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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

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U.S. COURT OF
FEDERAL CLAIMS

OREGON's HEALTH CO-OP, an Oregon nonprofit corporation Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 18-94 C

COMPLAINT

I. INTRODUCTION

1. The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 ("ACA"), significantly changed health insurance nationwide. By providing financial assistance for individuals to purchase "Qualified Health Plans" on the new "Health Insurance Marketplaces," and through a number of other health insurance market reforms, the ACA created access to health insurance for millions of previously uninsured Americans. These market reforms included prohibiting health insurers from denying coverage or setting premiums based on health status or medical history.

2. Due to the ACA's changes to the laws governing health insurance, and the absence of experience with Health Insurance Marketplaces and the populations enrolling in coverage through them, insurers lacked sufficient information to set premium rates accurately for Qualified Health Plans. Specifically, insurers lacked information regarding the number and health expenses of the new enrollees that would enroll in Qualified Health Plans.

3. In recognition of this challenge facing health insurers, and to encourage insurers to offer Qualified Health Plans at a reasonable price despite this uncertainty, Section 1342 of the ACA established a temporary "Risk Corridors Program." The Risk Corridors Program was

designed to help issuers of Qualified Health Plans weather short-term financial challenges caused by setting premium rates for a population about which the insurers lacked information. It was also intended to discourage participating insurers from being excessively conservative in their cost estimates, which would have increased premiums for the Qualified Health Plans and increased the Government's liability for premium tax credits to help low-income individuals purchase Qualified Health Plans.

4. Under this temporary Risk Corridors Program, the Government is legally responsible for making specific payments to participating insurers if their Qualified Health Plans' costs exceed target amounts during the first three years of operation of the Marketplaces (calendar years 2014 through 2016). While a Qualified Health Plan will still incur a loss if its costs exceed the target amount, the temporary Risk Corridors Program will cover some of those losses. Specifically, under the statute, if a participating insurer's allowable costs for any plan year are between 103 and 108 percent of the target amount, the Government must pay the insurer 50 percent of the amount in excess of 103 percent of the target amount; and if a participating insurer's allowable costs for any plan year are more than 108 percent of the target amount, the Government must pay the insurer 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.

5. Plaintiff Oregon's Health CO-OP ("OHC") is a nonprofit Consumer Operated and Oriented Plan ("CO-OP") domiciled in Oregon. A "CO-OP" is a nonprofit health insurance issuer partially funded by loans and grants from the federal government under the ACA. OHC was previously known as Community Care of Oregon, Inc. and adopted its current name on October 3, 2013.

6. OHC created, priced, and sold Qualified Health Plans in Oregon in 2014, 2015, and 2016.

7. Based upon its actual allowable costs, OHC is entitled to risk corridors payments from the Government of $1,528,717 for its 2014 Qualified Health Plans, $13,130,119 for its 2015 Qualified Health Plans, and $10,591,983 for its 2016 Qualified Health Plans.

8. However, the United States breached its statutory and contractual obligation to make full risk corridors payments. For the 2014 plans, the United States will pay OHC only $256,970 of the $1,528,717 that it is owed, or 16.8 percent. This includes the $192,891 prorated amount from the 2014 plan year collections, the $50,781 payment toward the 2014 amount from 2015 plan year collections, and the $13,298 expected payment toward the 2014 amount that CMS announced in its 2016 plan year statement (issued in November 2017). In addition, the Government has not paid any of its 2015 or 2016 risk corridors obligations, and the settlement of both years is past due.

9. Because of the Government's nonpayment of its risk corridors obligations, OHC had insufficient funds to complete the 2016 policy year and meet its risk-based capital requirements. As a result, OHC was ordered into state receivership in July of 2016, forcing over 22,500 Oregonians to find new health insurance and leaving providers across the State with unpaid medical claims for services delivered to OHC enrollees.

10. This lawsuit seeks the recovery of the $24,993,849 risk corridors shortfall the Government owes OHC for the 2014, 2015, and 2016 coverage years.

