES**, et al. Defendants.	Case No. 2:26-cv-00061-LGW-BWC

DECLARATION OF TYLER O. MARSHALL

I, Tyler O. Marshall, declare the following to be true and correct:

1. I am over twenty-one years of age, of sound mind, and fully competent to make this declaration.

2. I am a Director with Berkeley Research Group ("BRG") and have been retained by Crowell & Moring LLP ("Counsel") on behalf of Elevance Health, Inc. and its affiliated entities ("Elevance") to provide my opinions on certain aspects of the Centers for Medicare and Medicaid Services' ("CMS") calculation of the 2026 Medicare Advantage Stars Ratings ("Star Ratings").

3. BRG is a global consulting firm that helps leading organizations advance in three key areas: disputes and investigations, corporate finance, and performance improvement and advisory. For more than a decade, BRG has been a trusted advisor to clients on operations, compliance, and strategic issues in the Medicare Advantage ("MA") arena.

4. I am a leading expert in the managed care industry and especially in matters related to Medicare Advantage. My work includes legal and regulatory compliance consulting to Medicare Advantage Organizations ("MAOs"), as well as forensic and analytics support and expert guidance in internal investigations, state and federal investigations, and numerous litigation and arbitration matters. Specifically, I have provided expert guidance and assistance to multiple MAOs and their counsel within strategic and legal matters related to CMS's regulation and oversight of its annual Star Ratings program.

5. I have been asked by Counsel, in light of a recent related court decision,[1] to evaluate and compare CMS's recent recalculation of the Overall Star Rating for Clover Insurance Company ("Clover") contract H5141 against the recalculation methodology CMS explained in a Health Plan Management System ("HPMS") memo shared on June 17, 2026, for the redetermination of Overall Star Ratings for the 2026 Star Ratings.[2] Counsel specifically asked me to attempt to determine and opine on how CMS may have executed its particular recalculation of the 2026 Overall Star Rating for Clover contract H5141.

Medicare Star Ratings Program

6. CMS has been publishing Medicare Star Ratings for MAOs since 2008. The purpose of the Star Ratings program is to "measure the quality of health and prescription drug services received by consumers enrolled in MA and Part D prescription drug plans" and "to provide people with Medicare and their caregivers with meaningful information about quality alongside information about benefits and costs to assist them in comparing Medicare health and drug plans and choosing the Medicare coverage option that best fits their health needs."[3] CMS calculates an annual Star Rating for each MAO contract using the weighted average of each contract's Star Ratings across several quality and performance measures (up to 43 for Medicare

[1] Clover Insurance Company v. U.S. Department of Health and Human Services, No. 2:25-cv-00142 (S.D. Ga. May 27, 2026).
[2] CMS, HPMS Memorandum, "Update to 2027 Quality Bonus Payment Determinations," June 17, 2026.
[3] CMS, "2026 Medicare Advantage and Part D Star Ratings," November 18, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-fact-sheet.pdf accessed July 3, 2026.

Advantage Part C and Prescription Drug Part D plans ("MA-PD"), up to 33 for Part C only plans, and up to 12 for Part D only plans).[4]

7. Each individual Star measure is derived from data identified by CMS for that particular measure, including data collected from MAOs, enrollee surveys, CMS contractors, and CMS. Contracts are scored for each applicable measure, and a contract's score translates into measure Star Ratings levels ranging from 1 to 5, with 1 being the worst and 5 being the best.[5] The individual Star Ratings are aggregated to an Overall Star Rating for each contract.

