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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

FILED
Nov 29 2017
U.S. COURT OF
FEDERAL CLAIMS

SCOTT AND WHITE HEALTH PLAN and INSURANCE COMPANY OF SCOTT AND WHITE,	§	
Plaintiffs,	§	
v.	§	**No.** 17-1850 C
THE UNITED STATES OF AMERICA,	§	
Defendant.	§	

COMPLAINT

Plaintiffs Scott and White Health Plan (SWHP) and Insurance Company of Scott and White (ICSW) bring this action against Defendant The United States of America for money damages resulting from its failure to make full risk-corridors payments to Plaintiffs for calendar years 2014, 2015, and 2016, as required by (1) Section 1342 of the Patient Protection and Affordable Care Act (the ACA), 42 U.S.C. § 18602, and its implementing regulation, 45 C.F.R. § 153.510(b), and (2) the parties' implied-in-fact contracts.

NATURE OF THIS ACTION

1. In late March 2010, the face of healthcare in the United States was changed radically by the ACA's enactment, Pub. L. 111-148. Before the ACA became effective on January 1, 2014, health insurers, such as Plaintiffs, among other things, could deny coverage to individuals and families, exclude pre-existing conditions from insurance coverage, and vary insureds' premiums based on their individual health status. After the ACA became effective, such practices were prohibited, beginning with health-insurance plans offered in the 2014 individual and small-group health-insurance market. This was a dramatic change from the pre-ACA practices governing health insurance in most states—especially in the individual health-

insurance market—and created a huge amount of uncertainty for insurers about who would sign up for coverage and their medical costs. Defendant, as well as the health-insurance industry, lacked the information and experience to predict the needs of newly insureds signing up for health-insurance plans starting in 2014 and models to accurately price them to reflect the medical costs associated with this new and untested marketplace.

2. The ACA also required individual health-insurance plans to provide coverage for certain benefit categories—ambulatory-patient services, emergency services, hospitalization, maternity and newborn care, mental-health and substance-use-disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic-disease management, and pediatric services—that often were not covered in pre-ACA plans. It further required certain benefits, which previously were subject to copays or other cost-sharing mechanisms, to be provided to insureds at no cost, making it difficult for insurers to predict their utilization once the ACA became effective.

3. In recognition of these uncertainties, the ACA created three programs—each of which was to be administered annually—to mitigate insurers' risks in the new health-insurance marketplace and to induce insurers to participate in it. Colloquially known as the "Three Rs," the programs are a permanent risk-adjustment program, a temporary transitional-reinsurance program, and a temporary risk-corridors program. This action is about the third one—the risk-corridors program.

4. A risk-corridors program helps mitigate the risk for insurers participating in a new insurance market by limiting unexpectedly high losses. Modeled after a similar program enacted as part of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act, the ACA's risk-corridors program, Section 1342, helped entice insurers, such as Plaintiffs, to offer

Qualified Health Plans (individually a QHP, and collectively, QHPs) by requiring Defendant to share in the QHP issuers' losses above certain thresholds during the ACA's first three calendar years, 2014-2016. In return for the loss sharing, Section 1342 also required QHP issuers to share with Defendant their profits above certain thresholds during those years.

5. This loss-sharing induced insurers, such as Plaintiffs, to sell QHPs by limiting their risk during the ACA's early years. No matter how experienced an insurer was, the new demographics of insureds and the new required benefits meant that there was an unpredictable level of risk in how the market would operate. The risk-corridors program protected insurers that either were unable to accurately estimate and price that risk because of the lack of information about, and experience in, the market or had an unexpectedly high number of sick insureds buy their plans by giving them payments to buffer their losses. In return for this buffer, QHP issuers that either priced their premiums higher than the total medical costs plus estimated profit or had lower-than-expected numbers of costly insureds buy their QHPs paid Defendant a part of their profit while the newly-created insurance market stabilized.

6. The risk-corridors program was intended to (a) encourage healthcare insurers to sell QHPs, (b) reduce the likelihood that QHP issuers would include in their premiums an additional amount to guard against the risk and uncertainty of insuring a new and unknown population of insureds, (c) provide a safety net sufficient to keep QHP issuers in business, (d) provide for year-over-year stability in premiums for consumers, and (e) provide QHP issuers with time to learn about the new market so that they could adjust their QHP pricing accordingly. QHP issuers were supportive of this program because it would allow them to sell QHPs while providing a safety net against extreme losses.