II. JURISDICTION

11. This Court has jurisdiction over this action pursuant to the Tucker Act, 28 U.S.C. § 1491, because Section 1342 is a money-mandating statute providing that, when certain easily determinable financial criteria are met, the Government "shall pay to the plan an amount"

specified by statute. An implementing regulation, 45 C.F.R. § 153.510, similarly requires the Government to make payments of the same amounts. The Tucker Act is also the jurisdictional basis for OHC's claim based on the Government's breach of an implied-in-fact contract.

III. PARTIES

12. Plaintiff Oregon's Health CO-OP or "OHC" is a nonprofit, member-governed health insurer that provided individual and group insurance plans based in Oregon. OHC stopped doing business in July 2016, and the Director of the State of Oregon's Department of Consumer and Business Services, as the court-appointed Receiver, took over the company's assets to help pay claims and enroll policyholders in new plans. All policies written by OHC were canceled as of July 31, 2016. OHC was placed in liquidation on March 2, 2017.

13. Defendant is the United States of America ("the Government"). The United States Department of Health and Human Services ("HHS") is an Executive Agency of the United States government, tasked with administering the Section 1342 Risk Corridors Program. Responsibility for that program was delegated within HHS to the Centers for Medicare & Medicaid Services ("CMS").

IV. FACTUAL ALLEGATIONS

A. The Affordable Care Act and the Risk Corridors Program.

14. In 2010, Congress enacted the ACA. The ACA reformed health insurance markets nationwide, including by imposing new requirements on health insurers. For example, insurers can no longer deny coverage to individuals due to pre-existing conditions, and certain health plans must meet provider network adequacy requirements and cover essential health benefits, among many other new requirements.

15. The ACA also created new Health Insurance Marketplaces (also called "Health Exchanges") and authorized insurers to sell Qualified Health Plans on those Marketplaces.

Qualified Health Plans must provide essential health benefits, comply with network adequacy standards, and follow established limits on cost-sharing, among other things. Qualified Health Plans must be certified by each Marketplace in which they are sold. ACA § 1301, 42 U.S.C. § 18021.

16. An individual is eligible to purchase a Qualified Health Plan through a Marketplace if he or she: is a citizen or national of the United States, or a lawfully present non-citizen; is not incarcerated; and meets certain residency requirements. ACA § 1312(f), 42 U.S.C. § 18032(f); *see also* 45 C.F.R. § 155.305(a). Under Sections 1401 and 1402 of the ACA, an individual eligible to purchase a Qualified Health Plan may be eligible for a tax credit and/or cost sharing reductions, if affordable minimum essential coverage is not otherwise available to the individual and his or her income is below a certain level. § 155.305.

17. The ACA established the CO-OP program "to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans." Under the CO-OP program, certain nonprofit health insurers were eligible for federal loans and grants for start-up costs and to meet state solvency requirements. ACA § 1322.

18. Under the ACA, OHC and other Qualified Health Plan issuers had to navigate the new health insurance reforms while attempting to predict health care costs for a population (individuals purchasing Qualified Health Plans) for which there was no historical data. As a result, insurers faced significant challenges and uncertainties in setting premium rates for their Qualified Health Plans.

19. To address these uncertainties and to entice insurers to offer Qualified Health Plans, the ACA created three market stabilization programs, commonly called the "3Rs": reinsurance, risk adjustment, and risk corridors.

20. This lawsuit relates to the third program: the Risk Corridors Program. Section 1342 of the Act directs the Secretary of HHS to make payments to Qualified Health Plans under the temporary Risk Corridors Program. Under the Risk Corridors Program, HHS must make payments to any Qualified Health Plan that, for the applicable year, had costs that were more than 3 percent greater than a target amount based on aggregate premiums charged by the plan in the applicable year. Specifically, Section 1342 provides in relevant part:

> (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**.

(emphasis added).

21. Section 1342(c) defines allowable costs as "an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan." Section 1342(c) defines target amount as "an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan."

22. The Risk Corridors Program partially protected Qualified Health Plan issuers in the individual and small group markets from uncertainty in rate setting for the first three years of ACA implementation, *i.e.*, 2014 through 2016, by transferring a portion of an issuer's losses to the

federal Government. The Program only ran from 2014 to 2016 because Congress expected that insurers would need three years to learn about the new insurance market and Qualified Health Plan enrollees, after which they would have sufficient actuarial information to set accurate premiums. *See Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 77 Fed. Reg. 17,220, 17,221, 17,236–39 (Mar. 23, 2012).