8. The Overall Star Rating assigned to an MAO is critically important to the MAO and the beneficiaries enrolled in its contracts as it has a direct impact upon the total payments that CMS makes to the MAO through additional rebates and Quality Bonus Payments ("QBPs"), as well as a direct impact on the premiums and benefits that the MAO is able to offer to enrollees, thereby influencing a Medicare beneficiary's choice when enrolling in an MAO plan. MAO contracts that receive at least 3.5 out of 5 Stars may be eligible for an increased percentage rebate. Larger percentage rebates are available for contracts with higher Star Ratings above 3.5. A portion of these rebates are returned to plan enrollees in the form of supplemental benefits or lower premiums. MAO contracts that receive at least 4 out of 5 Stars also qualify for a QBP. Additionally, MAOs that achieve an Overall 5-Star Rating are allowed to market to and enroll beneficiaries throughout the year, rather than only during annual Medicare open enrollment periods.[6]

---

[4] A maximum of 33 Part C measures are grouped to calculate a Part C Rating and a maximum of 12 Part D measures are grouped to calculate a Part D Rating. Summary ratings are calculated from the weighted average Star Ratings of the included measures. (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.).

[5] CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.

[6] The annual Medicare open enrollment period lasts from October 15th through December 7th each year. Beneficiaries already enrolled in Medicare Advantage also have an open enrollment period from January 1st through March 31st each year. (*See* https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan, accessed July 3, 2026 and https://www.cms.gov/files/document/medicare-communications-marketing-guidelines-2-9-2022.pdf, accessed July 3, 2026.)

Clover Star Ratings Lawsuit Decision

9. On November 7, 2025, Clover brought a lawsuit against CMS and related federal defendants. The lawsuit alleged twenty of the forty-three measures used to calculate the 2026 Star Ratings and determine Clover's 2026 Overall Star Rating for its H5141 contract did not go through notice and comment rulemaking in the manner required by CMS's regulations. It also alleged that many of these measures were based on data that CMS did not collect as of November 1, 2003, as required by CMS's regulations (among other arguments).[7] The twenty measures were as follows:

C03: Annual Flu Vaccine
C04: Improving or Maintaining Physical Health
C05: Improving or Maintaining Mental Health
C15: Reducing the Risk of Falling
C16: Improving Bladder Control
C22: Getting Needed Care
C23: Getting Appointments and Care Quickly
C24: Customer Service
C25: Rating of Health Care Quality
C27: Care Coordination
C32: Reviewing Appeals Decisions
C33: Call Center – Foreign Language Interpreter and TTY Availability
D01: Call Center – Foreign Language Interpreter and TTY Availability
D05: Rating of Drug Plan
D06: Getting Needed Prescription Drugs
D08: Medication Adherence for Diabetes Medications
D09: Medication Adherence for Hypertension (RAS antagonists)
D10: Medication Adherence for Cholesterol (Statins)
D11: MTM Program Completion Rate for CMR
D12: Statin Use in Persons with Diabetes (SUPD)

10. A May 27, 2026 Order issued by the Court in response to Clover's motion for expedited summary judgment concluded that "ten challenged measures rely on non-Section 1395w-22(e) data" and that "CMS erred in considering the [] measures." The Court also determined that "[b]ecause CMS did not undertake the required notice-and-comment rulemaking

[7] Clover Insurance Company v. U.S. Department of Health and Human Services, No. 2:25-cv-00142 (S.D. Ga. November 7, 2025), Complaint.

with respect to [] ten measures, the manner in which Clover's 2026 Star Rating was calculated is procedurally invalid." Therefore, the Court agreed with Clover and granted in part Clover's expedited motion for summary judgment, ordering CMS to "set aside" the 2026 Star Rating for Clover and "recalculate that rating in a manner consistent with this Order."[8]

11. Clover later revealed through an 8-K SEC filing on June 18, 2026, that H5141 received a recalculated 2026 Overall Star Rating of 4.5 Stars.[9] In the 8-K, Clover indicated that CMS informed Clover that, consistent with a court judgment, CMS had recalculated the 2026 Star Rating for the Company's PPO Medicare Advantage contract, H5141, from 3.5 Stars to 4.5 Stars and that HPMS reporting displays the Company's PPO Medicare Advantage contract, H5141, rated at 4.5 Stars.

