IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH NET, LLC; CELTIC GROUP, INC. ; and WELLCARE HEALTH PLANS, INC.,

Plaintiffs,

v.

THE UNITED STATES OF AMERICA,

Defendant.

Case No. 16-1722C
Judge Ryan T. Holte

UNOPPOSED MOTION FOR LEAVE TO AMEND COMPLAINT

Pursuant to RCFC 15, Health Net, LLC ("Health Net"), Celtic Group, Inc. ("Celtic"), and WellCare Health Plans, Inc. ("WellCare") (collectively, "Plaintiffs") hereby move to seek this Court's leave to amend their Complaint to update the damages amount for benefit years 2014 and 2015 and to include additional damages for benefit year 2016 for Health Net, as well as to include damages for benefit years 2014-2016 for Celtic, and damages for benefit years 2015 and 2016 for WellCare, and file the attached Amended Complaint.[1]

Plaintiffs' Complaint currently seeks damages for the Government's failure to make risk corridors payments for benefit years 2014 and 2015 owed to Health Net. Plaintiffs seek this Court's leave to amend their Complaint to update the damages amount for benefit years 2014 and 2015, and to include damages related to unpaid risk corridors payments for benefit year 2016, as well as damages incurred by related entities, Celtic and WellCare. The usual rule is that leave to amend should be liberally granted, and here, allowing Plaintiffs to amend the Complaint

[1] On May 12, 2020, the Court granted Plaintiff's first motion for leave to amend the Complaint (ECF No. 26). In order to conserve judicial resources, Plaintiffs seek to file the Amended Complaint attached to this motion in lieu of the Amended Complaint attached to the first motion.

would conserve judicial resources while not prejudicing the Government. It would be more efficient for Plaintiffs to file an amended complaint in this docket rather than file a new complaint and use additional court resources. Meanwhile, the Government would not be prejudiced, as the case is currently stayed, and the Government has not yet filed its responsive pleading.

For the foregoing reasons, Plaintiffs respectfully request that this Court grant this motion, and allow Plaintiffs to file the attached Amended Complaint. Prior to filing this motion, counsel of record for Plaintiffs contacted the counsel of record for the Government for the Government's position on Plaintiffs seeking leave to amend. The Government does not oppose this motion.

Dated: May 27, 2020

Respectfully submitted,

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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH NET, LLC; CELTIC GROUP, INC.; and WELLCARE HEALTH PLANS, INC., Plaintiffs, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 16-1722C Judge Ryan T. Holte **AMENDED COMPLAINT**

Health Net, LLC ("Health Net"), Celtic Group, Inc. ("Celtic"), and WellCare Health Plans, Inc. ("WellCare") (collectively, "Plaintiffs"), on behalf of their aggrieved subsidiaries, bring this action seeking damages and other relief for the Defendant's violation of Section 1342 of the Patient Protection and Affordable Care Act ("Section 1342") and 45 C.F.R. § 153.510(b) ("Section 153.510"). This action seeks the risk corridors payments the Government owes Plaintiffs for benefit years 2014, 2015, and 2016. In support of this action, Plaintiffs state and allege as follows:

NATURE OF ACTION

1. In March 2010, the United States Government ("Defendant" or "Government") enacted the Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010), 124 Stat. 119 and the Health Care and Education Reconciliation Act, Pub. L. 111-152, (March 30, 2010), 124 Stat. 1029 (collectively the "Affordable Care Act" or the "Act" or "ACA").

2. The Act represented a major shift in health care regulation and coverage in the country. The ACA ushered in a host of market-wide reforms and requirements affecting the private health insurance industry. Among other things, the Act addressed the scope of covered

services, availability of coverage, renewability of coverage, out-of-pocket costs for consumers, pricing, and other coverage determinants. The Act limits health insurance product variation and restricts pricing and underwriting practices. For example, by placing restrictions on the premium spread based on the age of the policy holder, the Act ensures that premiums are based on community rating (*i.e.*, the risk pool posed by the entire community) instead of an assessment of an individual's health status. The Act also provides for guaranteed issuance of coverage and renewability of coverage.

3. The ACA requires individuals to purchase coverage if they are not otherwise insured, but also created an elaborate scheme of federal subsidies to offset the cost of coverage. Another hallmark of the Act was its establishment of health insurance exchanges, which are online marketplaces through which individuals and small groups may purchase health insurance. The ACA's individual mandate coupled with the availability of federal subsidies dramatically increased the number of individuals—many previously uninsured—purchasing health insurance. Created by Title I, Subtitle D of the ACA, the health insurance exchanges "are designed to bring together buyers and sellers of insurance, with the goal of increasing access to coverage" offered in a competitive marketplace.

4. Any plan offered in the individual and small group markets is required to be a qualified health plan ("QHP"), which means a health plan that meets certain standards established by the Centers for Medicare & Medicaid Services ("CMS") in order to be sold to consumers through the exchanges. Specifically, the ACA requires QHPs to cover essential

health benefits ("EHBs").[1] Certain benefits previously subject to copays or other cost-sharing mechanisms are now, as EHBs, required at no cost to the insured.