23. By limiting risk, the Risk Corridors Program encouraged issuers to participate in the Marketplaces. Without the program, insurers faced the possibility of significant losses given the unknown demographics of the new enrollees. In addition, the program allowed insurers to keep premium rates at affordable levels by not adding a risk premium to account for actuarial uncertainties. CMS, *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (Mar. 2012), *available at* https://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf.

24. The Risk Corridors Program also addresses situations in which a health insurer had charged premiums higher than necessary (in retrospect) to cover its costs. Section 1342(b)(2) provides for payments ***by*** the health insurer ***to*** the Government in that circumstance:

> (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.

25. In Section 1342(a), Congress instructed that the ACA Risk Corridors Program "shall be based on the program for regional participating provider organizations under part D of

title XVIII of the Social Security Act." Commonly referred to as "Medicare Part D," that program provides comprehensive Medicare coverage of outpatient prescription drugs. *See* Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 42 U.S.C. §§ 1395w-101 *et seq.* (2003). The Medicare Part D program also utilizes risk corridors, under which the Government annually makes risk corridors payments to, or receives risk corridors payments from, plan sponsors, depending on whether a sponsor's actual expenses exceed, or fall short of, anticipated expenses, by specified amounts. 42 U.S.C. § 1395w-115(e).

B. Implementation of the ACA Risk Corridors Program.

26. On March 23, 2012, HHS promulgated final regulations implementing the ACA's Risk Corridors Program. 77 Fed. Reg. 17,220 (codified at 45 C.F.R. Part 153). The final rules require Qualified Health Plan issuers to "adhere to the requirements set by HHS in [§§ 153.500–.530] and in the annual HHS notice of payment and benefit parameters," and provide that "Qualified Health Plan issuers *will receive payment* from HHS" in amounts consistent with the statutory provisions of Section 1342(b)(1). 45 C.F.R. § 153.510 (emphasis added).

27. A year later, on March 11, 2013, HHS published another final rule that, among other things, included notice of benefit and payment parameters for calendar year 2014, to enable the insurers to establish their rates for the first year of the Marketplaces (2014). In the preamble, CMS 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." *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013).

28. CMS also provided that the deadline for the Government to make risk corridors payments to issuers "should be the same" as the deadline by which issuers with allowable annual

costs that are less than 97 percent of the target amount must make risk corridors payments to the Government. 77 Fed. Reg. at 17,238. CMS ended up imposing a 30-day deadline for Qualified Health Plan issuers that owe payments under the program to make those payments to the Government. 45 C.F.R. § 153.510(d).

C. Regulatory Approval of OHC's 2014 Qualified Health Plans.

29. Through the enactment of the ACA in 2010, the regulations and the preambles thereto, as well as letters, memoranda, and other written and oral communication, CMS offered to provide tax credits, cost sharing subsidies, risk corridors payments, and other reimbursement to qualified entities, such as OHC, that agreed to sell and provide Qualified Health Plan coverage in 2014, 2015 and/or 2016, under the terms and conditions set forth in the ACA, its implementing regulations, and CMS policy and guidance. *See, e.g.*, 45 C.F.R. Parts 144, 147, 148, 150, 153–156; *Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014); 78 Fed. Reg. 15,410; 77 Fed. Reg. 17,220; CMS, Federal Marketplace Progress Fact Sheet (May 31, 2013), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ffe.html; CMS, Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Apr. 5, 2013), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

30. OHC accepted CMS's offer to sell and provide Qualified Health Plan coverage. Long before OHC's Qualified Health Plans went to market, OHC actuaries began working on calculating premium rates for the unknown population that would purchase Qualified Health Plans.

31. Regulatory approval for Qualified Health Plans is a two-step process: (1) Qualified Health Plans' rates and other features must be approved by state insurance regulators for

compliance with state and federal law; and (2) Qualified Health Plans must be certified by the Marketplace (also called the Exchange) for compliance with the federal requirements governing Qualified Health Plans specifically. In states that choose to operate their own Marketplace, as Oregon did for 2014, the state officials running the Marketplace certify the Qualified Health Plans for compliance with the federal Qualified Health Plan requirements.