7. Section 1342 of the ACA and its implementing federal regulation, 45 CFR § 153.510(b), are unequivocal about the risk-corridors payments that Defendant must make. If a QHP insurer's losses for policies during calendar years 2014-2016 exceeded certain defined amounts, then Defendant *must* pay it a defined part of the losses the following year. Conversely, if the QHP insurer's profits during those years exceeded certain defined amounts, it must pay Defendant a defined part of them during the following year.

8. Despite these express and binding obligations, there have been many attempts to prevent Defendant from timely making risk-corridors payments to the QHP issuers insuring millions of previously uninsured and under-insured Americans. From its inception, the ACA has been the subject of great controversy, and politically-driven spending bill disputes and appropriations acts that have unlawfully and inappropriately interfered with Defendant's ability to make due and owing risk-corridors payments.

9. In the Consolidated and Further Continuing Appropriations Act for 2015, Pub. L. 113-235 (the 2015 Spending Bill), a year later in the Consolidated Appropriations Act for 2016, Pub. L. 114-113 (the 2016 Spending Bill), and once more in the Consolidated Appropriations Act for 2017, Pub. L. 115-31 (the 2017 Spending Bill and with the 2014 Spending Bill and the 2015 Spending Bill, the Spending Bills), Congress included riders prohibiting the agencies responsible for the ACA's administration, the Centers for Medicare & Medicaid Services (CMS) and its parent department, the United States Department of Health & Human Services (HHS), from making risk-corridors payments from funds established for, or appropriated to, CMS and HHS.

10. The Spending Bills have prevented HHS and CMS from paying QHP issuers, such as Plaintiffs, their full risk-corridors receivables for calendar years 2014, 2015, and 2016.

This, in turn, has created an extraordinary burden on such insurers because, as many industry experts predicted, each of those years were incredibly tumultuous in the new health-insurance market. For example, during 2014 and 2015, QHP issuers incurred almost $8.67 billion in losses that were compensable under the risk-corridors program, and, on information and belief, losses for calendar year 2016 will be about the same as those in the prior years. Due to the 2015 Spending Bill and 2016 Spending Bills, however, more than $8 billion of the mandatory risk-corridors payments for calendar years 2014 and 2015 were not paid, and the 2017 Spending Bill continues the nonpayment for calendar year 2016.

11. As result of the nonpayment of risk-corridors receivables, many insurance companies experienced cash-flow problems or were unable to meet regulatory reserve requirements. Those QHP issuers that have been unable to remedy the cash-flow or reserve shortfalls have been forced out of business. This, in turn, has forced hundreds of thousands of Americans to switch to other QHP issuers, often with less attractive pricing or different provider networks, requiring their insureds to switch doctors.

12. The nonpayment of the required risk-corridors receivables also required QHP issuers to raise their rates greatly while decreasing benefits to protect against potential losses from the new risk pool that needs more time to stabilize, resulting in much higher costs to American taxpayers in the long run than the temporary risk-corridors program itself.

13. By this lawsuit, Plaintiffs, who are QHP issuers, seek to recover the risk-corridors payments due and owing to them by Defendant. Despite its after-the-fact politicization, the risk-corridors program, which is far and away the smallest of the Three Rs, was the most important of them in the ACA's crucial early years because its purposes were to induce health insurers, such as Plaintiffs, to sell QHPs and to allow QHP issuers to function and survive while the new health

insurance market stabilized and more risk and cost data became available. The law is clear: Defendant must abide by its statutory and contractual obligations to make risk-corridors payments fully and timely. By this action, Plaintiffs seek to compel it do so.

JURISDICTION

14. This Court has subject-matter jurisdiction over this action under the Tucker Act, 28 U.S.C. § 1491(a), which allows this Court to hear claims for money damages against Defendant "founded either upon . . . any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States . . . ." As discussed below, Section 1342 of the ACA is a statute requiring Defendant to make risk-corridors payments to QHP issuers, such as Plaintiffs; Section 153.510(b) of Title 45 of the Code of Federal Regulations (the Code) is a HHS regulation requiring Defendant to make such payments to such issuers; and implied-in-fact contracts exists between Plaintiffs and Defendant requiring such payments.