5. Of course, in order for the ACA to be successful, Congress had to attract health insurers to participate in the exchanges and agree to offer QHPs. This was not a forgone conclusion. After all, the new exchanges posed a vastly enlarged and uncertain insurance risk—insurers considering whether to participate in the exchanges had to confront the arduous task of setting premiums for a large cohort of insureds for whom nobody (the insurers or the Government) had sufficient data on which traditional pricing models could be built.

6. Congress therefore created mechanisms to entice insurance companies into the exchanges to offer plans at affordable premiums while also limiting (but not eliminating) the risks posed to them by doing so in light of the uncertainties about the newly insured. In particular, the ACA created three marketplace premium stabilization programs: a permanent risk adjustment program, a temporary reinsurance program (for each of 2014, 2015, and 2016), and a temporary "risk corridors" program (again, for each of the 2014, 2015, and 2016 benefit years, *i.e.*, the calendar year for which a health plan provides coverage for health benefits). The risk corridors program ("RCP"), like the other two premium stabilization programs, was designed to limit the effects of adverse selection and to mitigate the uncertainty inherent in establishing rates for new, unquantifiable health insurance risks in the context of an untested regulatory framework.

[1] EHBs 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.

7. The RCP is required by statute to be modeled after a similar program enacted as part of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act.

8. Specifically, the Act's framework compares "allowable costs" (essentially claims costs and adjustments for quality improvement activities, reinsurance, and risk adjustment charges or payments) with a "target amount" (the QHP's premium less its allocable administrative costs). If the ratio of a QHP issuer's allowable costs to the target amount is greater than 1, then it experiences losses; if the ratio is less than 1, then it experiences gains. The RCP mandates that if an insurer's allowable costs "for any plan year" exceeded the target amount, the Government "shall pay to the plan" a portion of such excess allowable costs pursuant to the statutory formula. And, conversely, the statute requires that plans that incurred allowable costs below the target amount in the benefit year "shall pay" a portion of their realized savings to the Government, as calculated according to the same statutory formula.

9. With Section 1342, the Government created an obligation to "pay" certain participating QHP issuers in accordance with the statutory payment formula. This obligation was undefinitized (an unmatured commitment), in that payment was not due until QHP issuers submitted their calculation of revenue and cost data to CMS so that the obligation could be definitized to a precise amount. Section 1342 contained no other material steps or preconditions encumbering or permitting avoidance of CMS's statutory obligation to "pay" in accordance with the formula.

10. Despite these express and binding obligations, the RCP—like the ACA as a whole—was targeted by congressional opponents who, lacking the votes to amend the law itself, sought to impede, through appropriations, CMS's ability to administer the program as mandated by the ACA. In particular, in the Consolidated and Further Continuing Appropriations Act, 2015

(Pub. L. No. 113-235) ("2015 Spending Rider"), the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Rider"), and the Consolidated Appropriations Act, 2017 (Pub. L. No. 115-31) ("2017 Spending Rider," collectively, the "Spending Riders"), Congress prohibited CMS and HHS from using certain accounts to fund the Government's risk corridors payment obligations. Specifically, Congress prohibited CMS from using the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, as well as funds transferred from other accounts funded by the Spending Riders to the CMS Program Management account, for the applicable fiscal years.

11. The practical effect of the Spending Riders was that CMS could not pay QHP issuers their full risk corridor receivable amounts due for 2014, 2015, and 2016. During 2014, QHP issuers incurred almost $2.9 billion in losses that were compensable under the risk corridor provisions of the ACA. The QHP issuers on the whole incurred even greater compensable losses in 2015 and 2016 which CMS has not paid because of the Spending Riders.

12. Nevertheless, Congress did not otherwise restrict availability of federal funds, and did not amend Section 1342 to limit, much less eliminate, the Government's risk corridors payment obligations to insurers under the ACA.

13. Plaintiffs are wholly owned subsidiaries of Centene Corporation, and Plaintiffs' subsidiaries[2] are QHP issuers under the ACA.

14. In 2014, Plaintiffs, through their subsidiaries, provided health insurance to their members on the state-based Marketplaces in Arkansas, California, Massachusetts, and Oregon,

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[2] These subsidiaries include: Health Net Life Insurance Company, Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Health Plan of Oregon, Inc., Celtic Insurance Company, CeltiCare Health Plan of Massachusetts, WellCare Health Plans of Kentucky, Inc., and WellCare of New York.

and the federally-facilitated Marketplaces in Arizona and Illinois. In 2015 and 2016, Plaintiffs continued to supply QHPs on Marketplaces in Arkansas, California, Massachusetts, Arizona, Illinois, Kentucky, and New York.