HPMS Memo: Update to 2027 Quality Bonus Payment Determinations

12. On June 17, 2026, CMS released a memorandum through HPMS[10] in which it explained that it would be "voluntarily recalculating the 2027 Quality Bonus Payment (QBP) ratings [derived from the 2026 Star Ratings] for certain Medicare Advantage (MA) contracts" in light of the recent court decision in *Clover Insurance Company v. Department of Health & Human Services, Civ. A. No. 25-142 (S.D. Ga.)* issued on May 27, 2026. Importantly, the HPMS memo also notes that "[i]f a contract's recalculation results in a lower rating than the previously assigned rating, CMS will not update the contract's 2027 QBP rating; it will be held harmless in this recalculation."

13. CMS indicated that its recalculation of ratings "removed all the Part D measures and the following Part C measures: Special Needs Plan Care Management, Complaints about the Health Plan, Members Choosing to Leave the Plan, Plan Makes Timely Decisions about Appeals,

[8] Clover Insurance Company v. U.S. Department of Health and Human Services, No. 2:25-cv-00142 (S.D. Ga. May 27, 2026), Order.
[9] Clover Health Investments, Corp., Current Report (Form 8-K) (June 18, 2026) (reporting CMS's recalculation of the Company's 2026 Star Rating and resulting 2027 Quality Bonus Payment rating), Item 8.01, "Other Events", available at: https://investors.cloverhealth.com/static-files/0826f123-8065-4310-8f2e-f9b1ae820925 accessed July 3, 2026.
[10] CMS, HPMS Memorandum, "Update to 2027 Quality Bonus Payment Determinations," June 17, 2026.

Reviewing Appeals Decisions, and Call Center – Foreign Language Interpreter and TTY Availability." Notably, this list contains eighteen total measures, which includes ten of the twenty at-issue measures from the Clover decision plus another eight measures not addressed by the Clover decision. The measures included in the Clover decision and HPMS memo, including the ten that are overlapping, are as follows:

Clover Decision Measures	HPMS Memo Measures
C03: Annual Flu Vaccine	
C04: Improving or Maintaining Physical Health	
C05: Improving or Maintaining Mental Health	
	C07: Special Needs Plan (SNP) Care Management
C15: Reducing the Risk of Falling	
C16: Improving Bladder Control	
C22: Getting Needed Care	
C23: Getting Appointments and Care Quickly	
C24: Customer Service	
C25: Rating of Health Care Quality	
C27: Care Coordination	
	C28: Complaints about the Health Plan
	C29: Members Choosing to Leave the Plan
	C31: Plan Makes Timely Decisions about Appeals
C32: Reviewing Appeals Decisions	C32: Reviewing Appeals Decisions
C33: Call Center – Foreign Language Interpreter and TTY Availability	C33: Call Center – Foreign Language Interpreter and TTY Availability
D01: Call Center – Foreign Language Interpreter and TTY Availability	D01: Call Center – Foreign Language Interpreter and TTY Availability
	D02: Complaints about the Drug Plan
	D03: Members Choosing to Leave the Plan
	D04: Drug Plan Quality Improvement
D05: Rating of Drug Plan	D05: Rating of Drug Plan
D06: Getting Needed Prescription Drugs	D06: Getting Needed Prescription Drugs
	D07: MPF Price Accuracy
D08: Medication Adherence for Diabetes Medications	D08: Medication Adherence for Diabetes Medications
D09: Medication Adherence for Hypertension (RAS antagonists)	D09: Medication Adherence for Hypertension (RAS antagonists)
D10: Medication Adherence for Cholesterol (Statins)	D10: Medication Adherence for Cholesterol (Statins)
D11: MTM Program Completion Rate for CMR	D11: MTM Program Completion Rate for CMR
D12: Statin Use in Persons with Diabetes (SUPD)	D12: Statin Use in Persons with Diabetes (SUPD)

Opinion 1:

It is improbable that CMS recalculated Clover's Overall Star Ratings under the HPMS memo methodology.

