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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

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U.S. COURT OF
FEDERAL CLAIMS

BLUE CROSS & BLUE SHIELD OF VERMONT,
Plaintiff,

v.

THE UNITED STATES OF AMERICA,
Defendant.

Case No. 18-373 C

COMPLAINT

Plaintiff Blue Cross & Blue Shield of Vermont (BCBSVT) brings this action to recover damages caused by the federal government's failure to reimburse it, and many other health insurers, for the cost of benefits guaranteed under the Affordable Care Act (ACA). Under the ACA, low-income Americans are eligible for two kinds of federal subsidies to make health insurance more affordable: advance premium tax credits, which reduce the cost of insurance premiums; and cost-sharing reductions, which reduce out-of-pocket costs such as deductibles and co-payments without increasing premiums. This case is about the cost-sharing reductions (CSRs).

By design, CSRs are benefits flowing from the federal fisc to the ACA's intended low-income beneficiaries. For pragmatic reasons, the ACA enlists insurers as conduits for this benefit by requiring them to provide the CSRs to their eligible insureds. In the next breath, the ACA then requires the federal government to make the insurers whole with "timely and periodic" payments sufficient to cover the CSRs the insurers provided.

For three-and-a-half years, the federal government did just that. In October 2017, however, it halted its payments to insurers. As a result, while BCBSVT must continue to provide, under the law, CSR benefits to its eligible insureds, BCBSVT receives no reimbursement from the federal government for those costs—even though the ACA unequivocally requires this of the government. The government's default has caused substantial financial harm to BCBSVT.

Through this action, BCBSVT seeks to enforce the federal government's obligation to cover the CSR benefits BCBSVT provides under the ACA. BCBSVT seeks as damages all CSR payments that the federal government has failed to make since the beginning of October 2017. In support of its claims, BCBSVT alleges as follows:

JURISDICTION AND VENUE

1. The Court has subject-matter jurisdiction and venue lies in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491. The money-mandating statute that provides Tucker Act jurisdiction is Section 1402 of the Affordable Care Act, codified at 42 U.S.C. § 18071. That statute requires the federal government to make CSR payments to issuers of qualified health plans under the ACA. A federal regulation that implements Section 1402, 45 C.F.R. § 156.430, likewise mandates that the federal government make these payments. BCBSVT seeks monetary damages of more than $10,000 for the federal government's violation of these money-mandating provisions.

2. The Court also has subject-matter jurisdiction pursuant to the Tucker Act over Plaintiff's contract claims.

3. The Court also has subject-matter jurisdiction pursuant to the Tucker Act over Plaintiff's Takings Clause claim.

4. The actions and decisions of the agencies of the federal government at issue in this action were conducted on behalf of the Defendant within the District of Columbia.

5. BCBSVT has standing and this dispute is ripe because the federal government has failed to pay cost-sharing reduction payments presently due and owing to BCBSVT.

PARTIES

6. Plaintiff BCBSVT is a nonprofit hospital service corporation and a nonprofit medical service corporation organized under the laws of Vermont, with its principal place of business in Berlin, Vermont. *See* Vt. Stat. Ann. tit. 8, §§ 4511–23 (defining nonprofit hospital service corporations); *id.* §§ 4581–95 (defining nonprofit medical service corporations). The company has been a key component of Vermont's health care landscape for more than 30 years, consistently committed to the health of Vermonters, outstanding member experiences, and responsible cost management.

7. BCBSVT is Vermont's largest health insurer, writing coverage for over 140,000 Vermonters, and covering approximately 70% of Vermont's fully-insured major medical health insurance market. This includes approximately 70,000 members enrolled in coverage through Vermont Health Connect (VHC), Vermont's ACA-mandated health benefit exchange, making up more than 80% of VHC's total enrollment.

8. Since the inception of Vermont Health Connect, BCBSVT—one of only two participating health insurers—has actively supported the ACA's and the State's shared aim that "[a]ll Vermonters . . . receive affordable and appropriate health care at the appropriate time in the appropriate setting," 2011 Vt. Acts & Resolves 48, § 1a(1). For example, in one year alone, BCBSVT engaged in-person with over 44,000 Vermonters at over 650 outreach activities; fielded nearly 47,000 calls from Vermonters between April and December 2013; assisted those Vermonters with understanding their coverage options; and anticipated and executed multiple contingency plans to maintain continuity as VHC worked through operational and technical difficulties. These actions reflect BCBSVT's vision of a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care.