15. This controversy is ripe because CMS and HHS have not timely made all risk-corridors payments due to SWHP for calendar years 2014 and 2015 and have said that they will not timely pay Plaintiffs the full amount of such payments due for calendar year 2016, all as required by the foregoing statute and regulation and the parties' contract.

PARTIES

16. SWHP is a not for profit Texas health maintenance organization with its principal place of business at 1206 West Campus Drive, Temple, Texas 76502. Because it offered QHPs during calendar years 2014-2016, it was entitled to risk-corridors payments under Section 1342 of the ACA and its implementing regulations for calendar years 2014-2016.

17. ICSW, an affiliate of SHWP, is a Texas licensed for-profit insurance company with its principal place of business at 1206 West Campus Drive, Temple, Texas 76502. Because it offered QHPs during calendar years 2015 and 2016, it was entitled to risk-corridors payments under Section 1342 of the ACA and its implementing regulations for calendar years 2015 and 2016.

18. Defendant is the United States of America, acting through the HHS and CMS.

FACTUAL ALLEGATIONS

A. The Risk-Corridors Program.

19. The ACA has three insurance premium stabilization programs. Known colloquially as the "Three Rs," they are (a) a permanent risk-adjustment program, which collects funds from health-plan providers in the individual and small-group markets that have enrolled lower-risk enrollees and transfers the funds to health-plan providers that have enrolled higher risk enrollees, (b) a temporary reinsurance program, which collects contributions from all commercial health-plan providers based on the number of its insureds and pays those funds to health-plan providers based upon their high-cost claims in the individual and small-group markets, and (c) a temporary risk-corridors program. Both the reinsurance and risk-corridors programs were for the ACA's first three calendar years, 2014-2016, and were to be administered annually.

20. Section 1342 of the ACA mandates the risk-corridors program. It provides, in pertinent part:

> (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 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 the allowable costs in excess of 108 percent of the target amount.

42 U.S.C. § 18062 (emphasis added). Section 1342 also requires QHP issuers to pay escalating portions of any outsized profits made during calendar years 2014-2016. *Id.* § 1342(b)(2). "Allowable costs" and "target amounts" as used in Section 1342's "payments-out" and "payments-in" provisions are defined by the statute. *Id.* § 1342(c).

21. As directed by the ACA, HHS adopted regulations implementing the risk-corridors program. Section 153.500 of the Code defines all necessary terms (including, among others, "qualified health plan," "risk corridors," "allowable costs," and "target amount"), and Section 153.510 of the Code implements the risk-corridors program. It provides, in pertinent part:

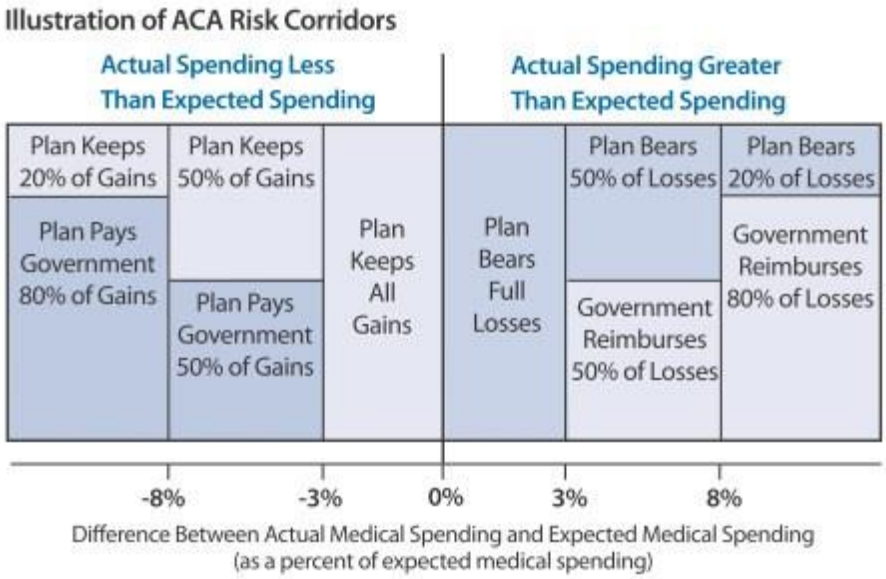
> (b) HHS payments to health insurance issuers. *QHP issuers will receive payment from HHS in the following amounts, under the following circumstances*:
>
> (2) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, *HHS will pay the QHP issuer* an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

> (3) 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.