14. To my knowledge, the exact methodology CMS applied to Clover following the court decision to recalculate H5141 at 4.5 Stars has not yet been made publicly available. Therefore, I have been asked by Counsel to attempt to recalculate Clover's H5141 contract's Overall Star Ratings under both a methodology consistent with the Clover decision (i.e., removing the twenty measures the court agreed should be excluded – "Clover Decision")[11] and the methodology described by CMS's HPMS memo indicating an industry-wide recalculation of 2026 Star Ratings (i.e., removing CMS's eighteen listed measures – "HPMS Memo").[12]

15. To assess the potential effect of the application of these two methodologies on Clover's H5141 contract, using the 2026 Star Ratings Technical Notes and the 2026 publicly released performance data Medicare Report Card Master Table,[13] I addressed the three primary components factoring into the calculation of the contract's Overall Star Rating: (1) the weighted average Star Rating; (2) the Reward Factor; and (3) the Categorical Adjustment Index ("CAI") factor value. The Reward Factor is an adjustment added to a contract's calculated ratings to reward "high and stable relative performance" and is determined using a formula that is dependent on a comparison of the contract's specific results to industry-wide variance and weighted average Star Ratings thresholds. The CAI is "an analytical adjustment factor that is added to or subtracted from a contract's Overall and/or Summary Star Ratings to adjust for the average within-contract disparity in performance for Low Income Subsidy/Dual Eligible (LIS/DE) beneficiaries and disabled beneficiaries."[14]

---

[11] Clover Insurance Company v. U.S. Department of Health and Human Services, No. 2:25-cv-00142 (S.D. Ga. May 27, 2026), Order.
[12] CMS, HPMS Memorandum, "Update to 2027 Quality Bonus Payment Determinations," June 17, 2026.
[13] CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026, and CMS, 2026 Star Ratings Data Tables, available at: https://www.cms.gov/files/zip/2026-star-ratings-data-tables.zip, accessed July 4, 2026.
[14] *Ibid*.

16. First, I recalculated two new weighted average Star Ratings across all applicable measures' Star Ratings using the assigned weights for each applicable measure. The weighted average was calculated separately based on the two different sets of included measures from the two methodologies described above: Clover Decision and HPMS Memo.

17. Next, I analyzed multiple scenarios under each methodology by applying all potential Reward Factors from 0.0 to 0.4 to show the potential Overall Star Ratings that could result from each Reward Factor option. Because the Reward Factor amount (of the possible options 0.0, 0.1, 0.2, 0.3, and 0.4) is determined using a formula that is dependent on a comparison of a contract's specific results to industry-wide variance and weighted average Star Ratings thresholds, I cannot definitively determine which updated Reward Factor CMS applied for its recalculation of H5141, so I applied them under all possible scenarios.[15]

18. Finally, I applied the CAI factor value as originally applied for the H5141 contract per the CAI tab of the 2026 publicly released performance data Medicare Report Card Master Table.[16] The H5141 contract was indicated by the Master Table to be in the CAI Final Adjustment Category 5, which equated to an adjustment value of 0.018790 per the 2026 Technical Notes. Similar to the Reward Factor, without knowing the updated Category crosswalk to the adjustment value as shown under the prior calculation in the 2026 Technical Notes (if CMS recalculated and recreated one), I can only assume the originally reported value.[17]

---

[15] It is unclear if CMS did or will calculate new Variance or Performance Summary thresholds following the industry-wide recalculation. With only the originally reported thresholds based on all measures made publicly available, I cannot reliably determine the Variance Category and related dependent Reward Factor, so I instead review all Reward Factor options per the Technical Notes that could have been applied depending on where the recalculated contract compared to potential updated thresholds. (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.)

[16] CMS, 2026 Star Ratings Data Tables, available at: https://www.cms.gov/files/zip/2026-star-ratings-data-tables.zip, accessed July 4, 2026.

[17] It is unclear if CMS did or will calculate new CAI factors for each plan excluding any measures at-issue as many of these measures are included in the CAI adjustment calculation per the 2026 Technical Notes. (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.)

19. Table 1 below outlines the results of my analysis of the potential Overall Star Ratings for H5141 achieved under the two methodologies, assuming the current CAI value, and all potential Reward Factor options.

