IN THE UNITED STATE COURT OF FEDERAL CLAIMS

BCBSM, INC. Plaintiffs, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 16-1253C Judge Mary Ellen Coster Williams

JOINT STATUS REPORT

As required by this Court's Order dated August 16, 2018, the parties respectfully submit the following Joint Status Report within 30 days on which the judgments in *Land of Lincoln Mutual Health Insurance Company v. United States*, No. 17-1224, and *Moda Health Plan, Inc. v. United States*, No. 17-1994, became final and non-appealable. (*See* Order dated Aug. 16, 2018, Doc. No. 10.) *Land of Lincoln* and *Moda Health* involved claims by health insurers against the United States of America (the "United States") claiming money owed to them under the risk corridors program of the Patient Protection and Affordable Care Act ("ACA"). The cases were consolidated before the United States Supreme Court with the cases brought by two other insurers, Maine Community Health Options and Blue Cross and Blue Shield of North Carolina. On April 27, 2020, the Supreme Court issued its final ruling in the four consolidated risk corridors cases. *See Maine Community Health Options v. United States*, ("*Maine Cmty.*") No. 18-1023, 590 U.S. ___, 140 S.Ct. 1308, 2020 WL 1978706 (U.S. Apr. 27, 2020).

As set forth in the Parties' respective statements, the United States requests forty-five days to recommend next steps, including consensual resolution, and respectfully asks that the Court defer the government's obligation to respond to the complaint or any amended complaint upon consideration of the joint status report it proposes be due at the end of the requested 45-day period; for the reasons stated below, Plaintiff opposes this request and seeks the entry of a final judgment.

Plaintiffs' Position

A. Procedural History And Amending Complaint

BCBSM, Inc., d/b/a Blue Cross and Blue Shield of Minnesota ("BCBSM" or "Plaintiff") filed a Complaint against the United States on October 3, 2016, seeking money damages arising from Section 1342 of the ACA, 42 U.S.C. § 18062, and 45 C.F.R. § 153.510(b), the risk corridors program of the ACA. (Compl., Doc. No. 1.) BCBSM's claims and requested relief for payment under Section 1342's formula raise "identical and related legal theories" to numerous other cases that had been brought against the United States by health insurers seeking payment pursuant to the Risk Corridor program of the ACA under Section 1342's formula. (*See* Joint Motion To Stay Proceedings, Doc. No. 6.)

On December 1, 2016, BCBSM and the United States (collectively, "the Parties") filed a Joint Motion To Stay Proceedings "to stay this action pending further developments in several earlier-filed cases raising similar issues," recognizing that the issues presented in this case are the same as the issues raised in earlier-filed risk corridor cases, including *Land of Lincoln* and *Moda*. (Joint Motion To Stay Proceedings, Doc. No. 6.) Pursuant to the Parties' request for a stay until "30 days after the judgments in *Moda* and *Land of Lincoln* have become final and no further review is available," the Court entered an Order dated December 5, 2016, staying this case. (Order, Doc. No. 7.) As stated in the Order, this Court specifically noted the Parties' agreement that the *Land of Lincoln* matter involved "identical and related legal theories to those asserted by Plaintiff [BCBSM]." (*Id.*)

On July 24, 2018, the Parties filed a Joint Status Report. (Doc. No. 8.) Reiterating their position stated in the Joint Motion To Stay Proceedings, the Parties advised the Court that BCBSM's "Complaint asserts theories substantially similar to those considered in the *Land of*

Lincoln and *Moda* appeals." (Joint Status Report And Request To Continue Stay Of Proceedings, Doc. No. 8.) The Parties requested that the case be stayed and that they "file a status report with this Court within 30 days after the judgments in *Moda* and *Land of Lincoln* have become final and no further review is available." (*Id.*) By Order dated July 25, 2018, the Court granted the Parties' request and ordered the Parties to "file a joint status report within 30 days after the judgments in *Moda* and *Land of Lincoln* have become final." (Order, Doc. No. 9.)

On April 27, 2020, the Supreme Court issued its decision in the consolidated appeals involving *Maine Community Health Options, Moda Health Plan, Land of Lincoln*, and *Blue Cross Blue Shield of North Carolina*. *See Maine Cmty.*, 590 U.S. ___, 140 S. Ct. 1308, 2020 WL 1978706. The Supreme Court held that the Tucker Act, 28 U.S.C. § 1491, provides the proper statutory vehicle for pursing an action against the United States by health insurers for money owed under the risk corridors program of the ACA. *See id*. 590 U.S. ___, 140 S. Ct. at 1327 ("We hold that petitioners properly relied on the Tucker Act to sue for damages in the Court of Federal Claims.") As to the specific claim for money damages, the Supreme Court held that "[t]he Risk Corridors statute created a Government obligation to pay insurers the full amount set out in § 1342's formula,"[1] which obligation was "neither contingent on nor limited by the availability of appropriations or other funds,"[2] "nor repealed." *Id.*, 590 U.S. ___, 140 S. Ct. at 1323. The Supreme Court remanded the cases to the United States Court of Federal Claims for further proceedings consistent with its opinion. *Id.*, 590 U.S. ___, 140 S. Ct. at 1331.

[1] *Id.*, 590 U.S. ___, 140 S.Ct. at 1319

[2] *Id.*, 590 U.S. ___, 140 S.Ct. at 1323.

BCBSM seeks to amend its Complaint to include the claims of its subsidiary HMO Minnesota d/b/a Blue Plus as well as the updated and undisputed figures under Section 1342's formula for risk corridors payments as determined by the United States, specifically by the Centers for Medicare & Medicaid Services ("CMS").[3] The United States has stated that it does not object to the filing of an amended Complaint, which is attached as Exhibit A. As subsequently used in this Joint Status Report, "BCBSM" refers to both BCBSM and HMO Minnesota d/b/a Blue Plus.

B. The Supreme Court's Decision in *Maine Community Health Options* is Dispositive of BCBSM's Claims

The question before the Supreme Court in the consolidated *Maine Community* appeal was whether the United States was required to pay health insurers the amount of their losses calculated in accordance with the ACA's statutory formula on such claims brought pursuant to the Tucker Act. *Id.,* 590 U.S. ___, 140 S. Ct. at 1318. "These cases are about whether petitioners—insurers who claim losses under the Risk Corridors program—have a right to payment under § 1342 and a damages remedy for the unpaid amounts." *Id.*, 590 U.S. ___, 140 S. Ct. at 1315. The Supreme Court summarized the issues before it:

> First, did § 1342 of the Affordable Care Act obligate the Government to pay participating insurers the full amount calculated by that statute? Second, did the obligation survive Congress' appropriations riders? And third, may petitioners sue the Government under the Tucker Act to recover on that obligation?