45 C.F.R. § 153.510(b) (emphasis added).

22. This payment regulation, as well as a companion regulation about the risk-corridors requirements, further mandate that QHP issuers must (a) adhere to the requirements set by HHS for participants in the risk-corridors program, (b) satisfy certain requirements with respect to defining their premium data and administrative and other allowable costs, and (c) timely submit all necessary information for risk-corridors payment calculations. 45 C.F.R. §§ 153.510, 153.530. If QHP issuers abide by these requirements and satisfy the necessary criteria, they are eligible for "payments out" from the risk-corridors program after the payment amount is calculated.

23. Section 1342 of the ACA and Section 153.510 of the Code further provide that if a QHP issuer's actual claims in a calendar year covered by the risk-corridors program are 3 to 8 percent or greater than the claims projected when the issuer set rates for the year, Defendant must reimburse the issuer for half of the excess. If, however, actual claims are more than 8 percent greater than the projected claims, Defendant essentially covers 80 percent of the excess. The following chart from the American Academy of Actuaries shows this obligation and the QHP issuers' corresponding obligation to pay Defendant, if their profits exceed certain amounts:



24. Simply put, the risk-corridors program's adoption was a recognition of the reality that QHP issuers generally would have less experience in how to accurately price policies in the individual market rather than the group market and no experience estimating benefit utilization, risk-pool composition, and medical-spending costs for QHPs, which included new demographics and new mandatory coverage requirements. The risk-corridors program was designed to draw in issuers and help keep premiums at manageable levels while the issuers developed enough experience to properly price their QHPs without a safety net. The goal was to create a "virtuous cycle," that is, by keeping premiums low, more people would buy QHPs, which, in turn, would allow issuers to develop the necessary utilization, cost, and risk-pool experience required to help them accurately set premiums and offer more expansive health-insurance plans, which, in turn, would draw in yet more insureds. A broad collection of economists, health-policy experts, insurance companies, and regulators agreed with the fundamental principles underlying the risk-corridors program and, therefore, strongly supported its inclusion in the ACA.

25. Based on the risk-corridors program and the other two "Three R" programs, hundreds of issuers, including Plaintiffs, offered thousands of QHPs. Since QHPs were first

offered in January 2014, it has become clear that the risk-corridors program is—as predicted—highly necessary for many of the QHP issuers to survive the early, tumultuous years of the new insurance market. However, it bears noting, even at full payment, the risk-corridors program is by far the smallest of the "Three R" programs.

B. The Risk-Corridors Program Is Politicized Just as It Began

26. Since its enactment, the ACA has been controversial. It twice has withstood scrutiny before the United States Supreme Court, and still faces certain legal and political challenges. The risk-corridors program, however, was largely uncontested during the ACA drafting process. This likely is because, as noted above and expressly provided in Section 1342(a) of the ACA, it was based on a similar program contained in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act.

27. Even though the risk-corridors program has neither been amended nor repealed in any respect since the ACA's enactment, Defendant has taken steps to frustrate it. The first such step was in early 2014, when HHS and CMS unexpectedly took the position that the program needed to be self-funding—or "budget neutral"—even though neither the ACA nor its implementing regulations provide for this.

28. For example, on March 11, 2014, HHS's final "Notice of Benefit and Payment Parameters for 2015," for the first time, included language in the rule commentary saying that the agency would apply a budget-neutral approach:

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

29. Similar language about budget neutrality was found throughout the rule on the CMS's "Exchange and Insurance Market Standards for 2015," published on March 2, 2014.

30. HHS, however, had made contrary statements in the past, noting that it would not apply budget neutrality to the risk-corridors program because it could *not* legally do so. For example, in its March 2013 "Notice of Benefit and Payment Parameters for 2014," the first year of QHPs sales and the risk-corridors program, 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 ACA." 78 Fed. Reg. 15,410, at 15,473.