15. CMS has conceded that Plaintiffs are owed $98,317,042.69[3] under the risk corridors program for their participation in the California, Massachusetts, Arizona, and Oregon Marketplaces for benefit year 2014. In addition, Plaintiffs are owed $325,437,293.35[4] for their participation in the Arkansas, California, Arizona, Kentucky, and New York Marketplaces for benefit year 2015, and $29,310,722.04 for their participation in the California, Arizona, Illinois, Kentucky, and New York marketplaces for benefit year 2016.

16. To date, however, CMS has stated publicly in sub-regulatory guidance that it will not make full payment under the RCP until a later—but as-of-yet undetermined—date, if at all.

17. By this lawsuit, Plaintiffs seek full payment of the risk corridors payments to which they are entitled from the Government under the ACA for benefit years 2014, 2015, and 2016. The law is clear, and the Government must abide by its statutory obligations. Plaintiffs respectfully ask the Court to compel the Government to do so.

JURISDICTION

18. This Court has jurisdiction over the subject matter of this action pursuant to the Tucker Act, 28 U.S.C. § 1491. The statutory cause of action giving rise to this Court's Tucker Act jurisdiction is Section 1342, a money-mandating statute that requires payment from the federal government to QHP issuers, like Plaintiffs' subsidiaries, that satisfy certain criteria.

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[3] The amount published by CMS is $98,307,913.79, but this amount has been updated to $98,317,042.69 to reflect the data resubmission for CeltiCare Health Plan of Massachusetts.
[4] The amount published by CMS is $324,691,927.80, but this amount has been updated to $325,437,293.35 to reflect the data resubmission for Health Net of Arizona, Inc.

Section 153.510(b) is a money-mandating regulation that implements Section 1342 and thus also obligates payment from the federal government to QHP issuers that satisfy certain criteria.

19. In the alternative, the Contract Disputes Act, 41 U.S.C. §§ 7101 *et seq.*, a money-mandating statute, provides Plaintiffs a cause of action that gives rise to this Court's jurisdiction pursuant to the Tucker Act.

20. This controversy is ripe because CMS has failed to pay Plaintiffs the full amount they are owed for 2014, 2015, and 2016 as required by Section 1342 and Section 153.510 and the parties' implied-in-fact contract.

PARTIES

21. Health Net is a Delaware limited liability company with its principal place of business in Woodland Hills, California, and is a wholly owned subsidiary of Centene Corporation.

22. Celtic is a Delaware limited liability company with its principal place of business in Chicago, Illinois, and is a wholly owned subsidiary of Centene Corporation.

23. WellCare is a Delaware limited liability company with its principal place of business in Tampa, Florida, and is a wholly owned subsidiary of Centene Corporation.

24. Plaintiffs, through their subsidiaries, are QHP issuers on the exchanges in the states of Arkansas, California, Massachusetts, Arizona, Illinois, Kentucky, and New York, and previously operated on the Oregon exchange, and offer comprehensive health insurance benefits to individuals, families, and businesses.

25. The defendant is the United States Government, acting through CMS (or CMS's parent agency HHS). Unless otherwise noted, references in this Complaint to CMS include HHS where applicable.

FACTUAL ALLEGATIONS

A. The Affordable Care Act Established a "Risk Corridors" Program with Two-Way Payment Obligations.

26. The Affordable Care Act established three insurance premium stabilization programs to address uncertainties in the Marketplace, commonly referred to as the "Three Rs": (1) a three-year risk corridors program; (2) a three-year reinsurance program; and (3) a permanent risk adjustment program. Both the reinsurance and risk corridors programs were in effect in 2014, 2015, and 2016.

27. Section 1342 of the Affordable Care Act, as codified at 42 U.S.C. § 18062, created the risk corridors program. In relevant part that Section 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. No. 111-148, § 1342 (emphases added). Section 1342 also includes a provision dealing with "payments in," requiring QHP issuers to pay amounts to HHS if the plans' actual costs are

less than its targeted costs. *Id.* at § 1342(b)(2). For both the "payments out" and "payments in" provisions, the terms "allowable costs" and "target amount" are defined by the statute. *Id.* at § 1342(c).

28. HHS implemented the risk corridors program in the Code of Federal Regulations at 45 C.F.R. § 153.510. In relevant part, Section 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.