Id., 590 U.S. ___, 140 S. Ct. at 1319. The Supreme Court answered "yes" to each question. *Id.*

Summarizing the risk corridors program, the Supreme Court explained that Section 1342 of the ACA "set a formula for calculating payments under the program: If an insurance plan loses

[3] Under RCFC Rule 15(a)(1)(B), a party can amend a pleading once as a matter of right within 21 days of the filing of a responsive pleading. In this case, no responsive pleading has been filed by the government because of the stay that has been in place since December 5, 2016. Accordingly, BCBSM can amend its complaint as a matter of right upon the lifting of the stay.

a certain amount of money, the Federal Government 'shall pay' the plan; if the plan makes a certain amount of money, the plan 'shall pay' the Government." *Id.*, 590 U.S. ___, 140 S. Ct. at 1315 (statutory citations omitted.) Reflecting on the statute's language, the Supreme Court noted, "the statute meant what it said; The Government 'shall pay' the sum that § 1342 prescribes." *Id.*, 590 U.S. ___, 140 S. Ct. at 1321. The Supreme Court determined that the obligation was "neither contingent on nor limited by the availability of appropriations or other funds." *Id.*, 590 U.S. ___, 140 S. Ct. at 1323. Additionally, the Supreme Court held that Congress did not repeal the statutory obligation, nor was the obligation otherwise discharged. *Id.*, 590 U.S. ___, 140 S. Ct. at 1323-27. Based on these conclusions, the Supreme Court ruled "that § 1342 of the Affordable Care Act established a money-mandating obligation, that Congress did not repeal this obligation, and that petitioners may sue the Government for damages in the Court of Federal Claims." *Id.*, 590 U.S. ___, 140 S. Ct. at 1331.

Undisputedly, BCBSM, through its Qualified Health Plans, participated in the ACA Health Insurance Exchanges Marketplace for calendar years 2014, 2015, and 2016. Also undisputedly, as a result, BCBSM suffered losses under the risk corridors program and is owed payments under Section 1342's formula.

The risk corridors amounts owed to BCBSM are based on the United States' calculations and CMS's reports. The United States has specifically admitted its obligation to pay BCBSM, Inc. and its subsidiary Blue Plus, for their risk corridor losses that total $262,586,241.31 for calendar years 2014, 2015 and 2016, of which the United States has paid only $1,169,212.87. *See* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs (reports dated November 19, 2015, November 18, 2016, and November 15, 2017). BCBSM, Inc.'s risk corridor losses for calendar years 2014, 2015 and 2016 (as confirmed by CMS's published

calculations) were $6,955,635.49, $174,955,826.46 and $68,940,048.25 respectively for a total of $250,851,510.20. *Id*. The United States has paid BCBSM $1,169,212.87 of its calendar year 2014 losses. *Id*. Blue Plus's risk corridor losses for calendar years 2015 and 2016 (as confirmed by CMS's published calculations) were $5,893,267.11 and $5,841,464.97 respectively for a total of $11,734,731.08. *Id*. The United States has not reimbursed Blue Plus for any of its risk corridor losses. *Id*. The total unreimbursed risk corridor payments owed to BCBSM, Inc. and its subsidiary Blue Plus are $261,417,029.41.

BCBSM, Inc. has confirmed that neither BCBSM nor Blue Plus owe the United States any off-setting debt, and the United States has not disputed this confirmation. Accordingly, $261,417,029.41 is the total amount of Plaintiffs' risk corridors payments due as damages caused by the United States' breach of its statutory payment obligation.

The Supreme Court's decision in *Maine Community Health Options* is dispositive of the legal issues in this case, and the holdings apply to the relief sought under BCBSM's claim under the Tucker Act for money damages under Section 1342's formula. This cannot be reasonably disputed: the United States admits that the claims asserted by Moda, Land of Lincoln, and other claimants suing the United States for payments under the risk corridors program—including the plaintiffs whose claims were at issue in consolidated decision in *Maine Community Health Options v. United States*—sought "relief under identical and related legal theories to those asserted by BCBSM." (*See* Joint Motion To Stay Proceedings, Doc. No. 6.) In addition, the allegations underlying BCBSM's claim against the United States for payment under Section 1342, brought under the Tucker Act, is substantially identical to the insurers' claims against the United States that were decided by the Supreme Court's decision in *Maine Community Health Options*.

C. Plaintiffs' Proposed Next Steps for Prompt Resolution

The Supreme Court observed that its holding in favor of health insurers seeking payment from the United States under the risk corridors program "reflect[s] a principle as old as the Nation itself: The Government should honor is obligations." *Id.*, 590 U.S. ___, 140 S. Ct. at 1331. That obligation having been now determined—which determination applies to BCBSM's claim for payment under Section 1342—the United States should promptly pay BCBSM the money to which BCBSM is entitled under Section 1342's formula. Because the Supreme Court has already determined liability, and because CMS has already determined the amount due under this statutory formula, the United States must promptly pay BCBSM.

BCBSM, Inc., for itself and Blue Plus, respectfully proposes that the Court enter a final judgment in the amount of $261,417,029.41 on the proposed and undisputed amended Complaint.

D. The Additional 45-Day Delay Requested By Defendant "To Consider" Its Position Is Unwarranted

Defendant proposes the Court allow it 45 additional days, not to resolve BCBSM's specific claims based on application of the Supreme Court's ruling in *Maine Community Health Options*, but rather "to consider" how such ruling impacts all of the 64 pending risk corridors cases plus its position as to potential hypothetical claimants who have not filed suit but who may seek damages under section 1342. Defendant does not provide a reason why it is not able to promptly reach final resolution of BCBSM's specific damage claim—which, as addressed above, is a straight-forward application of the Federal Government's already determined payment amount owed under Section 1342's formula with a deduction of the government's pro rata payments received by BCBSM. Rather, Defendant references unrelated plaintiffs and hypothetical plaintiffs in stating that it wants to assess all claims by health insurers that could possibly assert a claim under Section 1342's formula, whether or not similarly situated to BCBSM, including those claimants who, unlike

BCBSM, the government may have disputes as to the amount owed. Notably, Defendant does not seek the additional time to specifically resolve BCBSM's claim. And, significantly, Defendant is not committing to actually take any next steps, other than to use the requested 45 additional days "to consider" the matters.

Defendant provides four general reasons for seeking addition time "to consider" next steps, yet without committing to any next step. Defendant asserts its interest to: (i) confer with various components within the Department of Justice and Department of Health and Human Services "to discern a path forward;" (ii) consider how the Supreme Court's ruling impacts all of the risk corridors cases in which a plaintiff seeks damages under section 1342; (iii) determine the precise amount of risk corridors payments that have already been paid to every health insurer under the entire risk corridors program, whether or not the insurer has asserted a claim for payment; and (iv) propose an unspecified process that resolves all existing and all potential claims arising from the risk corridors program despite referencing considerations that do not apply to BCBSM—e.g., plaintiffs participating in both individual cases and in class actions and plaintiffs who may have off-setting debt. (*See* Defendant's position below). Notably, Defendant does not assert that any of these considerations applies to BCBSM's claims, which damage claim has been already determined by CMS and for which there is no off-setting debt owed to the Defendant. These reasons proffered by the Defendant simply do not apply to the resolution of BCBSM's claims and a further delay "to consider" next steps is unwarranted for resolving BCBSM's claims.

