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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

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U.S. COURT OF
FEDERAL CLAIMS

COMMON GROUND HEALTHCARE
COOPERATIVE,

Plaintiff,
on behalf of itself and all others
similarly situated,

vs.

THE UNITED STATES OF AMERICA,

Defendant.

No. 17-877 C

CLASS ACTION COMPLAINT

Plaintiff Common Ground Healthcare Cooperative (“CGHC” or “Plaintiff”), on behalf of itself and all those similarly situated, as defined below, brings this class action for the Defendant’s (i) violation of Section 1342 of the Patient Protection and Affordable Care Act (“Section 1342”), (ii) violation of 45 CFR § 153.510(b) (“Section 153.510”); and (iii) violation of other applicable law, damages, and other relief, and alleges as follows:

NATURE OF THE ACTION

1. In late March 2010, the federal government of the United States of America (“Defendant,” or the “Government”) changed the face of healthcare in the nation by enacting The Patient Protection and Affordable Care Act (Pub. L. 111-148) (the “Affordable Care Act” or the “Act” or “ACA”) and The Health Care and Education Reconciliation Act (Pub. L. 111-152). Together, these acts are often colloquially known as “Obamacare” and represent the most significant healthcare statutes in recent U.S. history.

2. Before these laws went into effect, health insurers and health plan providers were (among other things) permitted to deny coverage to individuals and families, exclude pre-existing conditions from insurance coverage, and vary insureds’ premiums based on their individual health status. After the two acts went into effect, such practices were prohibited

beginning with plans offered in the 2014 individual market. This was a dramatic change from the pre-ACA rules governing health insurance in most states—especially in the individual insurance market—and created a huge amount of uncertainty for health plan providers regarding who would sign up for coverage and what the medical cost for caring for this new population would be. In particular, health plan providers had no data or tools to predict the needs of the newly insured beneficiaries signing up for plans starting in 2014, nor a model to price these ACA plans to reflect the medical costs associated with this new and untested marketplace.

3. Additionally, the ACA requires health plans in the individual and small group markets to cover essential health benefits (“EHBs”), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. In many cases, the EHBs were an expansion of what was covered pre-ACA. Preventive care benefits previously subject to copays, deductibles and other cost-sharing mechanisms, or even exclusion from payment, were now mandated to be provided at no cost to the insured, making it difficult to predict utilization of these services.

4. In recognition of these uncertainties, the Affordable Care Act included three risk-sharing programs intended to mitigate the risk to health plan providers inherent in this new marketplace. Known as the “Three Rs,” these programs included a permanent risk-adjustment program (“risk adjustment”), a transitional reinsurance program designed to run from 2014-2016

(“reinsurance”), and a temporary risk corridor program that was also supposed to run from 2014-2016 (“risk corridor”). This case is about the third program: risk corridors.

5. A “risk corridor” is a program designed to mitigate risk for participants in a new insurance market by limiting both unexpectedly high gains *and* losses. Modeled after a similar program enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act that was signed into law in 2003 under President George W. Bush, the Affordable Care Act’s risk corridor program helped entice health plan providers to participate by offering qualified health plans on the ACA’s new insurance exchanges. Section 1342 of the ACA contained two related mandatory terms for all qualified health plan (“QHP”) issuers: (1) any QHP issuer agreeing to operate on an exchange would *receive* compensation from the Government if its losses exceeded a certain defined amount due to high utilization and high medical costs, and (2) the QHP issuers were required to *pay* the government a percentage of any profits they made over similarly defined amounts.

6. This structure encouraged competition and attracted participants by limiting the risk arising from entering the exchange market during the early years of its implementation. No matter how experienced a health plan provider was, the new demographics of insureds within the exchanges meant there was an unpredictable level of risk in how the market would operate. Health plan providers that were unable to accurately estimate and price that risk due to the lack of pre-existing information about the market, and/or had an unexpectedly high number of sick insureds purchase their plan, would receive risk corridor payments to buffer the losses due to above-average risk. The temporary nature of the risk corridor program was meant to provide a safety net sufficient to keep health plan providers in business, provide time to learn about the dynamics of this new market, and adjust pricing accordingly. Meanwhile, health plan providers

that priced their premiums higher than the total medical cost plus estimated profit, and/or had lower-than-expected numbers of costly insureds purchase plans, would be required to pay the government a portion of their profit while the newly created insurance market stabilized. Issuers offering qualified health plans under the Affordable Care Act were supportive of this program because it would allow them to comply with the Affordable Care Act while providing a safety net against extreme losses.