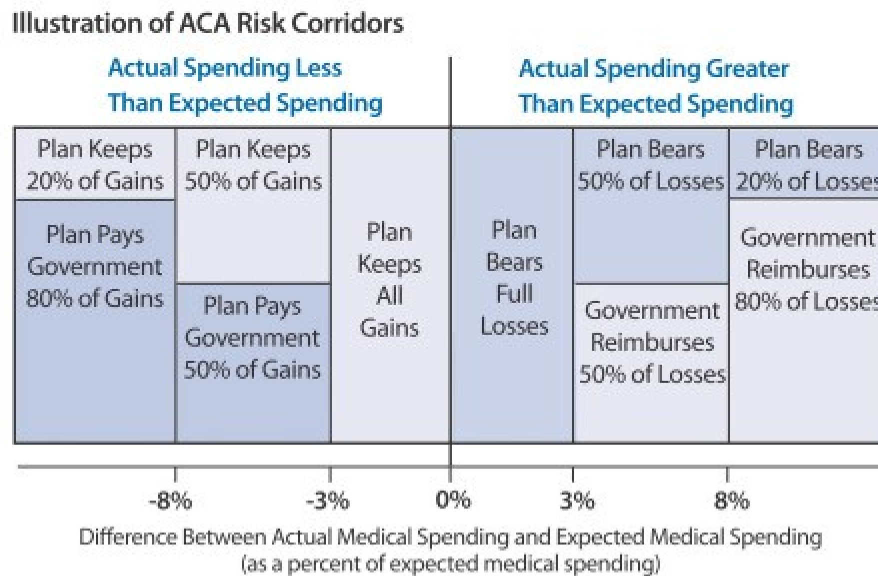
(emphases added).

29. This regulation and other regulations adopted by HHS further mandate certain data reporting requirements and deadlines applicable to the QHP issuers. 45 C.F.R. §§ 153.510, 153.530. Following verification by HHS of the QHP issuers' data submissions, HHS is required to pay the insurers based on the plan's excess expenses (one amount for expenses greater than 103 percent and a graduated fixed percentage for expenses greater than 108 percent of each QHP issuer's target amount).

30. The Government gave no indication at that time that it would subsequently refuse to pay its risk corridors obligations, or hold payments due for a particular plan year until a later and indefinite date.

31. The QHP issuers' and the Government's respective payment obligations pursuant

to Section 1342 are graphically depicted in the following chart from the American Academy of Actuaries:



32. The purpose of the risk corridors program—in conjunction with the other of the Three Rs—was to induce health insurer participation in the health insurance exchanges by mitigating their risk of excessive costs. Congress recognized that this could only work effectively if the payment obligations were honored on an annual benefit or plan year basis. The program would hardly be able to serve its purpose of mitigation if, after incurring potentially millions of dollars in unbudgeted expenditures over a plan year, QHP issuers could not timely collect the reimbursements owed to them by the Government pursuant to the statutory formula as soon as the plan's accounting for the preceding year (which established the amounts owed) was finalized.

33. Section 1342 does not establish a fund into which QHP issuers must make payments due or from which payments must be made under the risk corridors program, *i.e.*, the statute does not create a single account to service both payments in and payments out. Nor does the statute provide that the RCP may, let alone must, be budget neutral. In other words,

payments out are ***not*** subject to payments in, and vice versa. The statute is clear that the Government will share in the losses for plans with higher-than-anticipated costs so that if, hypothetically, all plans have higher-than-anticipated costs, the Government would need to make payments even though there would be no insurer payments coming in. The program could not have been subject to budget neutrality for the reason stated in the preceding paragraph. Had the program been cabined by budget neutrality concerns, the ACA would have failed to attract sufficient insurers into the marketplace because the venture would have been too risky. HHS's timely payment to plans under the RCP is essential to realizing Congress's intent to stabilize premiums.

34. The fact that Section 1342 is expressly modeled on the Medicare Part D program, which is not required to be budget neutral, *see* 42 C.F.R. § 423.336, reinforces how Congress intended the RCP to work.

B. QHP Issuers Participated in Exchanges and Set Prices in Reliance on the Risk Corridors Program.

35. As previously noted, health insurers' commitment to participate on the Exchange was fixed and irrevocable by September 2013. Plaintiffs and other insurers entered onto the exchanges with the express understanding—based on the plain text of Section 1342—that if their allowable costs "for any ***plan year***" exceeded the target amount, the Secretary "***shall pay to the plan***" the amounts set forth in the ACA. The implementing regulations at 45 C.F.R. § 153.510 expressly reiterated this ACA requirement, stating that when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the amounts set forth in the ACA. The Government gave no indication at that time that it would subsequently not pay its risk corridors obligations, or hold payments due for a particular plan year until a later and indefinite date.

36. Health insurers relied on the statutorily mandated RCP and the other premium stabilization programs in setting their premiums for each year of the RCP. It was not until October 2015 that the Government first indicated that it would pay only 12.6 percent of its obligations under the RCP for the already completed 2014 benefit year.[5] Similarly, it was not until November 2016 that CMS definitively stated it would not make payments for the already completed 2015 benefit year.[6]

37. The premium stabilization programs of the ACA were essential to expanding the risk tolerance of entrants, such as Plaintiffs, to the Marketplace. The existence of the risk corridors program safeguards also helped to prevent unnecessarily high premium rates to offset the many uncertainties of the newly developing individual and small group markets that otherwise made it difficult to create budgets and forecasts.

C. The Risk Corridors Program is Not Administered as Promised.

38. Since its enactment, Congress has not altered the Government's obligations under the ACA's risk corridors program. Despite this, the Government has taken several steps to frustrate the efficacy of the RCP.