Defendant's position stated below does not demonstrate a need for an additional 45 days to resolve this case; BCBSM's entitlement to the above-stated amount is based on the Federal

Government's own calculations and figures.[4] The Federal Government already has publicly reported the precise amounts of risk corridors payments it owed BCBSM, Inc. and Blue Plus for each of the calendar years 2014, 2015, and 2016. *See* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs (reports dated November 19, 2015, November 18, 2016, and November 15, 2017). (*See* above reference and stated amounts.) Additionally, the Federal Government has already determined the precise amount of pro rata risk corridor payments that the Government has paid to BCBSM. Moreover, BCBSM has confirmed in writing that it has no offsetting debt owed to the United States, and Defendant has never asserted that BCBSM owes United States any amount that would constitute a debt that could offset the risk corridor damages owed to BCBSM. Without any offsetting debt, the amount of damages that Defendant owes BCBSM is undisputable: the amount is $261,417,029.41. Potential disputes as to payment amounts with other plaintiffs or other hypothetical claimants—as the Defendant suggests below—neither have any relevance to BCBSM's entitlement to judgment on its undisputable payment amount nor would provide fair justification to delay resolution of BCBSM's claim.

An additional 45 days is not reasonably needed to consider how the Supreme Court's decision in *Maine Community Health Options* "impacts" this case. As noted above, the decision's impact is clear. The Supreme Court ruled Defendant is liable to pay health insurers who participated in the ACA the amount of risk corridors payments under Section 1342's schedule.

[4] In justifying the further delay, Defendant states the HHS "made additional pro rata distribution of risk corridors collections to many of the plaintiffs before this Court. HHS is now determining the precise amount of risk corridors payments paid to and remaining for each health insurance issuer before this Court, as well as to any issuer with a potential risk corridors claim." As explained above, this does not apply to BCBSM, whose precise risk corridors payment amount that is still owing has been already determined by CMS. Additionally, Defendant seeks additional time to determine if "some of the plaintiffs may have outstanding debts owed to HHS under other ACA programs." However, this consideration does not apply to BCBSM.

BCBSM asserted the same statutory risk corridor claim that the Supreme Court resolved in favor of the insurers. The Supreme Court's decision is thus dispositive of BCBSM's statutory claim for payment owed.

While Defendant's position is that "it would be most appropriate and fair to resolve all issuers' potential entitlement under section 1342 in a similar manner," Defendant's stated justifications for the delay "to consider" matters generally undermines any need for a further delay to resolve BCBSM's claims; the issues to which Defendant identifies as needing additional time to address do not apply to BCBSM's claims. Entry of judgment for BCBSM should not be delayed by Defendant's obligations in other risk corridors cases that may have issues and disputes not present in this case.

Defendant's final position is that it needs time to assess potential, yet unspecified, defenses and counterclaims. For a case that has been pending for more than three and a half years and includes identical claims asserted in cases that have resulted in summary judgment against the government,[5] Defendant does not reasonably need a further delay to assess whether it has any unspecified defenses or counterclaims that Defendant has not raised in other similar risk corridors cases.

Fundamentally, it is unfair to BCBSM to further delay payment on its claim, which claim accepts the Federal Government's own Section 1342 calculations, in order for Defendant to consider how to address claims of other claimants whose entitlement to specific payment amounts may be disputed. Defendant has owed a substantial amount of money to BCBSM since the end of 2014 (based on CMS' calculation of the Section 1342 payment due for calendar year 2014), and BCBSM cannot recover prejudgment interest on the amounts owed under its Complaint, which

[5] *See, e.g., Moda Health Plan, Inc. v. United States,* 130 Fed. Cl. 436 (2017) (Wheeler, J.).

has been pending since 2016. *See, e.g., Connecticut Yankee Atomic Power Co. v. United States*, 142 Fed. Cl. 87, 91 (2019) (finding no just reason for delay of entry of judgment where damages owed was not disputed and prejudgment interest was unavailable."). As the Supreme Court noted, "[t]he Government should honor is obligations." *Maine Cmty.*, 590 U.S. ___, 140 S. Ct. at 1331. Indeed, in honoring its statutory obligations to BCBSM, the Court should enter a final judgment in favor of BCBSM in the amount of $261,417,029.41. Based on the Supreme Court's decision in *Maine Community Health Options v. United States*, BCBSM respectfully submits that there is no legitimate basis to delay the proceedings in this case.

The United States' Position

On April 27, 2020, the Supreme Court issued its decision in *Maine Community Health Options v. United States*, No. 18-1023, 590 U.S. --- (2020). The Supreme Court held that the risk corridors statute, section 1342 of the Patient Protection and Affordable Care Act ("ACA"), "created an obligation neither contingent on nor limited by the availability of appropriations or other funds." Slip Op. at 16. The Court also determined that the obligation was not affected by subsequently enacted legislation and held that the "petitioners may seek to collect payment through a damages action in the Court of Federal Claims." Id. at 30. Along with three other similar risk corridors cases, the Court reversed the judgments of the Federal Circuit and remanded the cases to that court for further proceedings consistent with the opinion.

The United States continues to review the Supreme Court's opinion. That process of review requires that we confer with various components within the Department of Justice and the Department of Health and Human Services in order to discern a path forward. We ask the Court to permit the United States additional time to consider how the Supreme Court's ruling impacts all of the cases in this Court in which a plaintiff seeks damages under section 1342, so that we may

propose an efficient and appropriate process to reach a conclusion in this, and every other risk corridors case before the Court.

We also request additional time for review because risk corridors was a nationwide program involving every single health insurance issuer participating on an ACA Exchange during benefit years 2014, 2015, or 2016. Some of those issuers are represented in the more than 64 individual cases pending before this Court; others are represented in this Court through either of two class actions; and still other issuers have not commenced litigation. The United States believes it would be most appropriate and fair to resolve all issuers' potential entitlement under section 1342 in a similar manner. In order to do so, the United States must consider and address a number of issues before these cases proceed.

To start, we note that since the time that most complaints were filed, the Department of Health and Human Services ("HHS") has made additional pro rata distribution of risk corridors collections to many of the plaintiffs before this Court. HHS is now determining the precise amount of risk corridors payments paid to and remaining for each health insurance issuer before this Court, as well as to any issuer with a potential risk corridors claim. Agency staff requires additional time to review the record of payments and charges and the history of distributions made to ensure they are complete and accurate. HHS must finish this review before the United States will be in a position to pursue a potential consensual resolution of an issuer's case, and that review is most efficiently done on a program-wide, rather than piecemeal (or ad hoc) basis. In light of the forgoing, Plaintiff's statements regarding the amounts due between the Parties is premature.

To cite another consideration, some of the plaintiffs may have outstanding debts owed to HHS under other ACA programs. In order to determine which issuers have such debts pending, HHS must review its records across ACA programs and distill that information for consideration

by government officials with authority to evaluate the issues. Those parties owing debts and the United States should then have an opportunity to confer to seek to resolve those issues, and, as necessary, to prepare and propose a procedure to dispose of outstanding matters. Finally, because the United States has not yet answered any of the plaintiffs' complaints, the United States needs to consider whether it would be appropriate to raise defenses not previously considered and whether to answer and counterclaim.

For all of these reasons, the United States requests that the Court allow the government 45 days within which to consider its position in these cases and to propose, jointly with the plaintiff to the extent possible, a course to govern proceedings moving forward. Within that time, the Court could allow plaintiff the opportunity to refine or update its claim for damages whether through formal amendment of its complaint or through less formal means. We also request that, in the interest of efficiency, the Court defer the government's obligation to respond to a complaint or an amended complaint upon consideration of the joint status report we propose be due at the end of the requested 45-day period.