32. OHC submitted its Qualified Health Plan rates for 2014 to Oregon state regulators for review and approval on April 30, 2013 (individual and small group). OHC submitted revised small group rates on October 31, 2013. Oregon regulators approved OHC individual rates on July 10, 2013 and small group rates on July 3, 2013. The Oregon regulators approved the revised small group rates on December 23, 2013.

33. OHC submitted its Oregon Qualified Health Plans to the "Cover Oregon" Marketplace through the National Association of Insurance Commissioner's ("NAIC") System for Electronic Rates & Forms Filing ("SERFF") system for review and certification on April 30, 2013. Cover Oregon certified OHC's Oregon Qualified Health Plans on September 4, 2013.

34. Consistent with CMS regulations and policy, OHC began selling Qualified Health Plans to consumers in Oregon on October 1, 2013, with coverage effective January 1, 2014. OHC provided health care coverage under these Qualified Health Plans to thousands of Oregonians, under the terms required by state and federal law and policy.

D. Changes to the Qualified Health Plan Risk Pool Resulting from Actions of the Federal Government.

35. In the final months of 2013, many health insurers began to cancel existing health insurance policies that were not compliant with the new ACA reforms that would become effective January 1, 2014. The cancellation of these policies created significant political pressure on the

Government, as many people had believed that the ACA would not cause them to lose their existing coverage.

36. On November 14, 2013, CMS responded by announcing a "transitional policy" designed to curb the cancellation of existing policies. Under the transitional policy, any coverage in effect on October 1, 2013 was not considered noncompliant for failure to comply with certain ACA reforms that otherwise became effective on January 1, 2014. CMS announced that this transitional policy would apply only to plan years beginning before October 1, 2014. States were encouraged, but not required, to apply a similar transitional policy. Letter from Gary Cohen, Dir., Ctr. for Consumer Information and Ins. Oversight ("CCIIO"), CMS, to State Insurance Commissioners (Nov. 14, 2013), *available at* https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF. Oregon applied the transitional policy.

37. Absent this transitional policy, which was not announced until after OHC and other issuers began selling Qualified Health Plans for 2014, millions of individuals who had existing individual market coverage that did not comply with the ACA would have had that coverage terminated and thus would have transitioned to a Qualified Health Plan effective January 1, 2014. These potential Qualified Health Plan enrollees, who ended up able to stay in their old plans under the transitional policy, were generally less expensive than those who were uninsured prior to their Qualified Health Plan enrollment, because the former group is less likely to have untreated health care conditions. Thus, the risk pool for Qualified Health Plans in Oregon was more expensive than could have been anticipated when insurers set their premiums.

38. In its November 2013 announcement of the transition policy, CMS recognized that Qualified Health Plan issuers had set rates based on the assumption that individuals who had

existing individual market coverage that did not comply with the ACA would have transitioned to a Qualified Health Plan effective January 1, 2014, something that would happen much less frequently due to the new transition policy. CMS assured issuers and state insurance commissioners that the risk corridors payments would at least partially offset any losses arising out of the new transition policy:

> Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue.

Id.

39. On March 5, 2014, CMS announced that it was extending its transitional policy for two years, *i.e.*, to policy years beginning on or before October 1, 2016. Memorandum from Gary Cohen, Dir., CCIIO, CMS, *Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016* (Mar. 5, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf. On February 29, 2016, CMS extended it again by one year, to policy years beginning on or before October 1, 2017, provided that all policies end by December 31, 2017. *See* Memorandum from Kevin Counihan, Dir., CIIOO, CMS, *Insurance Standards Bulletin Series – INFORMATION – Extension of Transitional Policy through Calendar Year 2017* (Feb. 29, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf.