9. The Defendant is the United States Government, acting through the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS), a subdivision of HHS.

FACTS

A. The Affordable Care Act Transforms The Health Care And Health Insurance Landscape.

10. In March 2010, Congress adopted the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

11. The ACA transformed the health insurance market as well as the federal government's role in regulating health insurance. As the Supreme Court explained, the ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).

12. Specifically, the ACA set three "key reforms" in motion. *Id.*, 135 S. Ct. at 2486. First, the ACA required insurers in the individual market to offer insurance without regard to a person's health, 42 U.S.C. § 300gg-1 (known as "guaranteed issue"), and prohibited insurers from charging a higher premium based on a person's health, *id.* § 300gg (known as "community rating"). Second, the ACA's "individual mandate" required individuals to maintain health insurance coverage or make a payment to the IRS, 26 U.S.C. § 5000A, in order to "minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums," 42 U.S.C. § 18091(2)(I). Finally, the ACA sought to make health insurance more affordable by providing premium tax credits and by reducing cost-sharing obligations for people below certain income thresholds. 26 U.S.C. § 36B; 42 U.S.C. § 18071. This lawsuit is about those cost-sharing reductions and the government's obligation to pay for them.

B. The ACA Promotes Access To Health Care By Creating Health Benefit Exchanges.

13. To increase access to affordable health insurance, the ACA required the creation in each state of an online health insurance marketplace, known as a health benefit exchange (or, simply, the "exchange"). 42 U.S.C. § 18031(b)(1). The exchange must facilitate the purchase of "qualified health plans" (QHPs), and it can make only QHPs available for purchase. *Id.* §§ 18031(b)(1)(A), (d)(2)(A)–(d)(2)(B)(i).

14. To be a QHP, a health plan must meet a number of criteria. 42 U.S.C. § 18021(a)(1). Among other things, a QHP must provide the "essential health benefits" established by HHS, and must be offered by a state-licensed issuer. *Id.* §§ 18021(a)(1)(B), 18022(a)–(b).

15. QHPs offered on exchanges are classified into four "metal levels"— platinum, gold, silver, and bronze—based on the plans' actuarial values. 42 U.S.C. § 18022(d); 45 C.F.R. § 156.140(a)–(b).

16. Platinum plans have the highest average actuarial values, which means that, under platinum plans, insureds' cost-sharing obligations are the lowest out of the four metal levels and the health insurer bears the greatest portion of covered health care costs. Gold plans have the next lowest cost-sharing obligations, followed by silver, and then bronze plans, which have the highest cost-sharing obligations.

17. A health insurer that offers plans on an exchange must offer QHPs at the gold and silver levels. 42 U.S.C. § 18021(a)(1)(C)(ii). A health insurer is not required to offer platinum or bronze-level plans.

18. Under the ACA, a State has the option of operating its own exchange consistent with the ACA's requirements. 42 U.S.C. § 18031(b). As discussed in more detail below, Vermont elected to operate its own exchange, known as Vermont Health Connect.

19. To be certified by the federal government as complying with the ACA, a state-run exchange must meet federal standards for offering QHPs for the individual and small-group markets. 45 C.F.R. §§ 155.100, 155.105. The small-group market consists of employers with less than either 50 or 100 employees, as defined by each State. 42 U.S.C. §§ 18024(b)(2)–(3).

20. Vermont initially defined small groups as employers with no more than 50 employees, later expanding that limit to 100. Vt. Stat. Ann. tit. 33, §§ 1803(b)(2), 1811(b)(3).

C. The ACA Promotes Affordability Through Premium Tax Credits And Cost-Sharing Reductions.

21. To encourage participation in the exchanges by making health insurance more affordable to a broader cross-section of consumers, the ACA provides for two integrated types of financial support for qualifying individuals: premium tax credits, which subsidize health insurance premiums; and cost-sharing reductions, which reduce a person's out-of-pocket costs without increasing her premiums. Together, they advance the ACA's systematic plan for making health insurance affordable for lower-income individuals.