Table 1

Recalculation Methodology	# of Excluded Measures	Included Measure Weighted Average Star Rating[18]	Potential Reward Factor	CAI Value	Final Summary Rating	Overall Star Rating
HPMS Memo	18	3.731707	0.0	0.018790	3.750497	4.0
HPMS Memo	18	3.731707	0.1	0.018790	3.850497	4.0
HPMS Memo	18	3.731707	0.2	0.018790	3.950497	4.0
HPMS Memo	18	3.731707	0.3	0.018790	4.050497	4.0
HPMS Memo	18	3.731707	0.4	0.018790	4.150497	4.0
Clover Decision	20	4.500000	0.0	0.018790	4.518790	4.5
Clover Decision	20	4.500000	0.1	0.018790	4.618790	4.5
Clover Decision	20	4.500000	0.2	0.018790	4.718790	4.5
Clover Decision	20	4.500000	0.3	0.018790	4.818790	5.0
Clover Decision	20	4.500000	0.4	0.018790	4.918790	5.0

20. As shown in Table 1, assuming the current CAI value, no matter the Reward Factor, under the recalculation methodology described in CMS's HPMS memo, the Overall Star Rating for H5141 only reaches 4.0 Stars. The H5141 contract can reach 4.5 Stars under the Clover Decision methodology and as high as a 5.0 depending on the Reward Factor.

21. Therefore, as demonstrated by the recalculated results above, it is improbable that CMS recalculated Clover's Overall Star Ratings under the HPMS memo methodology, as it intends to do for all other MAO contracts. Also as noted above, CMS plans to hold harmless any MAO contracts for which the recalculation under the HPMS Memo methodology results in a lower rating than the previously assigned rating. This likely results in 2026 Overall Star Ratings being calculated for MAOs under at least three distinct methodologies, *i.e.*, one methodology for

[18] Per the Technical Notes, if a contract has an Overall Star Rating of 4 or more stars use the higher of the overall rating with or without the Improvement Measures. Therefore, the weighted average Star Rating shown is the greater of the two weighted averages calculated with and without the Improvement Measures. (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated September 25, 2025, available at: https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf, accessed July 3, 2026.)

Clover, another for MAOs that are recalculated under the HPMS Memo, and still another for those MAOs that retain their original 2026 Star Ratings.

Opinion 2:

CMS's disparate treatment outlined in its HPMS memo creates a competitive disadvantage for "held harmless" MAOs.

22. When an MAO contracts with CMS, it does so through an annual financial bidding process. Each MAO's "bid" is based on its annual expected revenues and costs for the package of services it intends to provide. The bid is in the form of a per member per month dollar amount that represents the cost of providing services to a beneficiary with average health. The MAO also submits to CMS a detailed package on the benefits included and beneficiary cost sharing amounts for Part C services, as well as actuarial support and certification for the bid calculation. An MAO must prepare this information annually for every contract that it operates. The package of benefits must include at least all services that beneficiaries are entitled to receive under traditional (Part A and Part B) Medicare except hospice.[19]

23. During the bidding process, CMS also calculates a per member per month "benchmark" for each county in which MAOs operate. CMS calculates county-level benchmarks by determining the average spending in traditional Medicare adjusted for geography and demographics. These benchmarks act as targets against which MAOs bid to provide Part A and Part B coverage to beneficiaries by contract. The per member per month "base rate" that CMS ultimately pays to an MAO is the lower of the MAO's bid or the CMS-set county level benchmark.[20]

24. If an MAO's bid is lower than the benchmark, the MAO receives a rebate from CMS equal to a percentage of the difference between the benchmark and the bid. A portion of these rebates are returned to plan enrollees in the form of supplemental benefits or lower

[19] *See* MedPac, "Medicare Advantage Program Payment System," Revised October 2023, available at: https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_MA_FINAL_SEC.pdf, accessed July 3, 2026.
[20] *Ibid.*

premiums. If an MAO's bid is higher than the benchmark, the enrollees in that MAO pay a premium equal to the difference between the MAO's bid rate and the benchmark.[21]