31. On April 11, 2014, CMS issued a statement entitled "Risk Corridors and Budget Neutrality," noting that—

> if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments.

The document further said that future guidance would explain what would happen if there was still a shortfall after calendar year 2016.

32. In essence, HHS and CMS, without any basis in the ACA or its implementing regulations, said that the risk-corridors program would be administered by them to be budget neutral so that (a) if there was shortfall for calendar year 2014, QHP issuers, such as Plaintiffs, that were owed money under the program would only receive their pro-rata shares of what was paid in by other QHP issuers, and (b) if there were similar shortfalls in calendars 2015 and 2016, HHS and CMS would kick the can further down the road and let issuers know in 2017 or later when and how Defendant planned to make its mandatory risk-corridors payments for those years.

33. When HHS and CMS made these decisions, there also was a major debate on congressional appropriations and spending. While Budget neutrality likely was HHS's and CMS's solution to a difficult situation imposed by the ongoing spending debates, it was unsupported by the law. Section 1342 of the Act and Section 153.510 of the Code each affirmatively state that Defendant "shall" and "will" make risk-corridors payments to QHP issuers if they meet the statutory requirements, and that such QHP issuers "will receive payment from HHS" if they meet those requirements. Nothing in the statute or regulation allows risk-corridors payments to be paid solely from payments to Defendant by other QHP issuers or to be budget neutral. Nor do they allow Defendant to delay the risk-corridors payments owed for one calendar year until after the next calendar year's collections. In fact, QHP issuers are required to make their risk-corridors payments within thirty days after they receive notice of the amounts they owe under the risk-corridors program. 45 CFR § 153.510(d).

34. Notwithstanding HHS's and CMS's attempted solutions to portions of the spending debate, Congress soon took a far more drastic step. In late 2014, it adopted a massive spending bill to address many aspects of the federal government's budget. During this process, a contingent of Congressmen opposed to the ACA attached a rider to what eventually became the 2015 Spending Bill. This rider's goal was to prevent HHS and CMS from making risk-corridors payments from government funds. Thus, the 2015 Spending Bill provided, in pertinent part:

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

Pub. L. 113-235 at 362.

35. The 2015 Spending Bill was enacted on December 16, 2014, about a year after Plaintiffs and the hundreds of other QHP issuers began offering QHPs and eighteen or more months after they had submitted QHP rates for regulatory approval. Faced with this new development, QHP issuers, such as Plaintiffs, continued to abide by their obligations to Defendant and their insureds despite receiving little immediate guidance as to what would happen with respect to the risk-corridors payments.

36. Another provision was inserted into the following year's spending bill:

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

Pub. L. 114-113 at 383.

37. The 2016 Spending Bill, however, went one step further than the 2015 Spending Bill, specifically providing that special amounts appropriated to CMS and HHS in 2016 could *not* be used to fund the risk-corridors program:

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

Id. at 384 (emphasis added).

38. The 2017 Spending Bill has the same limitations as the 2016 Spending Bill with respect to 2017 HHS and CMS appropriations and their use for risk-corridors payments. Pub. L. 115-31, § 223.

39. Although the Spending Bills effectively tied HHS's and CMS's hands with respect to their obligation to make the risk-corridors payments expressly required by the ACA and its implementing regulations for calendar years 2014-2016, their text is significant because they only provide that HHS and CMS *cannot use certain sources of funds* to satisfy Defendant's risk-corridors-payment obligation. They do not speak to the obligation's continuing existence, and could not do so under applicable law because Plaintiffs (and other QHP issuers) have satisfied their obligations under Section 1342 of the ACA and Section 153.510 of the Code.

C. Constrained By The Spending Bill's Provisions, CMS And HHS Default On 87.5 Percent Of The 2014 Calendar Year Risk-Corridors Payments And 100 Percent Of The 2015 And 2016 Calendar Year Risk-Corridors Payments Due To SWHP And 100 Percent Of The 2016 Calendar Year Risk-Corridors Payments Due To ICSW.