Respectfully submitted,

Dated: May 27, 2020

Respectfully Submitted,

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Exhibit A

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

BCBSM, INC., and HMO Minnesota d/b/a Blue Plus, Plaintiffs, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 16-1253C Judge Mary Ellen Coster Williams

AMENDED COMPLAINT

Plaintiffs BCBSM, Inc. ("BCBSM") and its subsidiary, HMO Minnesota d/b/a Blue Plus ("Blue Plus") (hereinafter collectively referred to as "Plaintiffs"), by and through their undersigned counsel, bring this action against Defendant, the United States of America ("Defendant," "United States," or "Government"), and allege the following:

INTRODUCTION

1. BCBSM/Blue Plus bring this action to recover damages that are owed by Defendant for violations of the mandatory risk corridor payment obligations prescribed in Section 1342 of the Patient Protection and Affordable Care Act ("ACA"), and its implementing federal regulations, as well as Defendant's breaches of its risk corridor payment obligations under an implied-in-fact contract and the covenant of good faith and fair dealing implied in Defendant's contract with BCBSM/Blue Plus. In addition, Defendant has violated the Fifth Amendment of the U.S. Constitution by taking BCBSM's/Blue Plus' property without just compensation.

2. Congress's enactment in 2010 of the ACA marked a major reform in the United States health care market. The market reform extended guaranteed availability of health care to

most Americans and prohibited health insurers from using factors such as health status, medical history, gender, and industry of employment to set premium rates or deny coverage.

3. These dramatic changes to the health care market, including introducing previously uninsured or underinsured citizens into the health care marketplace, created great uncertainty for BCBSM/Blue Plus, which had no previous experience or reliable data to meaningfully assess the needs and medical cost associated with this new population of insureds and to set the premiums for these insureds.

4. Congress, acknowledging this uncertainty for health insurers, included in the ACA three risk-sharing, premium-stabilization programs to help protect participating health insurers against risk selection and market uncertainty as these dramatic market reforms were implemented. One of the programs is the temporary risk corridors program, which mandated that participating health insurers be paid annual risk corridor payments for each of the program's three years: 2014, 2015 and 2016.

5. Section 1342 of the ACA contains two related mandatory terms for all issuers who seek and obtain certification under the ACA of health plans as Qualified Health Plans ("QHPs"). First, any QHP issuer agreeing to participate shall receive compensation from the Government if the amount the QHP issuer collects in premiums in any one of these years falls short of a certain target amount due to high utilization and high medical costs. Second, the QHP issuers must pay the Government if the amount the QHP issuer collects in premiums exceeds its medical expenses by a similar target amount.

6. The temporary risk corridors program, modeled on a similar program in Medicare Part D, was intended to encourage health insurers to participate by easing the transition between

the old and new health insurance marketplaces. It was also designed to help stabilize premiums for consumers.

7. The United States has specifically admitted its obligation to pay BCBSM, and its subsidiary, Blue Plus, for their risk corridor losses that total $262,586,241.31 for calendar years 2014, 2015 and 2016, of which the defendant has paid only $1,169,212.87. BCBSM's risk corridor losses for calendar year 2014, 2015 and 2016 (as confirmed by CMS's published calculations) were $6,955,635.49, $174,955,826.46 and $68,940,048.25 respectively for a total of $250,851,510.20. Blue Plus' risk corridor losses for calendar year 2015 and 2016 (as confirmed by CMS's published calculations) were $5,893,267.11 and $5,841,464.97 respectively for a total of $11,734,732.08. The defendant has not reimbursed Blue Plus for any of its risk corridor losses. As noted above, the Government has paid BCBSM $1,169,212.87 of its calendar year 2014 losses. The total unreimbursed risk corridor payments owed to BCBSM and its subsidiary, Blue Plus, are $261,417,029.41.

8. This action seeks damages from the Government of $261,417,029.41, which represents the amount of risk corridor payments still owed to BCBSM and its subsidiary Blue Plus for calendar years ("CY") 2014, 2015 and 2016.

JURISDICTION AND VENUE

9. This Court has jurisdiction over this action and venue is proper in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1), because BCBSM and Blue Plus bring claims for damages over $10,000 against the United States founded on the Government's violations of the U.S. Constitution, a money-mandating Act of Congress, a money-mandating regulation of an executive department, and/or an implied-in-fact contract with the United States.

10. The actions and/or decisions of the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS") at issue in this lawsuit were conducted on behalf of the Defendant United States within the District of Columbia.

PARTIES

11. Plaintiff BCBSM, Inc. is a nonprofit corporation organized under the laws of the State of Minnesota, with its principal place of business in Eagan, Minnesota. BCBSM is a health insurer that does business in Minnesota as Blue Cross and Blue Shield Minnesota, an independent licensee of the Blue Cross and Blue Shield Association. BCBSM is a QHP issuer on MNsure, Minnesota's health insurance marketplace, for CY 2014, CY 2015, and CY 2016.

12. Plaintiff HMO Minnesota d/b/a Blue Plus ("Blue Plus") is a subsidiary of BCBSM and a nonprofit corporation organized under the laws of the State of Minnesota, with its principal place of business in Eagan, Minnesota. BCBS is Blue Plus' sole member. Blue Plus is a health maintenance organization insurer that does business in Minnesota. Blue Plus is a QHP issuer on MNsure, Minnesota's health insurance marketplace, for CY 2015, and CY 2016.

13. Defendant is the United States of America. The Department of Health and Human Services and the Centers for Medicare & Medicaid Services are agencies of the Defendant United States of America.

FACTUAL ALLEGATIONS

Congress Enacts the Patient Protection and Affordable Care Act

14. In 2010, Congress enacted the ACA, Public Law 111-148, 124 Stat. 119.

15. The ACA aimed to increase the number of Americans covered by health insurance and decrease the cost of health care.

16. The ACA requires health insurers that offer individual health insurance coverage in a state to accept every individual in the state that applies for coverage. Health insurers can no

longer deny coverage, exclude pre-existing conditions, or set premiums according to individual health status.

17. Beginning on January 1, 2014, individuals and small businesses were permitted to purchase private health insurance through competitive statewide marketplaces, often called Exchanges.

18. BCBSM participated in the Exchange in Minnesota in CY 2014, CY 2015, and CY 2016 and Blue Plus participated in the Exchange in Minnesota in CY 2015 and CY 2016.

The ACA's Risk Corridors Program

19. The ACA established three insurance premium stabilization programs, which began in 2014: temporary reinsurance and risk corridor programs to give insurers payment stability as insurance market reforms began, and an ongoing risk adjustment program that makes payments to insurers that cover higher-risk populations (*e.g.*, those with chronic conditions) to more evenly spread the financial risk borne by insurers.

20. The premium stabilization programs, including the risk corridor program, were offered to encourage participation by providing certainty and protecting against adverse selection in the health care market. The programs were also designed to protect consumers from increases in premiums due to health insurer uncertainty as the ACA's market reforms were implemented in 2014.

21. The mandatory risk corridor payments, along with the other financial protections that Congress provided in the premium stabilization programs, provided QHPs with the security to become participating health insurers in their respective states' Exchanges, despite the significant financial risks posed by the uncertainty in the new health care markets.

22. Section 1342 of the ACA expressly authorizes and requires the Secretary of HHS to establish and administer the temporary risk corridors program that provides for the sharing in

gains or losses resulting from inaccurate rate setting for CY 2014, CY 2015, and CY 2016 between the Government and QHPs in the individual and small group markets.