7. Section 1342 of the ACA and its implementing federal regulation, 45 CFR § 153.510(b), are unequivocal about the payments the Government must make. If the QHP issuers' losses in any year from 2014-2016 exceed certain defined amounts, then the Government must pay those QHP issuers a defined portion of those losses. Conversely, if the QHP issuers' profits in any year from 2014-2016 exceed certain defined amounts, then those QHP issuers must pay the Government a defined portion of those profits.

8. Despite these express and binding obligations, there have been numerous attempts to frustrate the Government's timely payments to the QHP issuers insuring millions of previously uninsured and under-insured Americans. From its inception, the Affordable Care Act has been a major point of political disagreement, and the risk corridor program in particular has been unlawfully and inappropriately interfered with via political spending bill disputes and appropriations acts.

9. In the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. 113-235) ("2015 Spending Bill"), a year later in the Consolidated Appropriations Act, 2016 (Pub. L. 114-113) ("2016 Spending Bill"), and yet again the following year in the Consolidated Appropriations Act, 2017 (Pub. L. 115-31) ("2017 Spending Bill," collectively with the 2015 Spending Bill and the 2016 Spending Bill, the "Spending Bills"), Congress included a parallel

set of riders that prohibited the Government from paying risk corridor amounts from the funds established for and/or appropriated to the Centers for Medicare & Medicaid Services (“CMS”) and its parent department, the United States Department of Health & Human Services (“HHS”).

10. The practical effect of the Spending Bills was to prevent CMS and HHS from paying QHP issuers their full risk corridor receivables due for the 2014, 2015, and 2016 plan years. This created an extraordinary burden on QHP issuers because, as many industry experts predicted, each of those plan years were incredibly tumultuous in the new market. During 2014 and 2015, QHP issuers incurred almost \$8.67 billion in losses that were compensable under the risk corridor provisions of the ACA, and, on information and belief, losses for the 2016 plan year have been equivalent, if not even higher. However, due to the 2015 and 2016 Spending Bills, over \$8 billion of those mandatory risk corridor payments for 2014 and 2015 were not paid, and the 2017 Spending Bill will continue that same nonpayment.

11. When CMS and HHS were unable to pay the QHP issuers their full risk corridor receivables for 2014-2016, many insurance companies experienced cash flow problems and/or were unable to meet regulatory reserve requirements. This required insurance companies to satisfy their cash flow and reserve shortfalls, or risk going out of business. Not all companies were able to remedy the cash flow and/or reserve shortfalls and did go out of business, forcing hundreds of thousands of Americans to switch to other carriers, often with less attractive pricing and/or different provider networks, which required these insured to switch doctors in order to retain insurance coverage and remain compliant with the individual mandate under the ACA.

12. This “bait and switch” paradigm has required QHP issuers to sharply raise their rates and decrease benefits to protect against potential losses from this new risk pool that needs

more time to stabilize, resulting in much higher costs to American taxpayers in the long run than the temporary risk corridor program itself, seemingly for perceived political gain.

13. By this lawsuit, Plaintiff seeks, on behalf of itself and all others similarly situated, full payment of the 2016 plan year risk corridor payments it is entitled to under the ACA. Despite its after-the-fact politicization, the risk corridor program is far and away the smallest of the Three Rs. Yet, it is simultaneously the most important of those programs in these early crucial years, because it was contemplated by the Affordable Care Act as a necessary component to allow QHP issuers to function and survive while the new health insurance market stabilized and they obtained more risk and cost data. The law is clear: the Government must abide by its statutory obligations. Plaintiff respectfully seeks to compel it do so.

JURISDICTION

14. This Court has jurisdiction over the subject matter of this action pursuant to the Tucker Act, 28 U.S.C. § 1491. The statutory basis for invoking jurisdiction is Section 1342, which is a money-mandating statute that requires payment from the federal government to QHP issuers that satisfy certain criteria, and Section 153.510(b), which is similarly money-mandating and requires payment from the federal government to QHP issuers that satisfy certain criteria.

15. This controversy is ripe because CMS and HHS have stated that they will not pay Plaintiff and the Class the full amounts they are owed for the 2016 plan year within the annual cycle required by Section 1342 and Section 153.510.