25. To encourage MAOs to compete for enrollees based on quality, the Affordable Care Act established QBPs that increase CMS's payments to MAOs based on the number of Stars the MAO's contract earns under the Medicare Star Ratings program. MAO contracts that receive at least 4 out of 5 Stars qualify for a QBP. QBPs are based upon the county-level benchmarks set by CMS during the annual Medicare Advantage bidding process. For most MAO contracts in bonus status, the benchmark is increased by up to five percentage points. For MAO contracts in "double bonus" counties, the benchmarks are increased by up to 10 percentage points.[22]

26. For MAOs with bids below the benchmark, the rebates they receive from CMS are also impacted positively by increases to the benchmarks for MAOs that receive at least 3.5 Stars.[23] These rebates are used by MAOs to enhance benefits or lower premiums for enrollees, which helps MAOs to attract and retain enrollees to remain competitive in their respective markets.

27. Importantly, as noted above, the HPMS memo from June 2026 regarding the industry-wide recalculation notes that "[i]f a contract's recalculation results in a lower rating than the previously assigned rating, CMS will not update the contract's 2027 QBP rating; it will be held harmless in this recalculation." Given the competitive bidding framework described above, the disparate treatment of MAO contracts under three different methodologies – the Clover

---

[21] *Ibid.*

[22] "Double bonus counties" are defined as urban counties with low traditional Medicare spending and historically high Medicare Advantage enrollment. Additionally, benchmarks are capped and cannot be higher than they would have been prior to the Affordable Care Act, which can result in MAOs that are eligible under the quality bonus program receiving a smaller percentage increase to their benchmark or possibly no increase at all. (Biniek, Jeannie Fugelsten, Ochieng, Nancy, Freed, Meredith, "Medicare Will Spend More Than $13 Billion on the Medicare Advantage Quality Bonus Program in 2026," *Kaiser Family Foundation*, July 1, 2026, available at: https://www.kff.org/medicare/medicare-will-spend-more-than-13-billion-on-the-medicare-advantage-quality-bonus-program-in-2026/, accessed July 3, 2026.)

[23] All plans that bid below the benchmark receive a percentage of the difference between the bid and benchmark as a rebate, ranging from 50% to 70% of the difference between the bid and the benchmark. The amount of the rebate paid to the plan is determined by the plan's Star Rating. Plans with < 3.5 Stars get a 50% rebate, plans with 3.5 to 4 Stars get 65%, and plans with 4.5+ Stars get 70%. (CMS, "Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," January 10, 2025, available at: https://www.cms.gov/files/document/2026-advance-notice.pdf, accessed July 3, 2026.).

Decision, the HPMS Memo, and the "held harmless" provision, creates an unlevel playing field that could undermine the competitiveness of the bidding process.

28. MAOs that fall into the "held harmless" bucket are not allowed to submit a revised bid for 2027 and, as a result, would be at a disadvantage under this scenario. For example, when a competitor MAO operating in the same service area is able to submit a revised bid due to its increased Overall Star Rating from the recalculation, the competitor submitting the revised bid would be making decisions with the benefit of more information than the "held harmless" MAO. The competitor could make adjustments to premium, go-to-market processes, and benefit design, for example, following the increased Star Rating. Whereas the "held harmless" MAO would not have that opportunity. The "held harmless" MAO would be disadvantaged as it would be forced to operate under 1) its decisions made prior to the June 2026 HPMS memo, 2) its previous bid, and 3) a competitive marketplace that has since changed. The "held harmless" MAO is no longer able to make decisions using the typical key known information about its competition – its competition's Star Ratings.