E. Program Developments in 2014 and 2015.

40. OHC's Qualified Health Plans began providing coverage as of January 1, 2014. On March 11, 2014, over five months after OHC's Qualified Health Plans had gone to market at the state-approved premium rates, HHS published a final rule with the notice of benefit and

payment parameters for the next calendar year, 2015. In the preamble, HHS stated that it projected that net risk corridors payments would be "budget neutral" for 2014, and thus HHS "intend[ed]" to implement the risk corridors program in a "budget neutral manner." *HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13,744, 13,787, 13,829 (Mar. 11, 2014) (eff. May 12, 2014). This was not inconsistent with previous HHS statements, as it was simply a prediction by HHS that the program would be budget neutral, *i.e.*, that the aggregate amounts of payments owed to Qualified Health Plans whose expenditures exceeded the target amounts would be offset by payments received by HHS from Qualified Health Plans whose expenditures fell short of the target amounts. HHS did not indicate that it would implement the risk corridors program in a budget neutral manner even if payments to HHS by Qualified Health Plans whose costs fell short were not sufficient to cover HHS's obligations to Qualified Health Plans whose costs exceeded premium revenues.

41. On April 11, 2014, over six months after OHC had begun selling 2014 Qualified Health Plans at approved rates, and over a year after HHS publicly stated that it would make full risk corridors payments "[r]egardless of the balance of payments and receipts" in the program, CMS issued questions and answers suggesting that, for 2015, if risk corridors collections were insufficient to make risk corridors payments for a year, all risk corridors payments for that year would be reduced pro rata to the extent of any shortfall. CMS indicated that risk corridors collections received for the next year would 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. *See* 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. After all issuers received full risk corridors

reimbursement owed for the previous year, any remaining funds would be used to fund current year payments. *Id.* CMS's suggestion in this questions and answers document that the Risk Corridors Program would be implemented in a budget neutral manner, regardless of whether the incoming payments sufficed to cover the payments owed to issuers, conflicted with CMS's explicit statement in the March 11, 2013 Final Rule that "[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 Fed. Reg. at 15,473.

42. Just a month later, in May 2014, HHS walked away from its April 2014 questions and answers by reaffirming that it had the legal authority to pay its entire risk corridors obligations regardless of the amount of payments the Government received through the program. Specifically, in a letter to the Government Accountability Office ("GAO") dated May 20, 2014, HHS stated that the CMS's general Program Management appropriation for fiscal year 2014 (Pub. No. 113-76) gave it the authority to make full risk corridors payments. *See* Letter from William B. Schultz, General Counsel, HHS, to Julia C. Matta, Assistant General Counsel, GAO (May 20, 2014). Then, one week later, in the Final Rulemaking for Exchange and Insurance Market Standards for 2015 and Beyond, HHS reiterated that it was legally obligated to make risk corridors payments in full. While HHS "anticipate[d] that risk corridors collections will be sufficient to pay for all risk corridor payments," HHS explained that, "[i]n 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" and thus "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." *Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014).

43. On September 30, 2014, the GAO issued a report on the ACA Risk Corridors Program, in which it concluded that the CMS Program Management fund for Fiscal Year ("FY") 2014 provides the Government with the authority and appropriations to make full risk corridors payments. GAO, *HHS—Risk Corridors Program*, B-325630 (Sept. 30, 2014), *available at* http://gao.gov/assets/670/666299.pdf.

F. Regulatory Approval of OHC's 2015 Qualified Health Plans.

44. OHC submitted its Qualified Health Plan rates to Oregon state regulators on June 2, 2014. Oregon state regulators approved OHC's 2015 rates on August 13, 2014.

45. OHC submitted its Qualified Health Plans to Cover Oregon through the NAIC's SERFF system for review and certification on June 30, 2014. Cover Oregon certified OHC's Oregon Qualified Health Plans on October 2, 2014.

46. OHC subsequently executed Qualified Health Plan Certification Agreements with CMS for Oregon for calendar year 2015.

47. Consistent with CMS regulations and policy, OHC began selling 2015 Qualified Health Plans to consumers in Oregon on October 1, 2014. These Qualified Health Plans offered coverage effective January 1, 2015. Throughout 2015, OHC provided health care coverage under these Qualified Health Plans to tens of thousands of Oregonians, under the terms specified in state and federal law and policy.