23. Congress required the ACA risk corridors program established in Section 1342 to be modeled after a similar program implemented as part of the Medicare Part D prescription drug benefit program.

24. The risk corridors program applies only to participating plans certified as QHPs. All insurers that elect to participate in the Exchanges are required by to obtain plan certification.

BCBSM Is A QHP Issuer

25. Based on Congress' statutory commitments set forth in the ACA, including but not limited to Section 1342 and the risk corridors program, BCBSM/Blue Plus agreed to become a QHP issuer and participate in the Exchange in Minnesota.

26. Before BCBSM and Blue Plus received QHP certification, BCBSM/Blue Plus executed attestations certifying their compliance with the obligations they were undertaking by agreeing to become, or continuing to act as, a QHP on the Exchange in Minnesota.

27. By executing and submitting its annual attestations to the State of Minnesota as required by CMS, BCBSM/Blue Plus agreed to the many obligations and responsibilities imposed upon all QHPs that accept the Government's offer to participate in the ACA Exchanges. Those obligations and responsibilities that BCBSM/Blue Plus undertook include, inter alia, licensing, employment restrictions, benefit design standards, cost-sharing limits, and participating in financial management programs established under the ACA (including the risk corridors program).

28. Through these annual attestations, BCBSM/Blue Plus affirmatively attested that they would agree to comply with certain "Financial Management" obligations, including, among others:

> 2.) Applicant attests that it will adhere to the risk corridor standards and requirements set by HHS as applicable for:
>
> > a. risk corridor data standards and annual HHS notice of benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 CFR 153.510);
> >
> > b. remit charges to HHS under the circumstances described in 45 CFR 153.510(c).

29. The financial risk sharing that Congress mandated through the risk corridors program was a significant factor in BCBSM's/Blue Plus' decision to agree to become a QHP and undertake the many responsibilities and obligations required for BCBSM/Blue Plus to participate in the Exchange.

30. BCBSM/Blue Plus demonstrated their willingness to be a meaningful partner in the ACA program and has done so in good faith, by agreeing to participate as a QHP on MNsure, rolling out competitive rates, and offering a broad spectrum of health insurance products, with the understanding that the United States would honor its statutory, regulatory, and contractual commitments regarding the premium stabilization programs, including the temporary risk corridors program.

The Risk Corridors Payment Methodology

31. Under the risk corridors program, the federal government collects charges from a health insurer if the insurer's QHP premiums exceed claims costs of QHP enrollees by a certain amount and makes payments to the insurer if the insurer's QHP premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments.

32. Congress, through Sections 1342(b)(1) and (2) of the ACA, established the payment methodology and formula to determine the amounts the QHPs must pay to the Secretary

of HHS and the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met.

33. The text of Section 1342(b) states:

> **(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 percent 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 allowable costs in excess of 108 percent of the target amount.
>
> **(2) Payments in**
>
> 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 less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062(b).

34. To determine whether a QHP pays into, or receives payments from, the risk corridors program, HHS compares allowable costs (claims costs subject to adjustments for health care quality, health IT, risk adjustment payments and charges and reinsurance payments) and the target amount—the difference between a QHP's earned premiums and allowable administrative costs.

35. Pursuant to the Section 1342(b) formula, each year for CY 2014, CY 2015, and CY 2016, QHPs with allowable costs that are less than 97 percent of the QHP's target amount are required to remit charges for a percentage of those cost savings to HHS, while QHPs with allowable costs greater than 103 percent of the QHP's target amount will receive payments from HHS to offset a percentage of those losses.

36. Section 1342(b)(1) provides the specific payment formula from HHS to QHPs whose costs in a calendar year exceed their original target amounts by more than three percent.

37. Section 1342(b)(1)(A) requires that if a QHP's allowable costs in a calendar year are more than 103 percent, but not more than 108 percent, of the target amount, then "the Secretary [of HHS] shall pay" to the QHP an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount.

38. Section 1342(b)(1)(B) further requires that if a QHP's allowable costs in a calendar year are more than 108 percent of the target amount, then "the Secretary [of HHS] shall pay" to the QHP 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.

39. Section 1342(b)(2) sets forth the amount of charges that must be remitted to HHS by QHPs whose costs in a calendar year are more than three percent below their original target amounts.

40. Section 1342(b)(2)(A) requires that if a QHP's allowable costs in a calendar year are less than 97 percent, but not less than 92 percent, of the target amount, then "the plan shall pay to the Secretary [of HHS]" an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs.

41. Section 1342(b)(2)(B) requires that if a QHP's allowable costs in a calendar year are less than 92 percent of the target amount, then "the plan shall pay to the Secretary [of HHS]" an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42. As detailed below, BCBSM/Blue Plus experienced allowable-cost losses of more than three percent of target amounts in the Minnesota ACA Individual Market, making it eligible to receive mandatory risk corridor payments required under Section 1342.

43. Congress did not impose any financial limits or restraints on the Government's mandatory risk corridor payments to QHPs in either Section 1342 or any other section of the ACA.

44. Congress also did not limit in any way the Secretary of HHS's obligation to make full risk corridor payments owed to QHPs, due to appropriations, restriction on the use of funds, or otherwise in Section 1342 or anywhere else in the ACA.

45. Congress has not amended Section 1342 since enactment of the ACA.

46. Congress has not repealed Section 1342.

47. HHS and CMS thus lack statutory authority to pay anything less than 100% of the risk corridor payments due to BCBSM/Blue Plus.

48. On March 11, 2013, HHS publicly affirmed—while health insurers, including BCBSM/Blue Plus, were contemplating whether to agree to participate in the new Exchanges that were beginning on January 1, 2014—that the risk corridors program is not statutorily required to be budget neutral. HHS further confirmed that, "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 FR 15409, 15473 (Mar. 11, 2013).

49. BCBSM/Blue Plus decided to become a QHP issuer based in part on the United States' commitment to make full risk corridor payments annually as set forth in Section 1342 of the ACA regardless of whether risk corridor payments to QHPs are actually greater than risk corridor charges collected from QHPs for a particular calendar year.

50. The United States, however, has refused to make full and timely risk corridor payments to BCBSM/Blue Plus, as set forth above, as required by Section 1342.

HHS's Risk Corridors Regulations

51. Congress authorized and directed HHS to establish and administer the risk corridors program enacted in Section 1342. Accordingly, CMS issued implementing regulations for the risk corridors program at 45 C.F.R. Part 153.

52. In 45 C.F.R. § 153.510, CMS adopted a risk corridors calculation that is mathematically identical to the statutory formulation in Section 1342 of the ACA, using the identical thresholds and risk-sharing levels specified in the statute. *See* 45 C.F.R. § 153.510.

53. Specifically, 45 C.F.R. § 153.510(b) prescribes the method for determining risk corridor payment amounts that QHPs "will receive":

> (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.