PARTIES

16. Plaintiff CGHC is a nonprofit corporation organized under the laws of the State of Wisconsin, with its principal place of business at 120 Bishop's Way, Suite 150, Brookfield, Wisconsin 53005. CGHC began providing QHPs to on the state-based health exchange in

Wisconsin in January of 2014. Throughout 2014, 2015, and 2016, CGHC continued to provide QHPs on the ACA exchange. For the 2016 plan year, CGHC has determined it is owed \$25,694,340 under the risk corridor program. The precise 2016 risk corridor receivable will be determined after the submission of final data to CMS later in 2017.

17. Pursuant to CMS statements, 2014 and 2015 unpaid risk corridor amounts will be paid before 2016 risk corridor payments are made. As a result, CMS plans to use risk corridor payments made by QHP issuers with an obligation to pay the Government under the criteria of the risk corridor program for 2016 to pay remaining 2014 and 2015 risk corridor obligations before making 2016 risk corridor payments. That will lead to insufficient payments for the 2016 plan year because it will shortchange the amounts for 2016, and CMS has stated unequivocally it will not draw on any other funds to pay outstanding risk corridor amounts.

18. Based upon the persisting losses experienced by QHP issuers in the individual market nationally, risk corridor payments due to the Government for the 2016 plan year are estimated to be very low, creating yet again a deficit for the risk corridor program.

19. The defendant is the Government, acting through the Centers for Medicare & Medicaid Services and United States Department of Health & Human Services.

FACTUAL ALLEGATIONS

A. In 2010, the Government Established a “Risk Corridor” Program Designed to Entice Issuers to Participate in the New Affordable Care Act Insurance Exchanges

20. With its passage in March 2010, the Affordable Care Act established three insurance premium stabilization programs. The Three Rs (as they are colloquially known) include: a permanent risk adjustment program, which collects funds from health plan providers in the individual and small group markets that have enrolled lower-risk enrollees and transfers the funds to health plan providers that have enrolled higher risk enrollees; a three-year

reinsurance program, which collects contributions from all commercial health plan providers based upon the number of people each carrier insures, and pays out those funds to health plan providers based upon their high-cost claims in the individual and small group markets; and a three-year risk corridor program. Both the reinsurance and risk corridor programs began in 2014 and concluded at the end of 2016.

21. Section 1342 of the Affordable Care Act mandates the risk corridor program. In relevant part for this lawsuit, it states:

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

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary *shall provide under the program established under subsection (a)* that if—

(A) a participating plan’s allowable costs for any plan year are more than 103 percent but not more than 108 of the target amount, the Secretary *shall pay to the plan* an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

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

Pub. L. 111-148 § 1342 [42 U.S.C. § 18062] (emphasis added). Section 1342 also includes a provision requiring qualified health plans to pay escalating portions of any outsized profits they make from 2014-2016. *Id.* § 1342(b)(2). For both the “payments out” and “payments in” provisions of Section 1342, the terms “allowable costs” and “target amount” are defined by the statute. *Id.* § 1342(c).

22. As directed by the ACA, HHS implemented the risk corridor program in the Code of Federal Regulations. 45 CFR § 153.500 provides definitions for all necessary terms (including, among others, “qualified health plan,” “risk corridors,” “allowable costs,” and “target amount”), and 45 CFR § 153.510 establishes the regulations implementing the risk corridor program. In relevant part, 45 CFR § 153.510 states:

(b) HHS payments to health insurance issuers. ***QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:***

(1) When a QHP’s allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, ***HHS will pay the QHP issuer*** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