G. Regulatory Approval of OHC's 2016 Qualified Health Plan.

48. OHC submitted its Qualified Health Plan rates to Oregon state regulators on April 30, 2015. Oregon state regulators approved OHC's 2016 rates on August 4, 2015.

49. OHC submitted its Qualified Health Plans to the Oregon Exchange through the NAIC's SERFF system for review and certification on May 1, 2015. The Exchange certified OHC's Oregon Qualified Health Plans on September 17, 2015.

50. OHC subsequently executed Qualified Health Plan Certification Agreements with CMS for Oregon for calendar year 2016.

51. Consistent with CMS regulations and policy, OHC began selling 2016 Qualified Health Plans to consumers in Oregon on October 1, 2015. These Qualified Health Plans offered coverage effective January 1, 2016. From January 1, 2016 through July 31, 2016, OHC provided health care coverage under these Qualified Health Plans to tens of thousands of Oregonians, under the terms specified in state and federal law and policy.

H. Congressional Action and the Government's Failure to Make Full Risk Corridors Payments.

52. On December 16, 2014—over a year after OHC began selling 2014 Qualified Health Plans on the Marketplaces, and over two months after OHC began selling 2015 Qualified Health Plans on the Marketplaces—Congress enacted the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, which contained the following provision:

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

53. Similar provisions have been incorporated in a number of subsequent appropriations bills. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113 (2015); Continuing Appropriations Act, 2017, Pub. L. No. 114-223, § 101, 130 Stat. 857 (2016); Further Continuing Appropriations Act, 2017, Pub. L. No. 114-254, 130 Stat. 1005 (2016); Pub. L. No. 115-30, 131 Stat. 134); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 135 (2017); Continuing Appropriations Act, 2018, 115 Pub. L. No. 56, 131 Stat. 1129 (2017).

54. On July 21, 2015, in a letter to state health insurance commissioners, CMS reaffirmed its commitment to making full risk corridors payments, on time and in full. CMS stated:

> CMS remains committed to the risk corridor program. As stated in our final payment notice for 2016, "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."

Kevin J. Counihan, Chief Executive Officer ("CEO"), Health Insurance Marketplace, Dir., CCIIO, CMS, to State Insurance Commissioners (July 21, 2015) *available at* https://www.cms.gov/CCIIO/Resources/Letters/Downloads/DOI-Commissioner-Letter-7-20-15.pdf.

55. However, on October 1, 2015—exactly two years after OHC began selling 2014 Qualified Health Plans, one year after OHC began selling 2015 Qualified Health Plans, and the very date on which OHC began selling its 2016 Qualified Health Plans—CMS announced that the risk corridors program would be "budget neutral" and that the Government would not make the full risk corridors payments for 2014. CMS stated that Qualified Health Plan issuers whose actual expenses exceeded their anticipated target amounts had submitted claims to the Government for $2.87 billion in risk corridors payments for 2014, and that Qualified Health Plan issuers whose actual expenses fell short of the target amount owed the Government $362 million in risk corridors payments for 2014. CMS stated that it would pay Qualified Health Plan issuers to whom money was owed only 12.6 percent of their 2014 risk corridors claims ($362 million divided by $2.87 billion). CMS asserted that the 87.4 percent shortfall would eventually be paid out of 2015 and 2016 risk corridors charges, but provided no explanation as to how this $2.5 billion shortfall for calendar year 2014 ($2.87 billion minus $362 million) would or could be closed by amounts owed by Qualified Health Plans for 2015 and 2016. *See* 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.

56. On November 19, 2015, CMS released a statement titled "Risk Corridors Payment and Charge Amounts for Benefit Year 2014." The statement included issuer-level data on the risk corridors charges and payments for the 2014 benefit year. It also confirmed that the 2014 risk corridors payment amounts will be prorated at 12.6 percent, and it indicated that HHS would beginning remitting payments to insurers in December 2015. 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.

57. On September 9, 2016, CMS released a statement titled "Risk Corridors Payments for 2015." The statement reported that, based on a preliminary analysis, HHS anticipated that all 2015 benefit year collections would be used towards remaining 2014 benefit year risk corridors payments, and no funds would be available from 2015 benefit year collections for 2015 benefit year risk corridors payments. Additionally, the statement confirmed that collections from the 2016 benefit year would 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. 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. *See also* 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.