54. Furthermore, 45 C.F.R. § 153.510(c) prescribes the circumstances under which QHPs "must remit" charges to HHS, as well as the means by which HHS will determine those charge amounts:

> (c) *Health insurance issuers' remittance of charges.* QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:
>
> > (1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and
> >
> > (2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

55. Additionally, 45 C.F.R. § 153.510(d) imposes a 30-day deadline for a QHP to fully remit charge payments to HHS when the QHP's allowable costs in a calendar year are less than 97 percent of the QHP's target amount, specifically stating that:

> (d) *Charge submission deadline.* A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

56. The regulation is silent on when HHS must tender full risk corridor payments to QHPs whose allowable costs in a calendar year are greater than 103 percent of the QHP's target amount.

57. During the proposed rulemaking that ultimately resulted in adoption of the 30-day charge-remittance deadline for QHPs at 45 C.F.R. § 153.510(d), CMS and HHS stated that the deadline for the Government's payment of risk corridor payments to QHPs should be identical to the deadline for a QHP's remittance of charges to the Government. *See* 76 FR 41929, 41943 (July 15, 2011) and 77 FR 17219, 17238 (Mar. 23, 2012).

58. On July 15, 2011, CMS and HHS printed the following in its proposed rule in the Federal Register:

> HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers.

76 FR 41929, 41943 (July 15, 2011).

59. On March 23, 2012, CMS and HHS printed the following in its final rule in the Federal Register:

> While we did not propose deadlines in the proposed rule, we . . . suggested . . . that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. *QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.*

77 FR 17219, 17238 (Mar. 23, 2012) (emphasis added).

60. When HHS implemented a final rule on March 11, 2013, regarding HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15409), HHS confirmed, "[t]he 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." 78 FR 15409, 15473 (Mar. 11, 2013).

61. Nothing in 45 C.F.R. Part 153 limits CMS's obligation to pay QHPs the full amount of risk corridor payments due based on appropriations or restrictions on the use of funds.

62. The United States should have paid BCBSM/Blue Plus their full risk corridor payments due but failed or refused to make full and timely risk corridor payments to them as required under Section 1342 of the ACA and 45 C.F.R. § 153.510.

The United States' Failure to Honor its Obligations

63. Beginning in 2014, after BCBSM/Blue Plus had already agreed to participate in MNsure in reliance on the Government's risk corridor payment obligations, the Government announced that the United States would not honor its payment obligations.

64. On March 11, 2014, HHS stated in the Federal Register that "HHS intends to implement this [risk corridors] program in a budget neutral manner." 79 FR 13743, 13829 (Mar. 11, 2014).

65. This statement was inconsistent with HHS's prior statement—made exactly one year earlier in the Federal Register, March 11, 2013—which stated: "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." 78 FR 15409, 15473 (Mar. 11, 2013).

66. On April 11, 2014, HHS and CMS issued a bulletin entitled "Risk Corridors and Budget Neutrality," which contained HHS and CMS's statement that:

> We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. ***However, 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. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Bulletin, CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (emphasis added).

67. The bulletin of April 11, 2014, was the first instance in which HHS and CMS publicly suggested that risk corridor charges collected from QHPs would be less than the Government's full mandatory risk corridor payment obligations owed to QHPs.

68. On December 16, 2014, Congress enacted the omnibus appropriations bill for fiscal year 2015, the "Consolidated and Further Continuing Appropriations Act, 2015" (the "2015 Appropriations Act"). Pub. L. 113-235.

69. In the 2015 Appropriations Act, Congress specifically targeted the Government's existing, mandatory risk corridors payment obligations owed to QHPs, including BCBSM, under Section 1342 of the ACA, limiting appropriations for those payment obligations from three large funding sources by including the following text at Section 227 of the 2015 Appropriations Act:

> ***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)***.

128 Stat. 2491 (emphasis added).

70. Section 1342(b)(1) of Public Law 111-148—referenced in the above quotation—is the ACA's prescribed methodology for the Government's mandatory risk corridor payments to QHPs.

71. Congress's failure to appropriate sufficient funds for risk corridor payments due for CY 2014 did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridor payments to QHPs, including to BCBSM.

72. On October 1, 2015, after collecting risk corridors data from QHPs for CY 2014, HHS and CMS announced that it intended to prorate the risk corridors payments owed to QHPs, including to BCBSM, for CY 2014, stating that:

> Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. **At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.**

Bulletin, CMS, "Risk Corridors Payment Proration Rate for 2014" (Oct. 1, 2015) (emphasis added).

73. HHS and CMS further announced on October 1, 2015, that they would be collecting full risk corridors charges from QHPs in November 2015 and would begin making the prorated risk corridor payments to QHPs starting in December 2015. *See id.*

74. On December 18, 2015, Congress enacted the Omnibus appropriations bill for fiscal year 2016, the "Consolidated Appropriations Act, 2016" (the "2016 Appropriations Act"). Pub. L. 114-113.

75. In the 2016 Appropriations Act, Congress again specifically targeted the Government's existing, mandatory risk corridor payment obligations owed to QHPs, including to BCBSM/Blue Plus, under Section 1342 of the ACA, limiting appropriations for those payment obligations from three large funding sources by including the following text at Section 225 of the 2016 Appropriations Act:

> ***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)***.

129 Stat. 2624 (emphasis added).

76. Section 1342(b)(1) of Public Law 111-148 is the ACA's prescribed methodology for the Government's mandatory risk corridor payments to QHPs.

77. Congress's failure to appropriate sufficient funds for risk corridor payments due for CY 2014 and CY 2015 did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridor payments to QHPs, including to BCBSM/Blue Plus.

78. On September 9, 2016, HHS and CMS announced that it would continue to prorate the risk corridor payments owed to QHPs for CY 2015 and CY 2016:

> [B]ased on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments. . . . Collections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments.

Bulletin, CMS, "Risk Corridors Payments for 2015 [sic]" (Sept. 9, 2016).

79. HHS and CMS failed to provide BCBSM/Blue Plus with any statutory authority for their unilateral decision to make only partial, prorated risk corridor payments for CY 2014, and to withhold payment for the balance owed for CY 2014, CY 2015 and CY 2016.

80. The Government's written acknowledgement of its risk corridors payment obligation for CY 2014, CY 2015 and CY 2016, however, is an insufficient substitute for full and timely payment of the amounts owed as required by statute, regulation, contract, and HHS's and CMS's previous statements.

BCBSM's/Blue Plus' Risk Corridors Payments for CY 2014, CY 2015 and CY 2016

81. In a report released on November 19, 2015, HHS and CMS publicly announced QHPs' risk corridor charges and payments for CY 2014, and emphasized that "**Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated.**" Bulletin,

CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("CY 2014 Risk Corridors Report").

82. BCBSM's losses in the ACA Minnesota Individual Market for CY 2014 resulted in the Government being required to pay BCBSM a risk corridors payment of $6,955,635.49. *See* CY 2014 Risk Corridors Report at Table 24 – Minnesota.

83. The Government announced, however, that it would pay BCBSM a prorated amount of $877,652.80 for BCBSM's losses in the ACA Minnesota Individual Market for CY 2014. *See id.*

84. The Government made prorated risk corridor payments to BCBSM totaling $877,652.80. This amount represents only approximately 12.6% of CY 2014 risk corridor payments.