39. The first such step was in March 2014 when HHS unexpectedly took the position in sub-regulatory guidance that the risk corridors program would be self-funding or "budget-

[5] CMS, "Risk Corridors Payment Proration Rate for 2014" (Oct. 1, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf; CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[6] CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016), *available at* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/2015-rc-issuer-level-report-11-18-16-final-v2.pdf; *see also* 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 ("Sept. 2016 Memo").

neutral." Each spring, HHS publishes an annual rulemaking articulating the payment policies and requirements for participation in the ACA Marketplaces, the so-called annual Payment Rule. Specifically, in the preamble to the 2015 Payment Rule, issued in March 2014, and related guidance issued in April 2014, HHS indicated that it would attempt to administer the risk corridors program in a budget-neutral manner and would offset liabilities with future collections.

40. The preamble to the 2015 Payment Rule stated:

> [w]e 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.
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> 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014).

41. Then, in April 2014, CMS issued a statement entitled "Risk Corridors and Budget Neutrality," asserting:

> 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.
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> CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

42. That 2014 guidance departed radically from what the ACA intended and requires and what the implementing regulation reflected: the risk corridors program was enacted without regard to annual budget neutrality. Indeed, in its 2014 Payment Rule, issued March 11, 2013, HHS conceded as much, stating that "[t]he risk corridors program is not statutorily required to be budget neutral." 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013). Further, Congress stated expressly in Section 1342 that the RCP was to be modeled after the Medicare Part D risk

mitigation program, which is not budget neutral. *See* U.S. Gov't Accountability Office, GAO Report GAO-15-447 (April 2015) at 14 (available at http://www.gao.gov/assets/680/670161.pdf) ("For the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions.").

43. In short, the Government announced by agency fiat in the spring of 2014 that it would aspire to administer the risk corridors program in a budget neutral manner notwithstanding the lack of any statutory basis for doing so, and then reiterated that position for years 2015 and 2016 pointing to the April 11, 2014 "FAQ" on Risk Corridors and Budget Neutrality, suggesting that any decision on how the Government would make QHP issuers whole under the risk corridors programs would be left to some indeterminate later day.

44. The Government's budget neutrality approach is not supported by law. Neither Section 1342 nor Section 153.510 provides that the risk corridors payments will come from the pot of payments made to the Government by other insurers (*i.e.*, payments in). Nor does either provision contemplate permitting the Government to postpone payments that are owed until the following year's collections are accounted for or to never pay them at all.

45. On November 19, 2015, Defendant stated that, "HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter ***as a fiscal year 2015 obligation of the United States Government for which full payment is required***." CMS, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015). HHS thus concedes that the Government is obligated to make payment to QHP issuers under the RCP, despite to date only paying "12.6 percent" of what is owed toward 2014 and making a vague promise to pay more at some indeterminate point in the future.

D. Congress Declines to Appropriate Funds for the Risk Corridors Program.

46. In December 2014, Congress enacted the first of three appropriation riders prohibiting HHS's use of Medicare and certain other trust funds to make risk corridors payments. This "2015 Spending Rider" did not, however, eliminate the use of all funds in the CMS Program Management account, such as fees received by HHS for the federally-facilitated exchanges. And, more importantly, Congress *did not amend Section 1342 to require budget neutrality or to alter the underlying risk corridors obligations of the Government.* Given that the 2015 Spending Rider was enacted on December 16, 2014, nearly a year after QHP issuers began offering insurance on the newly formed exchanges, and approximately 18 months after they had submitted rates for regulatory approval, QHP issuers, including Plaintiffs' subsidiaries, continued to abide by their obligations to the Government and their insured, even while receiving little immediate guidance as to what would happen with the risk corridors payments.

47. In December 2015, Congress passed the 2016 Spending Rider, which continued the limits on the availability of funding for the RCP. As in the 2015 Spending Rider, the 2016 Spending Rider prohibited CMS from using trust funds and other accounts for the 2016 fiscal year to fund risk corridors payments. But, like the 2015 Spending Rider, *it did not amend Section 1342 to require budget neutrality or alter the underlying risk corridors obligations of the Government.*

48. On September 9, 2016, CMS issued a memorandum reiterating the agency's understanding that the Government owed "full" payment to insurers. Sept. 2016 Memo. That memorandum was followed by testimony of CMS Acting Administrator Andy Slavitt before the House Energy and Commerce Committee on September 14, 2016. Among other things, Mr. Slavitt stated without equivocation in response to a question posed by a committee member that, notwithstanding the lack of an appropriation to fund the payments due insurers under Section

1342, it was "an obligation of the federal government" to remit full payment to insurers.[7]

49. In May 2017, Congress passed the 2017 Spending Rider, again prohibiting CMS from using specified sources to fund risk corridors payments for the fiscal year ending September 30, 2017. But, like the earlier Spending Riders, *it did not amend Section 1342 to require budget neutrality or alter the underlying risk corridors obligations of the Government*.