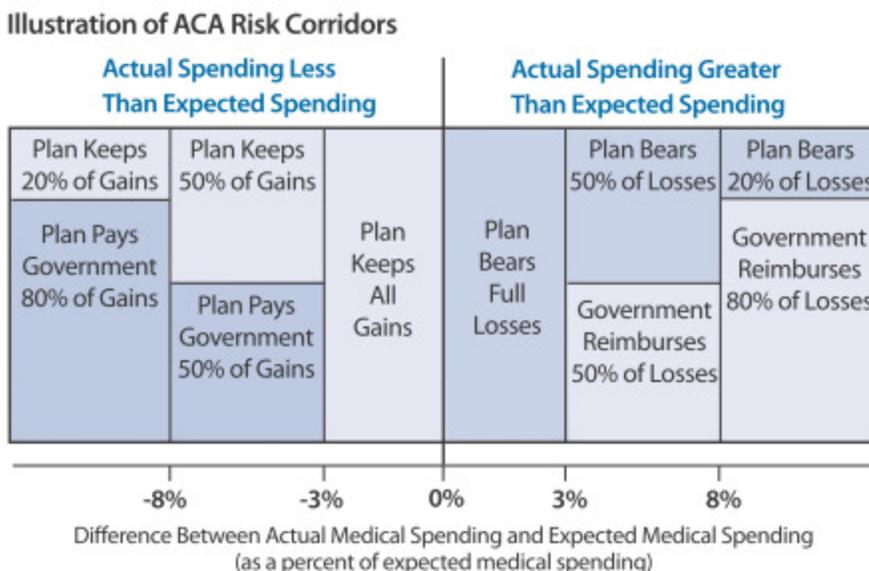
(2) When a QHP’s allowable costs for any benefit year are more than 108 percent of the target amount, ***HHS will pay to the QHP issuer*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(emphasis added).

23. This payment regulation, as well as a companion regulation regarding the risk corridor requirements (45 CFR § 153.530), further mandates that QHP issuers must adhere to the requirements set by HHS for participants in the risk corridor program, must satisfy certain requirements with respect to defining their premium data, allowable costs, and administrative costs, and must submit all necessary information for the risk corridor payment calculations by certain points established by statute, regulation, and HHS. 45 CFR §§ 153.510, 153.530. If QHP issuers abided by these requirements and satisfied the necessary criteria, they were eligible for “payments out” from the risk corridor program once the payments were calculated.

24. Section 1342 and Section 153.510 provide that if a QHP issuer’s actual claims in a year covered by the risk corridor program are at least 3% greater than the claims projected when the issuer set rates for that year, the Government must reimburse the issuer for half of the

excess. If actual claims jump 8% beyond projected claims, the Government covers 80% of the excess. The following chart from the American Academy of Actuaries graphically demonstrates this obligation (and the QHP issuers' corresponding obligation to pay the Government if their profits exceed certain amounts):



25. As another set of actuaries explained, “The goal of the risk corridor program is to protect health insurance issuers against this pricing uncertainty of their plans, temporarily dampening gains and losses in a risk-sharing arrangement between issuers and the federal government. Since the protection is only available for QHPs, it also provides a strong incentive for issuers to participate in the health insurance exchanges set up by the ACA. Lastly, it provides an incentive for issuers to manage their administrative costs optimally.”

26. Put simply, the risk corridor program recognizes that QHP issuers generally have less experience in how to accurately price policies in the individual market rather than the group market, and no relevant experience estimating benefit utilization, risk pool composition, and medical spending costs for insurance policies to the post-ACA market, which included a new demographic and new mandatory coverage requirements. The risk corridor program was

designed to draw in issuers and help keep premiums at manageable levels while those issuers developed enough experience to properly price plans without a safety net. The ultimate goal was to create what is known as a “virtuous cycle”; *i.e.*, by keeping premiums low, more people would enroll in the new health plans, which would enable issuers to develop necessary utilization, cost, and risk pool experience, which would help them accurately set premiums and offer more expansive health plans, which would draw in more insureds. A broad collection of economists, health policy experts, insurance companies, and regulators agreed with the fundamental principles underlying the program and therefore strongly supported its inclusion in the Affordable Care Act.

27. Based on the risk corridor program and the other two of the Three Rs, hundreds of issuers offered thousands of qualified health plans on the Affordable Care Act exchanges. They began offering insurance under the law’s new mandate at the beginning of 2014. In the time since, it has become clear that the risk corridor program is—as predicted—highly necessary for many of the QHP issuers to survive these early, tumultuous years of the new insurance market. However, it bears noting, even at full payment, the risk corridor program is by far the smallest of the Three R premium stabilization programs.

B. The Risk Corridor Program Is Politicized Just as It Begins

28. The Affordable Care Act and the Health Care and Education Reconciliation Act have created (and continue to create) substantial debate in the Government and populace. Indeed, the Affordable Care Act has twice withstood scrutiny before the Supreme Court of the United States, and still faces certain legal and political challenges. Despite this debate, however, the risk corridor program went largely uncontested during the drafting process. This is likely because, as noted above and explicitly stated in Section 1342, it was modeled after a similar

program enacted under President George W. Bush. Since Congress enacted the Affordable Care Act, it has not amended or otherwise attempted to modify the actual risk corridor program itself.