58. Congress never repealed or amended Section 1342 of the ACA.

59. OHC met all statutory and regulatory requirements that Qualified Health Plans must satisfy to participate in and receive payments from the Risk Corridors Program.

I. Risk Corridors Payments Owed to OHC.

60. According to CMS's calculations, for the 2014 payment year, the risk corridor amount due to OHC for the individual market was $1,528,717. CMS estimated that it would make risk corridors payments of $192,891 for OHC's individual market Qualified Health Plans, and would receive $53,520 for OHC's small group Qualified Health Plans. 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.

61. In November of 2016, CMS announced that it owed OHC $13,130,119 in risk corridors payments for the 2015 payment year; $12,246,712 for OHC's individual market Qualified Health Plans and $883,407 for its small group Qualified Health Plans. CMS also announced that it would make payments of just $50,781 toward the 2014 risk corridors payments owed to OHC from its 2015 risk corridors collections. 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.

62. In November of 2017, CMS announced that it owed OHC $10,591,983 in risk corridors payments for the 2016 payment year; $6,321,119 for OHC's individual market Qualified Health Plans and $4,270,864 for its small group Qualified Health Plans. CMS also announced that

it would make payments of just $13,298 toward the 2014 risk corridors payments owed to OHC, from its 2016 risk corridors collections. CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (Nov. 15, 2017), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

63. Because the Government did not collect sufficient risk corridors payments to meet its $2.87 billion outstanding obligation for the 2014 risk corridors payments, the Government will not pay any of the risk corridors payments it owes to OHC for 2015 and 2016. *See supra* ¶¶41–42, 52–59. For the 2014 plans, the United States will pay OHC only $256,970 of the $1,528,717 that it is owed, or 16.8 percent. This includes the $192,891 prorated amount from the 2014 plan year, the $50,781 payment toward the 2014 amount that was announced in the 2015 statement, and the $13,298 expected payment toward the 2014 amount that was announced in the 2016 statement.

64. In total, the federal government owes OHC $25,250,819 in risk corridors payments, and it will pay just $256,970 (just over 1 percent).

65. The premium rates OHC set for its Qualified Health Plans were lower than they would have been in the absence of the Government's promise of risk corridors. As a result, the Government's premium tax credit obligations under the ACA, which helped individuals enrolled in OHC Qualified Health Plans pay their premiums, were much less than they otherwise would have been.

J. OHC Receivership and Liquidation.

66. As a result of the federal government's non-payment of the risk corridors payments to OHC, OHC was unable to meet its capital reserve requirements.

67. On July 8, 2016, the Oregon Department of Consumer and Business Services announced that OHC would cease operations as of July 31, 2016. At that point, there were over 12,000 people with individual market coverage through OHC and 10,000 OHC enrollees in the small and large group market.

68. On July 11, 2016, a special enrollment period began for the over 22,000 OHC members to select coverage from another insurer. In addition, providers across the State that had provided services to OHC enrollees were left unpaid for valid medical claims.

69. On July 18, 2016, the Oregon Department of Consumer and Business Services announced that the other carriers in the individual market in Oregon had agreed to apply OHC members' already-accrued our-of-pocket expenses towards their new plans, which took effect August 1, 2016. Oregon's announcement about out-of-pocket expense carry-over did not apply to small groups; they noted that small group members may have to start over on their out-of-pocket expenditures, depending on the carrier that they chose to replace their coverage.

70. In March 2017, Oregon filed a petition for liquidation in order to liquidate OHC's remaining assets and distribute the money to creditors.

CLAIM FOR RELIEF

COUNT ONE
(Violations of Section 1342, Statutory Mandates, and Statutory Authority)

71. Plaintiff re-alleges and incorporates ¶¶ 1–70 of the Complaint as if set forth fully herein.

72. Section 1342 of the ACA and 45 C.F.R. § 153.510 require the Government to pay qualified insurers statutorily defined amounts as part of the Risk Corridors Program.

73. OHC satisfied all statutory and regulatory requirements for participation in and payments under the Risk Corridors Program in 2014, 2015, and 2016.