40. As noted above, SWHP offered QHPs during calendar years 2014-2016, and ICSW offered QHPs during calendar years 2015 and 2016. In doing so, Plaintiffs relied on, among other things, the ACA's risk-corridors program and its implementing regulation's promise that risk-corridors payments would be made to qualifying QHPs issuers fully and timely.

41. SWHP has complied in all material respects with all statutory and regulatory requirements to be eligible for payments under the ACA's risk-corridors program for calendar years 2014-2016. ICSW likewise has complied in all material respects with all statutory and regulatory requirements to be eligible for payments under that program for calendar years 2015 and 2016.

42. For calendar year 2014, SWHP, as acknowledged by Defendant, was due $770,409 in risk-corridors payments under the ACA and its implementing regulations. Because of the 2015 Spending Bill and because risk-corridors losses greatly exceeded risk-corridors gains under Section 1342 of the Code and its implementing regulations, CMS announced on November 19, 2015, that SWHP would be paid 12.6 percent of that amount, or $97,209. This percentage

was calculated by prorating the $363 million paid into the risk-corridors program by QHP issuers for calendar year 2014 across the $2.8 billion in risk-corridors payments due to QHP issuers for that year.

43. For calendar year 2015, SWHP, as acknowledged by Defendant, was due $20,981,838 in risk-corridors payments. Because of the 2016 Spending Bill and because risk-corridors losses for the year again greatly exceeded risk-corridors gains under Section 1342 of the Code and its implementing regulations, CMS, on November 18, 2016, confirmed that it would not make risk-corridors payments due and owing to QHP issuers, such as SWHP, for the 2015 calendar year, but instead would make more calendar year 2014 payments to such issuers during the winter of 2016-17 and that SWHP would be paid an additional $25,591 of its 2014 calendar year risk-corridors receivable.

44. For calendar year 2016, SWHP and ICSW, as acknowledged by Defendant, were due $25,086,485 and $75,429,033, respectively, in risk-corridors payments. Because of the 2017 Spending Bill and because risk-corridors losses for the year again greatly exceeded risk-corridors gains under Section 1342 of the Code and its implementing regulations, CMS, on November 13, 2017, advised QHP issuers, such as SWHP and ICSW, that it would not make the risk-corridors payments due and owing to them for the 2016 calendar year, but instead would make more calendar year 2014 payments to such issuers during the winter of 2016-17 and that SWHP would be paid an additional $6,701 of its 2014 calendar year risk-corridors receivable during 2018, leaving unpaid tens of millions of dollars in risk-corridors payments owed to SWHP for calendar years 2015 and 2016 and to ICSW for calendar year 2016. To date, SWHP has been paid only $114,266 of its risk-corridors payment due and owing for calendar year 2014, leaving $656,143 due and owing for that year.

45. Congress's failure to appropriate enough funds for risk-corridors payments for the 2014, 2015, and 2016 calendar years without changing or repealing Section 1342 of the ACA did not eliminate or abrogate Defendant's obligation to make full and timely risk-corridors payments to Plaintiffs and other QHP issuers for calendar years 2014-2016.

CAUSES OF ACTION

A. Count 1—Violation of Statutory and Regulatory Mandates to Make Risk-Corridors Payments.

46. Plaintiffs incorporate by reference Paragraphs 1 through 45 above as if fully set forth in this Count 1.

47. Pursuant to Section 1342 of the ACA and its implementing regulations, Defendant "shall establish" a risk-corridors program under which it was required without qualification to make full and timely risk-corridors payments to qualifying QHP issuers, such as Plaintiffs.

48. Plaintiffs offered certified QHPs in accordance with the processes prescribed by ACA and its implementing regulations, and Plaintiffs are QHP issuers for purposes of payments under the risk-corridors program. *See* 45 C.F.R. §§ 153.500, 155.20.

49. In 2014, 2015, and 2016, SWHP's allowable costs exceeded its target amount by substantially more than eight percent. It timely submitted all necessary data and complied with all other requirements for obtaining a payment under the ACA's risk-corridors program. *See* 45 C.F.R. § 153.530. Accordingly, Section 1342 of the ACA and Section 153.510(b) of the Code required Defendant to make risk-corridors payments of $46,838,732 to SWHP for the 2014-2016 calendar years. This mandate gave no discretion to Defendant as to the amount or timing of the payments. To date, Defendant has made risk-corridors payments of only $114,266 to SWHP, leaving $46,724,466 in such payments presently due and owing to SWHP by Defendant.