29. Despite this, the Defendant has taken several steps to frustrate the entire point of the risk corridor program: timely and complete payment to QHP issuers in order to permit them to survive and learn this new market in its early years. The first such step was in early 2014, when CMS and HHS suddenly took the position that the risk corridor program needed to be self-funding—or “budget neutral”—even though there is no such indication in the Affordable Care Act itself nor in its implementing regulations.

30. For example, on March 11, 2014, HHS’s final Notice of Benefit and Payment Parameters for 2015 included, *for the first time*, language in the rule commentary indicating that the agency would apply a budget neutral approach. The rule stated:

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

Similar language regarding budget neutrality was found throughout the rule on Exchange and Insurance Market Standards for 2015, published March 2, 2014. However, HHS made the exact opposite statements—indicating it would not apply budget neutrality to the program, because it could not—for several years prior. *See* 78 Fed. Reg. 15,410, at 15,473 (“The Risk Corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.”); Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, at 30,260 (May 27, 2014) (“ . . . HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.”); HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, at 10,779 (Feb. 27, 2015) (“HHS

recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.”); CMS, “Risk Corridors Payments for 2015” (Sept. 9, 2016), *available at* <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF#sthash.F6vymHRx.dpuf> (“HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation¹ of the United States Government for which full payment is required.”).

31. Then, on April 11, 2014, CMS issued a statement entitled “Risk Corridors and Budget Neutrality,” in which it stated that, “if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments.” This document further stated that future guidance would explain what would happen if there was still a shortfall after 2016.

32. In essence, both CMS and HHS stated, without basis in the Affordable Care Act or any modifying statutes, that the risk corridors program would become budget neutral and that, if 2014 resulted in a shortfall, QHP issuers owed money under the program would only receive pro rata shares of what was paid in by other QHP issuers. If there was a similar shortfall in 2015 and/or 2016, then CMS and HHS would kick the can further down the road and let issuers know only in 2017 (if ever) what the Government planned to do to make them whole.

¹ The recording of risk corridor payments as an “obligation” has independent significance. Pursuant to the guidance set forth in the GAO’s Red Book, an agency should record as an “obligation” non-discretionary expenditures “imposed by law.” GAO, *Principles of Federal Appropriations Law*, 3d Ed., Vol. II, 2006 rev., p. 7-43, GAO-06-382SP.

33. At the time CMS and HHS made these decisions, the Government faced a major debate on congressional appropriations and spending. Budget neutrality may have been CMS's solution to a difficult situation imposed by the ongoing spending debates, but it is not supported by the law. Section 1342 and Section 153.510 each affirmatively state that the Government "shall" and "will" pay QHP issuers specific amounts if they meet the statutory requirements, and that those QHP issuers "will receive payment from HHS" if they meet the stated requirements. Nowhere in either Section does it say that the risk corridor payments will come from payments to the Government by other issuers. Nor does either Section state that the Government may put off the payments they owe until the next year's collections. (Indeed, the Government expects risk corridor payments *from* QHP issuers within 30 days after notification of the amounts they owe under the program. *See* 45 CFR § 153.510(d).)

34. Regardless of CMS's and HHS's attempted solutions to portions of the spending debate, certain members of the Government soon took a far more drastic step. Toward the end of 2014, Congress negotiated a massive spending bill to address numerous aspects of the Government's budget. During this process, a small contingent of Representatives and Senators opposed to the Affordable Care Act attached a rider to what eventually became the 2015 Spending Bill. This rider was aimed at cutting off CMS's and HHS's ability to make risk corridor payments from Government funds. The 2015 Spending Bill contained the following provision:

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

Pub. L. 113-235 at 362.

35. The 2015 Spending Bill was enacted on December 16, 2014, nearly a year after Plaintiff and the hundreds of QHP issuers in the Class began offering insurance on the ACA exchanges and eighteen or more months after they had submitted rates for regulatory approval. Faced with this new development, the QHP issuers continued to abide by their obligations to the Government and their insureds, but they received little immediate guidance as to what would happen with the risk corridor payments.

36. Another provision was inserted into the following year's spending bill. The relevant portion of the 2016 Spending Bill states:

SEC. 225. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) or Public Law 111-148 (relating to risk corridors).

Pub. L. 114-113 at 383.