E. Plaintiffs Have Suffered Substantial Harm as a Result of the Government's Refusal to Pay Amounts Owed.

50. An issuer of QHPs is required by federal regulations to set its ACA-related health insurance rates well before the year they become effective. This creates a challenge for QHP issuers, like Plaintiffs' subsidiaries, which seek to insure individuals who were previously uninsured and whose use of medical services once covered is difficult to predict.

51. Section 1342 of the ACA requires the Government to reimburse Plaintiffs a percentage of their higher-than-expected allowable costs incurred as a result of their participation on the marketplaces, just as it requires QHP issuers like Plaintiffs' subsidiaries to pay CMS a percentage of lower-than-expected allowable costs. In either case, the amount owed—either in or out—is calculated using the statutory formula.

52. The RCP was one of the principal marketplace premium stabilization programs created by the ACA. It was designed to *limit* the effects of adverse selection and to *mitigate* the uncertainty inherent in building rates for new, unquantified health insurance risks in the context of a reformed regulatory framework. Under Section 1342, payments out are not contingent on payments in.

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[7] CMS, Statement of Andy Slavitt Acting Administrator CMS on The ACA before the United States House Committee on Energy, *available at* http://docs.house.gov/meetings/IF/IF02/20160914/105306/HHRG-1 14-IF02-Wstate-SlavittA-20160914.pdf.

F. **2014 Risk Corridors Payments Owed to Plaintiffs**

53. Pursuant to their obligations under the ACA and 45 C.F.R. § 153.500 *et seq.*, Plaintiffs complied with their statutory requirements throughout the year and submitted all required data for the risk corridors calculations by the statutory deadline of July 31, 2015. *See* 45 C.F.R. § 153.530(d).

54. On October 1, 2015, HHS announced that funds paid by QHP issuers into the risk corridors program (payments in) would only be sufficient to cover 12.6 percent of risk corridors payment requests (payments out). Based on the Government's own official calculation, QHP issuers generated $362 million in risk corridors gains for the Government, but QHP issuers suffered $2.87 billion in compensable risk corridors losses. The 12.6 percent that could be paid reflected a prorated redistribution of the $362 million received from the few insurers that were required to pay the Government for the 2014 program year.

55. HHS' unilateral decision to pay only a small fraction of the amounts that it owes contradicts the express language of Section 1342, which states that if a plan's allowable costs "for any ***plan year***" exceed the target amount, the Secretary "***shall pay to the plan***" the amounts set forth in the ACA. The implementing regulations at 45 C.F.R § 153.510 expressly reiterate when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the amounts set forth in the ACA.

56. HHS has provided no coherent explanation for its decision to short-pay health plans. HHS stated that "[t]he risk corridors payments for program year 2014 [would] be paid in late 2015. The remaining 2014 risk corridors claims will be paid out of 2015 risk corridors collections, and if necessary, 2016 collections." HHS concluded that in the event of a shortfall for the 2016 program year, HHS "***will explore other sources of funding for risk corridors payments, subject to the availability of appropriations***. This includes working with Congress on

the necessary funding for outstanding risk corridors payments." HHS, has therefore, refused to pay an "obligation of the United States Government for which full payment is required."

57. As a result, although CMS conceded that Plaintiffs are entitled to $98,317,042.69 from the risk corridors program for the 2014 program year, the agency has only paid $16,463,632.14 of this amount, or approximately 16.7 percent.

G. 2015 Risk Corridors Payments Owed to Plaintiffs

58. As it did in relation to their 2014 risk corridors payments, Plaintiffs complied with their statutory requirements and submitted to HHS all data required by the ACA demonstrating that they experienced higher-than-expected allowable costs under the risk corridors program for benefit year 2015, entitling Plaintiffs to payment by HHS in the amount of $325,437,293.35 (as calculated pursuant to the formula prescribed in ACA Section 1342).

59. On September 9, 2016, HHS announced that funds paid by QHP issuers into the risk corridors program (payments in) for 2015 would *not* be used to pay the 2015 benefit year risk corridors payments. This announcement was confirmed in a subsequent memo, dated November 18, 2016.

60. As a result, although CMS conceded that Plaintiffs are entitled to $325,437,293.35 from the risk corridors program for the 2015 program year, HHS has not paid any of this amount, and has signaled it will not make full payment as required by the ACA. Instead, the 2015 "payments in" will be used to pay a portion of the 2014 benefit year risk corridors payments that remain outstanding. 2015 "payments in" have not been disbursed but are calculated at even smaller amounts than 2014 collections, leaving massive shortfalls for insurers.

61. Similar to the 2015 Spending Bill, the 2016 Spending Bill prevents CMS and HHS from making risk corridors payments using certain funding sources. As a result, HHS has

indicated that it will continue to treat the risk corridors program as "budget neutral" (although there is no basis in the ACA for doing so), and will use any funds received from QHP issuers for the 2015 risk corridors results to first pay down the $2.5 billion shortfall from 2014.