22. The ACA requires the federal government to provide premium tax credits to eligible individuals who purchase health insurance on the exchanges. Eligible individuals must have household incomes between 100% and 400% of the federal poverty level (FPL). 26 U.S.C. §§ 36B(b)(2)(A), (c)(2)(A)(i).

23. A subset of those who receive premium tax credits are also eligible for cost-sharing reductions. Cost-sharing means the portion of the health care costs that are covered by a person's health insurance, but that, under the terms of the policy, she pays out of her own pocket. Typically, this includes copayments, coinsurance, and deductibles.[1] Cost-sharing does not include insurance

[1] A deductible is "[t]he amount you pay for covered health care services before your insurance plan starts to pay." https://www.healthcare.gov/glossary/deductible/. A copayment is a "fixed amount ($20, for example) you pay for a covered health care service after you've paid your

premiums or additional amounts an insured must pay for services provided by an out-of-network provider.

24. Because insurers directly administer the cost-sharing provisions in the plans they offer, including the QHPs, the ACA uses health insurers as the mechanism to transfer the CSR subsidy from the federal government to the intended low-income beneficiaries. Specifically, Section 1402 requires that insurers reduce the cost-sharing obligations of certain eligible individuals enrolled in silver-level plans. 42 U.S.C. §§ 18071(a)(2), (c). The ACA sets forth the required cost-sharing reductions for eligible individuals with incomes between 100% and 250% of FPL. 42 U.S.C. § 18071(b).

25. These reductions are substantial. Silver-level plans must have actuarial values of at least 70%, meaning that the insurer expects to pay, on average, 70% of the covered health care costs of enrollees in those plans. The ACA's cost-sharing reduction provisions require insurers to increase the actuarial values to 94% for people with incomes between 100% and 150% of FPL, 87% for enrollees with incomes between 150% and 200% of FPL, and 73% for enrollees with incomes between 200% and 250% of FPL.[2]

26. This translates to large reductions in the deductibles and out-of-pocket maximums for eligible enrollees. For example, annual deductibles are reduced, on average, by over $3,000 for enrollees in the 100% to 150% range, by over $2,600 for those in the 150% to 200% range, and by almost $650 for those in the 200% to 250% range. Similarly, average annual individual out-of-

deductible." https://www.healthcare.gov/glossary/co-payment/. Coinsurance is the "percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible." https://www.healthcare.gov/glossary/co-insurance/.

[2] *See* Matthew Rae, et al., *Impact of Cost Sharing Reductions on Deductibles and Out-of-Pocket Limits* at 1, Henry J. Kaiser Family Found. (Mar. 22 2017), https://tinyurl.com/CSR-Impact.

pocket maximums are reduced by almost $5,600 in the 100% to 150% range, by approximately $4,650 in the 150% to 200% range, and by almost $1,300 in the 200% to 250% range.[3] QHP issuers like BCBSVT bear this cost in the first instance, in reliance on the clear statutory commitment that the federal government will reimburse those costs.

D. The Federal Government Must Make Periodic And Timely Payments To Reimburse Insurers Who Provide Qualified Health Plans Subject To Cost-Sharing Reductions.

28. The same section of the ACA that requires insurers to provide the cost-sharing reductions also obligates the federal government to reimburse insurers for the reductions: "An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A). The ACA further provides that the Secretary of HHS shall establish a program that includes "advance payments of . . . reductions to the issuers of the qualified health plans" and the "Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice." 42 U.S.C. §§ 18082(a)(3), (c)(3).

29. HHS adopted regulations that further implement the cost-sharing reductions. The regulations require insurers to apply CSRs for their insureds at the point when insureds would otherwise be required to pay the out-of-pocket costs. *See* 45 C.F.R. § 156.410(a) ("The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.").

30. The regulations reiterate the ACA's requirement that the federal government reimburse insurers for the cost-sharing reductions. The regulations state that insurers "will receive

[3] *Id.* at 2–4 & figs. 1–4.

periodic advance payments based on the advance payment amounts calculated in accordance with § 155.1030(b)(3) . . . .” 45 C.F.R. § 156.430(b). The regulations require QHP issuers to submit specific information to HHS demonstrating the “actual amounts” of the CSRs provided to plan enrollees and obligate HHS to “perform periodic reconciliations” of advance CSR payments against the actual CSRs provided to enrollees. *Id.* §§ 156.430(c)–(d).