37. This time, however, the 2016 Spending Bill went one step further and specifically noted that special amounts appropriated to CMS and HHS in 2016 could *not* be used to fund the risk corridors program. In relevant part, the Bill stated:

SEC. 226. In addition to the amounts otherwise available for the "Centers for Medicare and Medicaid Services, Program Management," the Secretary of Health and Human Services may transfer up to \$305,000,000 to such account from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to support program management activity related to the Medicare Program: *Provided, that except for the foregoing purpose, such funds may not be used to support any provision of Public Law 111-148 or Public Law 111-152 (or any amendment made by either such Public Law) or to supplant any other amounts within such account.*

Pub. L. 114-113 at 384 (emphasis added).²

² Section 227 of the 2015 Spending Bill, as well as Sections 225 and 226 of the 2016 Spending Bill, are collectively referred to in this Complaint as the "Spending Bill Provisions."

38. Then, in 2017, Congress once again enacted the same limitation to specific funds from the 2016 Spending Bill in the 2017 Spending Bill. Pub. L. 115-31 at Sec. 223.

39. As discussed below, the Spending Bill Provisions effectively tied CMS's and HHS's hands with respect to their obligations to make risk corridor payments for each of the 2014-2016 plan years. But the text of the Spending Bill Provisions is important, because they only state CMS and HHS *cannot use certain sources of funds* to satisfy the Government's obligations. The provisions do not speak to the continuing existence of the Government's obligations, nor could they under applicable law (particularly given that the QHP issuers have satisfied their obligations pursuant to Section 1342 and Section 153.510).

C. **Constrained by the Spending Bill Provisions, CMS and HHS Default on 87% of the 2014 Risk Corridor Payments to QHP issuers and 100% of 2015 Payments, Causing Significant Market Disruption**

40. Pursuant to their obligations under the Affordable Care Act and 45 CFR § 153.500 *et seq.*, Plaintiff and the Class members complied with their statutory requirements throughout the 2014, 2015, and 2016 plan years and, for the first two plan years, submitted all required data for the risk corridor calculations by the statutory deadline. *See* 45 CFR § 153.530(d). The Government then calculated the risk corridor payments in and out, and, after notifying the market of a month extension, announced the results in late 2015 and late 2016.

41. Due to a variety of factors—including, among other things, the expected pricing risks in a new insurance market with dramatically new demographics and new benefit requirements, as well as a higher-than-expected percentage of sick individuals due to certain policy changes in 2013 that allowed consumers to renew non-ACA compliant health plans even after the Affordable Care Act became effective—Plaintiff and the Class suffered substantial losses in each of the plan years covered by the risk corridors program. Based on the Government's own official calculations, QHP issuers generated only around \$457 million in risk

corridor gains for the Government in 2014 and 2015, but suffered over \$8.67 billion in compensable risk corridor losses in those same years. In CMS's October 1, 2015 and November 18, 2016 statements, it informed Plaintiff and the Class that they would receive just a small fraction of the amounts they were owed under the risk corridor program, which reflected a prorated distribution of the few hundred million dollars received from the few issuers that were required to pay the Government for the 2014 and 2015 plan years. CMS also reiterated its previous statement that it would be forced to maintain "budget neutrality" for the risk corridor program on a go forward basis.

42. As it became clear QHP issuers would only receive a tiny fraction of what they were owed under the risk corridor program, many began to fail. For example, nearly every consumer operated and oriented plans (CO-OPs) created under the Affordable Care Act announced they were unable to meet cash flow and/or regulatory reserve requirements and many closed their doors due to the deficit of risk corridor payments. As a young insurer, CGHC did not have the cash reserves to cover the degradation of the risk corridors receivable, which meant that CGHC's Risk Based Capital was reduced to company action levels and CGHC's publicly available financial statements showed a loss rather than a gain on its 2015 year-end financials. Because CMS's announcement regarding its change in the risk corridors program in October 2015 occurred after all plans and rates for 2014, 2015 and 2016 were filed and approved, CGHC had no ability to account for this change in its budget or build it into CGHC's pricing. As a result, CGHC suffered further losses in 2016.

43. A number of other insurance companies have also failed due to the Government's default on the risk corridor amounts it owed, and many more (including several of the nation's largest health plan providers) have withdrawn from the ACA exchanges entirely.