H. <u>2016 Risk Corridors Payments Owed to Plaintiffs</u>

62. Consistent with CMS regulations and policy, Plaintiffs began selling QHPs to consumers in Arkansas, California, Massachusetts, Arizona, and Illinois on or around November 1, 2015, with coverage effective January 1, 2016.

63. Plaintiffs complied with their statutory requirements and submitted to HHS all data required by the ACA demonstrating that it experienced higher-than-expected allowable costs under the RCP for benefit year 2016, entitling Plaintiffs to payment by HHS in the amount of $29,310,722.04.

64. Similar to the 2016 Spending Bill, the 2017 Spending Bill prevents CMS and HHS from making risk corridors payments using certain funding sources. As a result, HHS has indicated that it will continue to treat the risk corridors program as "budget neutral" (although there is no basis in the ACA for doing so), and will use any funds received from QHP issuers for the 2016 risk corridors results to first pay down the shortfall from 2014.

65. Despite the clear statutory mandate and its own multiple admissions of its obligations to the contrary, HHS has stated that it will not make timely and complete payment to QHP issuers.

66. HHS's unilateral decision to forgo payment of the amounts that it owes contradicts the express language of Section 1342, which states that if a plan's allowable costs "for any ***plan year***" exceeds the target amount, the Secretary "***shall pay to the plan***" the amounts set forth in the ACA. The implementing regulations at 45 C.F.R § 153.510 expressly reiterate when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will***

pay the QHP issuer" the amounts set forth in the ACA.

67. The Government, by refusing to meet its 2014, 2015, and 2016 payment obligations under the risk corridors program in violation of Section 1342, abrogates its responsibility with respect to one of the key features of the ACA, *i.e.*, providing market-stabilization in the new exchanges. Withholding these payments defeats the very purpose of the risk corridors program, in violation of both the letter and spirit of the law.

* * * * *

68. Regardless of HHS's statements that it will manage the risk corridors program in a "budget-neutral" manner, and regardless of the acts of subsequent Congresses to limit the availability of certain funds to make payments owed to QHP issuers under the risk corridors program, the fact remains that the obligations of the Government under the ACA risk corridors program *have never been amended.* Section 1342 mandates payment to QHP issuers under certain conditions *without regard to budget neutrality*, and for the very purpose of stabilizing the market by mitigating annual losses of participating plans, a fact especially crucial for new entrants who relied on the promise of Congress that cost overruns would be partially mitigated through reimbursement. Notwithstanding subsequent agency pronouncements, *made only after QHP issuers such as Plaintiffs, entered the market*, CMS's implementing regulation (Section 153.510) reflected the mandatory nature of the payments without regard to budget neutrality.

69. Plaintiffs relied upon the risk corridors program when they entered and participated in the ACA exchanges, and when they designed and priced their 2014, 2015 and 2016 plans. At the end of benefit year 2014, Plaintiffs were *owed* money based on their participation in both the individual and small group market. HHS paid only a small fraction of the total that was due. The remainder in the amount of $81,853,410.55 is owed and presently

due. By the same token, the $325,437,293.35 losses sustained in the risk corridors program for benefit year 2015, and $29,310,722.04 losses for benefit year 2016, are owed to Plaintiffs under the express terms of Section 1342 of the ACA. By this lawsuit, Plaintiffs seek the immediate payment in full of risk corridors receivables for benefit years 2014, 2015, and 2016, so that it can continue to offer affordable health insurance as contemplated by the ACA.

CLAIM FOR RELIEF

COUNT I

(Violation of Statutory and Regulatory Mandate to Make Payments)

70. Plaintiffs re-allege and incorporate by reference the preceding paragraphs as if fully set forth herein.

71. As part of its obligations under Section 1342 of the ACA and its obligations under 45 C.F.R. § 153.510(b), the Government is required to pay any QHP issuer certain amounts exceeding the target costs they incurred in 2014, 2015, and 2016.

72. Plaintiffs are QHP issuers under the ACA and, based on their adherence to the ACA and their submission of allowable costs and target costs to CMS, satisfy the requirements for payment from the United States under Section 1342 of the ACA and 45 C.F.R. § 153.510(b).

73. The Government has failed, without justification, to perform as it is obligated under Section 1342 of the ACA and 45 C.F.R. § 153.510(b), and has affirmatively stated that it will not do so.

74. The Government's failure to provide timely payments to Plaintiffs is a violation of Section 1342 of the ACA and 45 C.F.R. § 153.510(b), and Plaintiffs have been harmed by these failures.

COUNT II

(Breach of Implied-In-Fact Contract to Make Payments)

75. Plaintiffs re-allege and incorporate by reference the preceding paragraphs as if fully set forth herein.

76. Plaintiffs entered into a valid implied-in-fact contract with the Government regarding the Government's obligation to make full and timely risk corridors payments in exchange for their agreements to become QHP issuers and participate in the exchanges.

77. Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's repeated admissions regarding their obligation to make risk corridor payments were made or ratified by representatives of the Government, including, but not limited to, Kevin Counihan, Director of Consumer Information and Insurance Oversight ("CCIIO") and CEO of the Health Insurance Marketplaces; Andrew Slavitt, Administrator of CMS; or other CMS officials, all of whom had actual authority to bind the Government. Section 1342, CMS's implementing regulations, and the repeated admissions by agency officials with authority to bind the Government constitute a clear and unambiguous offer by the Government to make full and timely risk corridor payments to health insurers, including Plaintiffs, that agreed to participate as QHP issuers in the ACA marketplaces. This offer evidences a clear intent by the Government to contract with Plaintiffs.

78. Plaintiffs accepted the Government's offer by agreeing to become QHP issuers, accepting the obligations, responsibilities, and conditions the Government imposed on QHP issuers under the ACA, *inter alia*, 45 C.F.R. §§ 153.10 *et seq.* and 155.10 *et seq.*, and proceeding to provide health insurance on the exchanges. Plaintiffs satisfied and complied with their

obligations and conditions which existed under the implied-in-fact contract.

79. The Government's agreement to make full and timely risk corridor payments was a significant factor material to Plaintiffs' decision to participate on the exchanges.

80. The parties' mutual intent to contract is further confirmed by the parties' conduct, performance and statements following Plaintiffs' acceptance of the Government's offer, 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 Fed. Reg. 15,409, 15,473 (Mar. 11, 2013).

81. The implied-in-fact contract was also supported by mutual consideration: The RCP's protection from uncertain risks and new market instability was a real benefit that significantly influenced Plaintiffs' decisions to agree to become QHP issuers and participate on the exchanges. Plaintiffs, in turn, provided a real benefit to the Government by agreeing to become QHP issuers and participating on the exchanges, as adequate insurer participation was crucial to the Government achieving the overarching goal of the ACA exchange programs—to guarantee the availability of affordable, high-quality health insurance coverage for all Americans by protecting consumers from increases in premiums due to health insurer uncertainty.

82. The Government induced Plaintiffs to participate on the exchanges for benefit years 2014, 2015, and 2016 by including the RCP in Section 1342 of the ACA and its implementing regulations, by which the Government committed to help protect health insurers financially against risk selection and market uncertainty.

83. The Government repeatedly acknowledged its commitments to share risk with QHP issuers and its obligations to make full and timely risk corridors payments to qualifying QHP issuers through its conduct and statements to the public and to Plaintiffs and other similarly

situated QHP issuers, made or ratified by representatives of the Government who had express or implied actual authority to bind the Government. *See, e.g.*, 77 Fed. Reg. 17,220, 17,238 (Mar. 23, 2012).

84. The Government also induced Plaintiffs to participate in the marketplaces during and after HHS and CMS's announcement in 2014 of their intention to implement the RCP in a budget neutral manner, by repeatedly giving assurances to QHP issuers that risk corridors collections will be sufficient to cover all of the Government's risk corridors payments, and that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("We anticipate that risk corridors collections ***will be sufficient*** to pay for all risk corridors payments.") (emphasis added); 79 Fed. Reg. 30,240, 30,260 (May 27, 2015) ("***In the unlikely event of a shortfall*** for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, ***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations.") (emphases added).

85. The Government continued to induce Plaintiffs to commit to participating on the exchanges for benefit year 2016 by providing assurance that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, Sept. 2016 Memo ("As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations.").

86. HHS and CMS acknowledged and published the full risk corridors payment amount of $98,317,042.69 that the Government concedes it owes Plaintiffs for benefit year 2014. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015). Of this amount, only $16,463,741.73 has been paid, and the remaining $81,853,410.55 is

currently due.

87. HHS and CMS also acknowledged and published the full risk corridors payment amount of $325,437,293.35 that the Government concedes it owes Plaintiffs for benefit year 2015. *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016). Under the same calculation validated by CMS for benefit years 2014 and 2015, CMS owes Plaintiffs $29,310,722.04 for benefit year 2016. *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year" (Nov. 15, 2017).

88. The Government's failure to make full and timely risk corridor payments to Plaintiffs is a material breach of the implied-in-fact contract, and Plaintiffs have been damaged by this failure. Plaintiffs therefore bring a claim for damages of $436,601,425.94 against the Government founded upon the Government's violation of an implied-in-fact contract.

PRAYER FOR RELIEF

Plaintiffs request the following relief:

A. That the Court award Plaintiffs monetary relief in the amounts to which Plaintiffs are entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b), in the amount of $81,853,410.55 (for benefit year 2014), $325,437,293.35 (for benefit year 2015), and $29,310,722.04 (for benefit year 2016).

B. That the Court award pre-judgment and post-judgment interest at the maximum rate permitted under the law;

C. That the Court award such court costs, litigation expenses, and attorneys' fees as are available under applicable law; and

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

Dated: May 27, 2020

Respectfully submitted,

/s/ Christopher Flynn
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