50. In 2016, ICSW's allowable costs exceeded its target amount by substantially more than eight percent. It timely submitted all necessary data and complied with all other requirements for obtaining a payment under ACA's risk-corridors program. *See* 45 C.F.R. § 153.530. Accordingly, Section 1342 of the ACA and Section 153.510(b) of the Code required Defendant to make a risk-corridors payment of $75,429,033 to ICSW for calendar year 2016. This mandate gives no discretion to Defendant as to the amount or timing of this payment. To date, Defendant has paid nothing to ICSW, leaving $75,429,033 presently due and owing to ICSW by Defendant.

51. Defendant's failure to fully and timely make the foregoing risk-corridors payments to Plaintiffs is a violation of Section 1342 of the ACA and Section 153.510(b) of the Code, and Plaintiffs have been damaged by them.

B. Count 2—Breach of Implied-In-Fact Contract.

52. Plaintiffs incorporate by reference Paragraphs 1 through 45 above as if fully set in this Count 2.

53. Each Plaintiff entered into a valid implied-in-fact contract with Defendant regarding Defendant's obligation to make full and timely payments under the ACA's risk-corridors program to such Plaintiff in exchange for it becoming a QHP issuer and offering QHPs during calendar years 2014-2016 for SWHP and calendar years 2015 and 2016 for ICSW.

54. Defendant made an unambiguous offer to Plaintiffs of a contract, provided that Plaintiffs fulfilled certain criteria, which they could accept by performance.

55. Specifically, Section 1342 of the ACA authorized HHS to enter into contracts to share in the profits and losses of issuers who offered QHPs. HHS's Notices of Benefit and Payment Parameters represented an offer to Plaintiff that if it sold QHPs, "[r]egardless of the

balance of payments and receipts, HHS will remit payment as required under section 1342 of the Affordable Care Act," 78 Fed. Reg. at 15,473, meaning that the Defendant would reimburse Plaintiffs for a share of its losses if its allowable costs were "more than three percent . . . of the target amount," 42 U.S.C. § 18062(b)(1).

56. Section 1342 of the ACA and Section 153.510(b) of the Code are objective manifestations of Defendant's intent to contract with insurers, such as Plaintiffs.

57. By complying with its obligations under Section 1342 of the ACA and its implementing regulations and by timely submitting all required data for risk-corridors calculations, Plaintiffs accepted Defendant's offer and thereby manifested its assent in the manner required by the ACA. Accordingly, an implied-in-fact contract between each Plaintiff and Defendant exists.

58. This contract was authorized or ratified by and through the words and actions of various HHS and CMS officials, all of whom had actual authority to bind Defendant, and was entered into with the mutual assent and consideration by both parties.

59. Plaintiffs have satisfied and complied with their obligations under their contracts.

60. Pursuant to the contracts, Defendant was obligated to make risk-corridors payment to (a) SWHP of $46,838,732 for calendar years 2014-2016, and (b) ICSW of $75,429,033 for calendar year 2016. Defendant has paid only $114,266 of the amount owed to SWHP and none of the amount owed to ICSW, and, therefore, owes SWHP and ICSW respectively $46,724,466 and $75,429,033 in risk-corridors payments.

61. On behalf of the Defendant, CMS and HHS have acknowledged their obligation to make all risk-corridors payments due for calendar years 2014-2016.

62. Defendant has breached its implied-in-fact contracts with Plaintiffs by failing to fully and timely make risk-corridors payments to them.

PRAYER FOR RELIEF

Wherefore, Plaintiffs pray for judgment:

A. awarding SWHP $46,724,466 and ICSW $75,429,033 for Defendant's failure to fully and timely pay them their risk-corridors payments due and owing to them;

B. awarding Plaintiffs pre- and post-judgment interest as allowed by law;

C. awarding Plaintiffs consequential damages, special damages, or other damages that result because of Defendant's non-performance and contract breaches;

D. awarding Plaintiffs court costs, litigation expenses, and attorney's fees as allowed by law; and

E. awarding Plaintiffs such other and further relief as the Court deems proper and just.

Respectfully submitted,

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