44. Additionally, due to the severe limitations placed upon CMS's and HHS's ability to pay the risk corridor payments in full, the National Association of Insurance Commissioners ("NAIC") issued guidance to state insurance commissioners recommending that QHP issuers *not* be permitted to admit risk corridor payments as balance sheet assets for purposes of meeting regulatory reserve requirements. Given CMS's budget neutrality guidance and the Spending Bill Provisions, the payments were too uncertain and therefore likely to overstate the financial health of issuers. Although NAIC—and, in several QHP issuers' case, their independent financial auditors—was likely correct to institute this guidance (as the Government's subsequent non-payments demonstrate), it created an incredible burden on QHP issuers. Had QHP issuers been permitted to record the risk corridor payments as balance sheet assets, many would not have run afoul of their regulatory reserve requirements and many would still be providing QHPs on the ACA exchanges today. But even for those QHP issuers that have survived notwithstanding the current market turmoil, the uncertainty the non-payments have caused means that QHP issuers—especially smaller issuers that cannot spread losses associated with the risk corridors across premiums in other channels or other markets—have had to offer health plans at higher prices than before to ensure they are protected from the unknown risk this nascent market still embodies. This is exactly the opposite of the risk corridors and other 3R programs' intended result.

D. The Government Has Indicated It Will Not Make the Full 2016 Risk Corridor Payments

45. Similar to the 2015 and 2016 Spending Bills, the 2017 Spending Bill prevents CMS and HHS from making any risk corridor payments from Government funds. As a result, the agencies have indicated that they will continue to treat the risk corridor program as budget neutral, and use any funds received from QHP issuers for the 2016 risk corridor results to first

pay down the \$8.6 billion shortfall from the 2014 and 2015 plan years.

46. The Government has effectively indicated it will fail to meet its risk corridor obligations for 2016 as well. As disclosed in their 2016 annual and fourth-quarter earnings, the nation's largest health plan providers suffered another year of large losses in the ACA exchanges. For example, Aetna reported pretax losses of \$450 million on its public exchange business last year. Humana reported \$168 million in estimated risk corridors receivables for the first three quarters of 2016, and UnitedHealth's 2016 losses were steep enough that it is participating in only three individual public exchanges in 2017, down from 34 in 2016. Anthem likewise reported losses in its public exchange business for 2016, pointing to "significant disruptions" on the public exchange market and insurers' "significant losses" on them that prompted many QHPs to withdraw entirely from states' individual exchanges for 2017.

47. These results are consistent with other current data, the sum total of which has caused market analysts to predict that the risk corridor program will continue to experience underfunding for 2016. *See, e.g.,* Bannerjee, D., Sung, J., & Marinucci, J., "The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer," at 2-5, *Standard & Poor's RatingsDirect* (Dec. 22, 2016). This is consistent with analysts' additional prediction that it will take at least three years for the Affordable Care Act exchange market to stabilize. *Id.* at 3.³

48. For these reasons, on information and belief, Plaintiff and the Class are currently owed even more risk corridor payments than the official 2014 and 2015 calculations and will prove the exact amount in this case. Furthermore, the 2016 risk corridor payments to the Government will be insufficient to satisfy the Government's full obligations to Plaintiff and the

³ Congress, of course, made the same prediction when enacting the risk corridor program, since the program is meant to run for only three years: 2014-2016.

Class for each of 2014-2016, and it will be insufficient to satisfy the obligations from all three years combined. Compounding this, CMS and HHS have indicated—as they must, due to the Spending Bill Provisions—they will not pay any amounts above what comes in from QHP issuers this year. Plaintiff and the Class are thus in a worse position than when the 2014 and 2015 shortfalls were first announced and have already been told that the Government will not resolve the situation despite its statutory obligations.

* * * * *

49. The Government’s failure to satisfy its monetary obligations and make its required risk corridor payments will have wide-reaching effects on millions of Americans in the form of restricted health plans and higher insurance premiums. Given QHP issuers relied upon the risk corridor program in designing and pricing their 2014, 2015, and 2016 plans, as was the intent of the program, Plaintiff, on behalf of itself and the Class, seeks the immediate payment in full of risk corridor receivables for 2016, once they are determined, to enable QHP issuers to survive and continue to offer Americans high-quality, affordable health insurance as contemplated by the Affordable Care Act.