29. One of CMS's stated goals of the Star Ratings program is "to provide people with Medicare and their caregivers with meaningful information about quality, alongside information about benefits and costs, to assist them in comparing plans and choosing the Medicare coverage option that best fits their health needs." To help facilitate a beneficiary's plan selection, CMS maintains a "plan compare" online tool on its Medicare.gov website that Medicare beneficiaries can use to help search for Medicare plans. The plan compare tool includes the Star Rating for each plan, which could influence a beneficiary's selection of one MAO over another MAO with similar benefits and cost sharing.[24]

30. The influence that the Star Ratings program has on Medicare Advantage enrollment is supported by recent enrollment figures. Prior to this recalculation, in 2026, 68% of Medicare Advantage Enrollees were in MAOs that received a Star Rating of 4 or above and

[24] *See* https://www.medicare.gov/plan-compare/#/?year=2026&lang=en, accessed July 3, 2026.

qualified for a quality bonus.[25] Further, a systematic literature review conducted in 2023 of PubMed MEDLINE, Embase, and Google attempted to identify articles that quantitatively assessed the impact of Medicare Star Ratings on health plan enrollment. The authors concluded, in part, that, "[i]ncreases in Medicare star ratings led to statistically significant increases in health plan enrollment and decreases in health plan disenrollment."[26] In other words, an MAO's Overall Star Rating and the ensuing competitive bid process for any given year has a direct impact on its enrollment, which demonstrates that MAOs with higher Star Ratings are at a significant advantage in the market to attract and retain enrollees. This is in addition to the impact a Star Rating can have on an MAO's revenue and ability to offer competitive benefits and cost-sharing options to its enrollees.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on July 6, 2026, in Washington, DC.

By: 

Tyler O. Marshall
Director
Berkeley Research Group

[25] Biniek, Jeannie Fugelsten, Ochieng, Nancy, Freed, Meredith, "Medicare Will Spend More Than $13 Billion on the Medicare Advantage Quality Bonus Program in 2026," *Kaiser Family Foundation*, July 1, 2026, available at: https://www.kff.org/medicare/medicare-will-spend-more-than-13-billion-on-the-medicare-advantage-quality-bonus-program-in-2026/, accessed July 3, 2026.

[26] Borrelli, Eric P et al. "Impact of star ratings on Medicare health plan enrollment: A systematic literature review," Journal of the American Pharmacists Association: JAPhA vol. 63,4 (2023): 989-997.e3, available at: https://doi.org/10.1016/j.japh.2023.03.009, accessed July 3, 2026.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

ELEVANCE HEALTH, INC., ANTHEM INSURANCE COMPANIES, INC., BLUE CROSS OF CALIFORNIA, WELLPOINT HEALTH PLANS, INC., WELLPOINT INSURANCE COMPANY, and WELLPOINT IOWA, INC. Plaintiffs, v. DEPARTMENT OF HEALTH AND HUMAN SERVICES and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Civil Action No. 2:26-cv-00061-LGW-BWC

DECLARATION OF VERONIKA CHERVENSKA

I, Veronika Chervenska, declare as follows:

1. I am the Medicare Chief Pricing Actuary for Elevance Health, Inc. ("Elevance"). I submit this declaration in support of Elevance's brief in support of its motion for a preliminary injunction in the captioned case.

2. As Chief Pricing Actuary, I am involved in the coordinated development, review, and submission of Elevance's Medicare Advantage bids, including the actuarial pricing, financial projections, benefit-cost estimates, risk-adjustment assumptions, and related analyses that support those bids. In that role, I oversee the actuarial workstreams that support the annual Medicare Advantage bid-development process and help ensure that Elevance's Medicare Advantage offerings are priced and evaluated in accordance with applicable CMS requirements, internal

governance standards, and business objectives. I work closely with the finance, product, compliance, operations, and growth functions that support the bid, benefit-design, and market-readiness processes described in this declaration. Through my role, I am familiar with the Medicare Advantage bid process, the actuarial and financial assumptions used in bid development, the Star Ratings, rebate and Quality Bonus Payment ("QBP") framework, and the operational calendar that governs the transition from bid development and submission to CMS review, approval, and the Annual Enrollment Period.

3. I am making these statements based on my personal knowledge and professional experience and judgment.

4. As my colleague, Jarod Blue, explains in his separate declaration, each year an MAO must submit a bid to CMS that represents, among other things, its estimated cost for covering Medicare-defined standard benefits to an average enrollee for the upcoming year. We provide CMS with extensive supporting documentation in submitting these bids, including information about the benefits and cost sharing that the plan will cover and a detailed financial breakdown of how the plan arrived at its bid amount, with the actuarial basis and support for the calculations.