74. The Government failed to provide the risk corridors payments owed to OHC for 2014, in violation of Section 1342 and 45 C.F.R. § 153.510. Specifically, by paying only $256,970 of the total $1,528,717 to which OHC is entitled, the Government owes OHC an additional $1,271,747 in 2014 risk corridors payments.

75. The Government has announced that it will not pay any of the $13,130,119 in risk corridors payments owed to OHC for 2015, in violation of Section 1342 and 45 C.F.R. § 153.510.

76. The Government has announced that it will not pay any of the $10,591,983 in risk corridors payments owed to OHC for 2016, in violation of Section 1342 and 45 C.F.R. § 153.510.

77. The mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not defeat a Government obligation created by statute. The Government is obligated to make full payment to an entity such as OHC, using the Judgment Fund. OHC is entitled to full payment from the Judgment Fund of the $24,993,849 in 2014, 2015 and 2016 risk corridors payments.

78. OHC is also entitled to full payment based on any other available funds or legal theories.

COUNT TWO
(Breach of Implied-in-Fact Contract)

79. Plaintiff re-alleges and incorporates ¶¶ 1–78 of the Complaint as if set forth fully herein.

80. OHC and CMS entered into an implied-in-fact contract requiring CMS to make risk corridors payments to OHC in the amount specified in Section 1342 and CMS's implementing regulations. Specifically, OHC agreed to sell and provide health care coverage to individuals under Qualified Health Plans in 2014, 2015, and 2016, subject to state and federal laws, regulations, and policies, in exchange for timely reimbursement from the Government, including

advance payment of tax credits for qualifying enrollees, cost sharing subsidies for qualifying enrollees, and risk corridors payments in the amount specified in Section 1342 and CMS's implementing regulations.

81. The terms of the offer and acceptance were unambiguously specified in the ACA and CMS's implementing regulations.

82. CMS agreed to this implied contract by and through the words and actions of Kevin Counihan, Director of CCIIO and CEO of the Health Insurance Marketplaces, and his predecessors in that position; Andrew Slavitt, Administrator of CMS, and his predecessors in that position; and/or other HHS and CMS officials, all of whom had actual authority to bind the Government. The Parties' implied-in-fact contract is confirmed by the Parties' statements, actions, and performance.

83. OHC satisfied its contractual obligations by selling and providing Qualified Health Plan coverage to qualifying individuals in 2014, 2015, and 2016.

84. The Government breached its contractual duty to OHC by:

a. Paying only $256,970 of the total $1,528,717 to which OHC is entitled in risk corridors payments for 2014;

b. Refusing to pay any of the $13,130,119 in risk corridors payments owed to OHC for 2015; and

c. Refusing to pay any of the $10,591,983 in risk corridors payments owed to OHC for 2016.

85. The mere failure of Congress to appropriate funds does not defeat the Government's contractual obligations. The Government is obligated to make full payment to OHC, using the Judgment Fund. OHC is entitled to full payment from the Judgment Fund of the

$1,271,747 in unpaid 2014 risk corridors payments, $13,130,119 in unpaid 2015 risk corridors payments, and $10,591,983 in unpaid 2016 risk corridors payments.

86. OHC is also entitled to full payment based on any other available funds or legal theories.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully asks this Court to enter judgment in its favor and against Defendant and to:

A. Award Plaintiff monetary relief equal to the difference between the amount Plaintiff received in risk corridors payments for 2014, 2015, and 2016 under Section 1342 and the amount it should receive or should have received under Section 1342;

B. Award damages sustained by the Plaintiff, in the amount equal to the difference between the amount Plaintiff received in risk corridors payments for 2014, 2015, and 2016 under Section 1342 and the amount it should receive or should have received under Section 1342;

C. Award Plaintiff such additional damages and other monetary relief as is available under applicable law;

D. To the extent available, award Plaintiff pre-judgment and post-judgment interest;

E. To the extent available, award Plaintiff costs and attorneys' fees; and

F. Award Plaintiff such other and further relief as this Court may deem necessary and proper.

Respectfully submitted,

/s/ Caroline M. Brown

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