85. HHS lacks the authority, under statute, regulation or contract, to unilaterally withhold full and timely risk corridor payments from QHPs such as BCBSM/Blue Plus. BCBSM's unreimbursed risk corridor payment for CY 2015 was $174,955,826.46 (as confirmed by CMS in a November 18, 2016 report) and unreimbursed risk corridor payment for CY 2016 was $68,940,048.25 (as confirmed by CMS in a November 13, 2017 report, which report was updated on November 15, 2017). HHS paid BCBSM an additional $291,560.07 in prorated payments of BCBSM's CY 2014 losses. HHS's total prorated payments of BCBSM's CY 2014 losses were $1,169,212.87. HHS has not made any prorated or other payments towards BCBSM's CY 2015 and CY 2016 losses.

86. Blue Plus' unreimbursed risk corridor payment for CY 2015 was $5,893,267.11 (as confirmed by CMS in a November 18, 2016 report) and unreimbursed risk corridor payment for CY 2016 was $5,841,464.97 (as confirmed by CMS in a November 13, 2017 report, which

report was updated on November 15, 2017). HHS has not make any prorated or other payments towards Blue Plus' CY 2015 and CY 2016 losses.

87. To the extent required, BCBSM/Blue Plus has exhausted its non-judicial avenues to remedy the Government's failure to provide the full and timely mandated risk corridor payments for CY 2014, 2015 and 2016 as required by statute, regulation and contract.

Supreme Court Decision

88. On April 27, 2020, the United States Supreme Court issued its decision in *Maine Community Health Options v United States.* In that decision, the Court rejected all of the arguments the United States asserted in support of its failure and refusal to fully reimburse Maine Community Health Options ("Maine") for the risk corridor payments it was owed. The Court held that the "shall pay" language in Section 1342 imposed a legal duty by the United States to pay the full risk corridor payment to Maine and that duty was not constrained or limited by either the Appropriation Clause or the Anti-Deficiency Clause. The Court further held that Section 1342 was not impliedly repealed by appropriation riders. Finally, the Court held Maine could collect the full amount of its risk corridor payment from the Judgment Fund through the Tucker Act.

COUNT I
Violation of Federal Statute and Regulation

89. BCBSM/Blue Plus reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

90. Section 1342(b)(1) of the ACA, as interpreted by the Supreme Court, mandates compensation, expressly stating that the Secretary of HHS "shall pay" risk corridor payments to QHPs in accordance with the payment formula set forth in the statute.

91. HHS and CMS's implementing regulation at 45 C.F.R. § 153.510(b) also mandates compensation, expressly stating that HHS "will pay" risk corridor payments to QHPs in accordance with the payment formula set forth in the regulation, which formula is mathematically identical to the formula in Section 1342(b)(1) of the ACA.

92. HHS and CMS's regulation at 45 C.F.R. § 153.510(d) requires a QHP to remit charges to HHS within 30 days after notification of such charges.

93. HHS and CMS's statements in the Federal Register on July 15, 2011, and March 23, 2012, state that risk corridor "payment deadlines should be the same for HHS and QHP issuers." 76 FR 41929, 41943 (July 15, 2011) and 77 FR 17219, 17238 (Mar. 23, 2012).

94. BCBSM/Blue Plus were QHP issuers, and were qualified for and entitled to receive mandated risk corridor payments from the Government.

95. BCBSM/Blue Plus are entitled under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b) to recover full and timely mandated risk corridor payments from the Government.

96. The United States has specifically admitted its obligation to pay BCBSM, and its subsidiary, Blue Plus, for their risk corridor losses that total $262,586,241.31 for calendar years 2014, 2015 and 2016, of which the defendant has paid only $1,169,212.87. BCBSM's risk corridor losses for calendar year 2014, 2015 and 2016 (as confirmed by CMS's published calculations) were $6,955,635.49, $174,955,826.46 and $68,940,048.25 respectively for a total of $250,851,510.20. Blue Plus' risk corridor losses for calendar years 2015 and 2016 (as confirmed by CMS's published calculations) were $5,893,267.11 and $5,841,464.97 respectively for a total of $11,734,732.08. The defendant has not reimbursed Blue Plus for any of its risk corridor losses. As noted above, the Government has paid BCBSM $1,169,212.87 of its calendar

year 2014 losses. The total unreimbursed risk corridor payments owed to BCBBSM and its subsidiary, Blue Plus, are $261,417,029.41.

97. The United States has failed to make full and timely risk corridor payments to BCBSM/Blue Plus, despite the Government repeatedly confirming in writing that Section 1342 mandates that the Government make risk corridor payments.

98. Congress's failure to appropriate sufficient funds for risk corridor payments did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridor payments to QHPs, including to BCBSM/Blue Plus.

99. The Government's failure to make full and timely risk corridor payments to BCBSM/Blue Plus constitutes a violation and breach of the Government's mandatory payment obligations under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b).

100. As a result of the United States' violation of Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b), BCBSM/Blue Plus have been damaged in the amount of $261,417,029.41, together with interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT II
Breach of Implied-In-Fact Contract

101. BCBSM/Blue Plus reallege and incorporates by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

102. BCBSM/Blue Plus entered into a valid implied-in-fact contract with the Government regarding the Government's obligation to make full and timely risk corridor payments to BCBSM/Blue Plus in exchange for BCBSM's/Blue Plus' agreement to become a QHP issuer and participate in the Minnesota Exchange.

103. Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's admissions regarding their obligation to make risk corridor payments were made by representatives of the Government who had actual authority to bind the United States, and constituted a clear and unambiguous offer by the Government to make full and timely risk corridor payments to health insurers, including to BCBSM/Blue Plus, that agreed to participate as QHPs in the ACA Exchanges.

104. BCBSM/Blue Plus accepted the Government's offer by agreeing to become a QHP issuer and to participate in and accept the uncertain risks imposed by the Exchanges.

105. By agreeing to become a QHP, BCBSM/Blue Plus agreed to provide health insurance on the Minnesota Exchange established under the ACA, and to accept the obligations, responsibilities and conditions imposed on QHPs—subject to the implied covenant of good faith and fair dealing—under the ACA and, *inter alia*, 45 C.F.R. §§ 153.10 *et seq.* and 155.10 *et seq*.

106. BCBSM/Blue Plus satisfied and complied with its obligations and/or conditions which existed under the implied-in fact contracts.

107. The Government's agreement to make full and timely risk corridor payments was a significant factor material to BCBSM's/Blue Plus' agreement to become a QHP issuer.

108. The parties' agreement is further confirmed by the parties' conduct, performance and statements following BCBSM's/Blue Plus' acceptance of the Government's offer, BCBSM's/Blue Plus' execution of attestations including the attestations regarding risk corridor payments and charges, and the Government's repeated assurances that full and timely risk corridor payments would be made and would not be subject to budget limitations. *See, e.g.*, 78 FR 15409, 15473 (Mar. 11, 2013).

109. The implied-in-fact contract was authorized by representatives of the Government who had actual authority to bind the United States and was entered into with mutual assent and consideration by both parties.

110. The risk corridors program's protection from uncertain risk and new market instability was a real benefit that significantly influenced BCBSM's/Blue Plus' decision to agree to become a QHP and to participate in Minnesota Exchange.

111. BCBSM/Blue Plus, in turn, provided a real benefit to the Government by agreeing to become a QHP and participate in the Minnesota Exchange, despite the uncertain financial risk.

112. The risk corridors program in Section 1342 of the ACA and its implementing regulations, by which Congress, HHS, and CMS committed to help protect health insurers financially against risk selection and market uncertainty encouraged BCBSM/Blue Plus to participate in the Minnesota Exchange.