5. For Calendar Year ("CY") 2027, we submitted initial bids to CMS by June 1, 2026. The Annual Enrollment Period ("AEP") for CY 2027 will commence on October 15, 2026.

6. I have been asked to explain, from an actuarial standpoint, how Elevance would likely be injured in the absence of obtaining immediate relief as requested in our preliminary injunction motion, *i.e.*, a recalculated Star Rating on the same terms as ordered for another MA contract in *Clover*, and why obtaining this relief by on or around August 14, 2026 is critically important. This relief is important because an MA contract's Star Rating dictates its rebates and

QBPs for the following calendar year. A higher rating results in more budgeted revenue for the following year.

7. Based on that higher budget, a contract has greater economic flexibility to offer additional benefits or lower premiums, thus making it more competitive and attractive to health insurance consumers considering Medicare Advantage for health insurance coverage. An MA contract factors the expected rebates and QBPs into its pricing calculations when preparing and submitting its bid to CMS for the following year.

8. Under CMS requirements, the actuarial certification accompanying that bid must be completed by a qualified actuary who attests, under professional standards, that the bid is accurate, complete, and consistent with the applicable benefit package. Preparing a revised bid to reflect a corrected Star rating is not a mechanical exercise. It requires the actuary to recalculate the benchmark, re-run the rebate calculation, redesign the benefit package to reflect revised rebate dollars, confirm compliance with all applicable bid standards, including Part D cost-sharing thresholds, Part C service category cost-sharing requirements, per-member-per-month actuarial equivalent cost-sharing, Total Beneficiary Cost ("TBC"), and optional supplemental benefit standards, and certify the result.

a. Part D cost-sharing thresholds are the maximum amounts a plan may require enrollees to pay out of pocket for prescription drugs at each formulary tier, which must fall within CMS-prescribed limits across benefit designs.

b. Part C service category cost-sharing requirements are CMS-established limits on the amount a plan may charge enrollees for each category of medical service, which vary by service type and must remain within actuarially justified ranges.

c. Per-member-per-month actuarial equivalent cost-sharing is the average cost-sharing obligation across all covered services, expressed on a per-member-per-month basis, which the actuary must certify is actuarially equivalent to the standard Medicare benefit package as defined under 42 C.F.R. § 422.100.

d. TBC is a CMS-calculated metric representing the estimated total out-of-pocket cost a beneficiary would face under a given plan design, which CMS uses to assess benefit competitiveness, and which must be recalculated whenever cost-sharing or premium inputs change.

e. Optional supplemental benefit standards are the regulatory requirements governing benefits a plan offers beyond the standard Medicare package which must be funded from the rebate and must comply with CMS's uniformity, meaningful benefit, and actuarial value requirements before they may be offered to enrollees.

9. Each of these standards must be satisfied independently, and a change in one often requires recalibration of the others. A meaningful increase in rebate dollars—such as would result from a corrected Star Rating—would require the actuary to revisit every one of these inputs before a revised bid could be certified and submitted. Based on my understanding of the CMS bid process, even if Elevance prepares proposed benefit changes in advance, it cannot complete and submit a revised bid immediately upon receiving relief. CMS would first need to recalculate the applicable Star Ratings and rebate and QBP amounts and make the revised TBC template available in HPMS. Those steps are outside Elevance's control and must occur before Elevance can finalize, certify, and resubmit any corrected CY 2027 bids. Accordingly, the on or around August 14, 2026, date is operationally important because a decision by that date would still leave only a limited period for

CMS action, actuarial certification, bid resubmission, and downstream implementation before the 2027 enrollment cycle.

10. Given the above, in my professional judgment, Elevance would need to obtain relief from this Court in the form of an order directing CMS to recalculate Elevance's 2026 Star Ratings consistent with the *Clover* decision by on or around August 14, 2026, in order for there to be sufficient time for all the moving pieces discussed here to fall into place and for revised MA contracts to be ready for 2027 enrollment.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 7 day of July, 2026.

Veronika Chervenska