CLASS ACTION ALLEGATIONS

50. Plaintiff brings this action as a class action under Rule 23(a) and (b) of the Rules of the United States Court of Federal Claims, on behalf of itself and others similarly situated. The proposed “Class” is defined as:

All persons or entities offering Qualified Health Plans under the Patient Protection and Affordable Care Act in the 2016 benefit year, and whose allowable costs in the 2016 benefit year, as calculated by the Centers for Medicare and Medicaid Services, were more than 103 percent of their target amounts (as those terms are defined in the Patient Protection and Affordable Care Act). Excluded from the Class is the Defendant and its members, agencies, divisions, departments, and employees.

51. There are hundreds of Class Members as described above, making the Class so numerous and geographically dispersed that joinder of all Class Members is impracticable.

52. There are questions of law and fact common to the Class that relate to the Government's actions and the type and common pattern of injury sustained as a result thereof, including, but not limited to:

- a. whether Section 1342 of the Affordable Care Act is a money-mandating statute;
- b. whether 45 CFR § 153.510 is a money-mandating regulation;
- c. whether the Government's failure to appropriate funds sufficient to make risk corridor payments to Plaintiff and the Class absolve it of its statutory obligations;
- d. whether the Government violated its obligations to pay Plaintiff and the Class risk corridor amounts in a reasonable time following the official calculation of those amounts; and
- e. whether the Government is liable to Plaintiff and the Class for failing to make risk corridor payments within a reasonable time following the official calculation of those amounts.

53. Plaintiff's claims are typical of the claims of the other Class Members. Plaintiff and the Class Members sustained damages arising out of Defendant's common course of conduct in violation of law as complained of herein. The injuries and damages of each Class Member were directly caused by Defendants' wrongful conduct in violation of the laws as alleged herein.

54. Plaintiff will fairly and adequately protect the interests of the Class Members. Plaintiff is an adequate representative of the Class and has no interests adverse to the interests of absent Class Members. Plaintiff has retained counsel competent and experienced in complex class action litigation, including commodity futures manipulation and antitrust class action litigation.

55. The prosecution of separate actions by individual Class Members would create a risk of inconsistent or varying adjudications.

56. The questions of law and fact common to the Class Members predominate over any questions affecting only individual members, including legal and factual issues relating to liability and damages.

57. A class action is superior to other available methods for the fair and efficient adjudication of this controversy. Treatment as a class action will permit a large number of similarly situated persons to adjudicate their common claims in a single forum simultaneously, efficiently, and without duplication of effort and expense that numerous, separate individual actions, or repetitive litigation, would entail. The Class is readily definable and is one for which records should exist in the files of the Defendant, Class Members, or the public record. Class treatment will also permit the adjudication of relatively small claims by many Class Members who otherwise could not afford to litigate the claims alleged herein, including because they have been put out of business by Defendant's conduct. This class action presents no difficulties of management that would preclude its maintenance as a class action.

CLAIMS FOR RELIEF

COUNT ONE

(Violation of Statutory and Regulatory Mandate to Make Payments)

58. Plaintiff realleges and incorporates the above Paragraphs 1-57 as if fully set forth herein.

59. As part of its obligations under Section 1342 of the ACA and/or its obligations under 45 CFR § 153.510(b), the Government is required to, subject to certain explicit statutory

and/or regulatory conditions, pay any QHP issuer certain amounts exceeding the target costs they incurred in 2016.

60. Plaintiff and the Class are QHP issuers under the ACA and, based on their adherence to the ACA and their submission of their allowable costs and target costs to CMS, satisfy the requirements for payment from the United States under Section 1342 of the ACA and 45 CFR § 153.510(b).

61. The United States has failed, without justification, to perform as it is obligated under Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b) and has affirmatively stated that it will not satisfy those obligations in the time frame required by the statutes and regulations for 2016.

62. The United States' failure to provide timely payments to Plaintiff and the Class is a violation of the Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b), and Plaintiff and the Class has been damaged thereby.

PRAYER FOR RELIEF

Wherefore, Plaintiff and the Class request the following relief:

A. That the Court certify this lawsuit as a class action under Rules 23(a), (b)(2), and (b)(3) of the Rules of the United States Court of Federal Claims, that Plaintiff be designated as class representative, and that Plaintiff's counsel be appointed as Class counsel for the Class;

B. That the Court award Plaintiff and the Class monetary relief in the amounts to which Plaintiff and the Class are entitled under Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b).

C. That the Court award appropriate declaratory relief, including but not limited to a declaration and judgment that Defendant's conduct alleged in the complaint violates the laws alleged in the complaint; and

D. That the Court award such other and further relief as the Court deems proper and just.

DATED: June 27, 2017

Respectfully submitted,

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