113. The Government repeatedly acknowledged its statutory and regulatory obligations to make full and timely risk corridor payments to qualifying QHPs through its conduct and statements to the public and to BCBSM/Blue Plus and other similarly situated QHPs, made by representatives of the Government who had actual authority to bind the United States.

114. Congress's failure to appropriate sufficient funds for risk corridor payments due did not defeat or otherwise abrogate the United States' contractual obligation to make full and timely risk corridor payments to BCBSM/Blue Plus.

115. The Government's failure to make full and timely risk corridor payments to BCBSM/Blue Plus is a material breach of the implied-in-fact contract.

116. As a result of the United States' material breaches of its implied-in-fact contract that it entered into with BCBSM/Blue Plus regarding the Exchange in Minnesota, BCBSM/Blue

Plus have been damaged in the amount of $261,417,029.41, together with any losses actually sustained as a result of the Government's breach, damages, interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT III
Breach of Implied Covenant of Good Faith and Fair Dealing

117. BCBSM/Blue Plus reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

118. A covenant of good faith and fair dealing is implied in every contract, express or implied-in-fact, including those with the Government, and imposes obligations on both contracting parties that include the duty not to interfere with the other party's performance and not to act so as to undermine the reasonable expectations of the other party regarding the fruits of the contract.

119. The implied-in-fact contract entered into between the United States and BCBSM/Blue Plus regarding the Minnesota Exchange created the reasonable expectations for BCBSM that full and timely risk corridor payments would be paid by the Government to QHPs, just as the Government expected that full and timely risk corridor remittance charges would be paid by QHPs to the Government.

120. By failing to make full and timely risk corridor payments to BCBSM/Blue Plus, the United States has undermined BCBSM's/Blue Plus' reasonable expectation regarding the fruits of the implied-in-fact contract, in breach of an implied covenant of good faith and fair dealing existing therein.

121. Congress granted HHS with rulemaking authority regarding the risk corridors program in Section 1342(a) of the ACA. HHS and CMS are permitted to establish annual charge remittance and payment deadlines that support QHP functions. HHS and CMS have an

obligation to exercise the discretion afforded to it in good faith and not arbitrarily, capriciously or in bad faith.

122. The United States breached the implied covenant of good faith and fair dealing by, among other things:

(a) Inserting in HHS and CMS regulations a 30-day deadline for a QHP's full remittance of risk corridor charges to the Government, but failing to create a similar deadline for the Government's full payment of risk corridor payments to QHPs, despite stating that QHPs and the Government should be subject to the same payment deadline (*see, e.g.*, 77 FR 17219, 17238 (Mar. 23, 2012);

(b) Requiring QHPs to fully remit risk corridor charges to the Government, but unilaterally deciding that the Government may make prorated risk corridor payments to QHPs;

(c) Legislatively limiting funding sources for risk corridor payments in appropriations acts after BCBSM/Blue Plus had undertaken significant expense in performing its obligations as a QHP in the Exchange in Minnesota, based on the reasonable expectation that the Government would make full and timely risk corridor payments if BCBSM/Blue Plus experienced sufficient losses.

123. As a direct and proximate result of the aforementioned breaches of the covenant of good faith and fair dealing, BCBSM/Blue Plus have been damaged in the amount of $261,417,029.41, together with any losses actually sustained as a result of the Government's breach, damages, interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT IV
Taking Without Just Compensation
in Violation of the Fifth Amendment to the U.S. Constitution

124. BCBSM/Blue Plus reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

125. The Government's actions complained of herein constitute a deprivation and taking of BCBSM's/Blue Plus' property for public use without just compensation, in violation of the Fifth Amendment to the U.S. Constitution.

126. BCBSM/Blue Plus have a vested property interests in their contractual, statutory, and regulatory rights to receive statutorily-mandated risk corridor payments. BCBSM/Blue Plus have a reasonable expectation of receiving the full and timely risk corridor payments payable to them under the statutory and regulatory formula, based on its implied-in-fact contract with the Government, Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's public statements.

127. The Government expressly and deliberately interfered with and has deprived BCBSM/Blue Plus of property interests and their reasonable expectation to receive full and timely risk corridor payments. On March 11, 2014, HHS for the first time announced, in direct contravention of Section 1342 of the ACA, 45 C.F.R. § 153.510(b) and its previous public statements, that it would administer the risk corridors program "in a budget neutral manner." 79 FR 13743, 13829 (Mar. 11, 2014).

128. On April 11, 2014, HHS and CMS stated for the first time that CY 2014 risk corridor payments would be reduced pro rata to the extent of any shortfall in risk corridor collections. *See* Bulletin, CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014).

129. Further, in Section 227 of the 2015 Appropriations Act and Section 225 of the 2016 Appropriations Act, Congress specifically targeted the Government's existing, mandatory

risk corridor payment obligations under Section 1342 of the ACA, expressly limiting the source of funding for the United States' CY 2014 risk corridor payment obligations owed to a specific small group of insurers, including BCBSM/Blue Plus. *See* 128 Stat. 2491 and 129 Stat. 2624. HHS and CMS continue to refuse to make full and timely risk corridor payments to BCBSM/Blue Plus, and therefore the Government has deprived BCBSM/Blue Plus of the economic benefit and use of such payments.

130. The Government's action in withholding, with no legitimate governmental purpose, the full and timely risk corridor payments owed to BCBSM/Blue Plus constitutes a deprivation and taking of BCBSM's/Blue Plus' property interests and requires payment to BCBSM/Blue Plus of just compensation under the Fifth Amendment of the U.S. Constitution.

131. BCBSM/Blue Plus are entitled to receive just compensation for the United States' taking of its property in the amount of $261,417,029.41, together with interest, costs of suit, and such other relief as this Court deems just and proper.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs demands judgment against the Defendant, the United States of America, as follows:

(1) For Count I, awarding damages sustained by Plaintiffs, in the amount of $261,417,029.41, as a result of the Defendant's violation of Section 1342(b)(1) of the ACA and of 45 C.F.R. § 153.510(b);

(2) For Count II, awarding damages sustained by Plaintiffs in the amount of $261,417,029.41, together with any losses actually sustained as a result of the Government's breach, and reliance damages, as a result of the Defendant's breaches of its implied-in-fact contract with Plaintiffs regarding risk corridor payments;

(3) For Count III, awarding damages sustained by Plaintiffs, in the amount of $261,417,029.41, together with any losses actually sustained as a result of the Government's breach, and reliance damages, as a result of the Defendant's breaches of the implied covenant of good faith and fair dealing that exists in the implied-in-fact contract regarding risk corridor payments;

(4) For Count IV, awarding damages sustained by Plaintiffs, in the amount of $261,417,029.41, as a result of the Defendant's taking of Plaintiffs' property without just compensation in violation of the Fifth Amendment to the U.S. Constitution;

(5) Awarding all available interest, including, but not limited to, pre- and post-judgment interest, to Plaintiffs;

(6) Awarding all available attorneys' fees and costs to Plaintiffs; and

(7) Awarding such other and further relief to Plaintiffs as the Court deems just and equitable.

Respectfully submitted,

Dated: _____, 2020

Respectfully Submitted,

s/ Doug P. Hibshman

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