E. The Federal Government Made Periodic And Timely Cost-sharing Reduction Payments For Three-And-A-Half Years.

31. Consistent with the ACA and its implementing regulations, HHS established a procedure and schedule for the federal government to make timely and periodic cost-sharing reduction payments to issuers of QHPs. Relying on the permanent appropriation included in the ACA, codified at 31 U.S.C. § 1324(b), HHS did in fact make CSR payments to QHP issuers every month for three-and-a-half years before improperly refusing to pay beginning in October 2017.

32. As its regulation provided, HHS arranged for monthly advance payments to issuers of QHPs. Specifically, HHS established “a payment approach under which HHS would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing amounts.” HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,486 (Mar. 11, 2013).

33. At the end of each plan year, the advance payments are reconciled with the actual cost-sharing reductions that each issuer made on behalf of its insureds. 45 C.F.R. § 156.430(c).

34. Along with the statutes and regulations that mandated these payments to issuers, HHS and CMS consistently stated that the payments would be made. For example, when HHS promulgated the final rule establishing a program of monthly payments, the notice stated that this “approach fulfills the Secretary’s obligation to make ‘periodic and timely payments equal to the

value of the reductions' under section 1402(c)(3) of the Affordable Care Act." HHS Notice, 78 Fed. Reg. at 15,486. The notice further explained that "cost-sharing reductions are reimbursed by the Federal government" and that "QHP issuers will be made whole for the value of all cost-sharing reductions." *Id.* at 15,480, 15,488.

35. Likewise, CMS manuals and guidance consistently advised that issuers "will be reimbursed any amounts necessary to reflect the CSR provided."[4]

36. The federal government made monthly advance payments to issuers of QHPs beginning in January 2014 and continuing through September 2017.

37. The federal government made monthly advance payments to BCBSVT beginning in January 2014 and continuing through September 2017.

F. The ACA Requires Increased Scrutiny Of Health Insurance Rates And Imposes Standards For Participating States Conducting Effective Rate Review.

38. The ACA brought an unprecedented level of scrutiny and transparency to health insurance rates. Coupled with the need to make QHPs ready for sale on exchanges in a timely manner, this amplified the need for state rate review processes to produce final QHP rates months before the January 1 start date of a given plan year.

39. Beginning with health insurance plans covering calendar year 2010, the ACA mandated "a process for the annual review . . . of unreasonable increases in premiums for health

[4] CMS, *Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015*, at 28 (Mar. 16, 2016), https://tinyurl.com/y8qq9yhx; *see also* CMS, *Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2016*, at 6 & n.8 (Dec. 27, 2016), https://tinyurl.com/yaphxuen; CMS, *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year*, at 1 (Feb. 13, 2015), https://tinyurl.com/y9fk3nvz.

insurance coverage." 42 U.S.C. § 300gg-94(a)(1). It required HHS to work with and assist States in reviewing health insurance rate increases. *Id.* §§ 300gg-94(a)(1), (b)(2), (c).

40. If a State has been deemed by CMS to have an Effective Rate Review Program, the State conducts the review of rate increases. 45 C.F.R. §§ 154.210, 154.301.

41. For a State's rate-review process to qualify as an Effective Rate Review Program, the state regulator must consider a detailed list of factors specified in the governing federal regulation, must make certain information publicly available, and must provide an opportunity for public comment. 45 C.F.R. § 154.301.

42. As discussed further below, Vermont has an Effective Rate Review Program through which it conducts the rate review required under the ACA.[5]

43. Because review of proposed health insurance rates is a complex process that requires detailed actuarial analysis and opportunities for public input, insurers are typically required to submit proposed rates for review well in advance.

44. To that end, CMS sets deadlines well before the January 1 start date of each policy year for submissions of proposed rates to States and CMS for review. For policies beginning January 1, 2017, CMS's deadline for insurers to submit rate-review filings to States with Effective Rate Review Programs was July 15, 2016, unless the State set an earlier deadline. CMS set November 1, 2016 as the target date for public posting of final rates.[6]

45. For policy year 2018, the CMS deadline for insurers to submit rate-review filings to States with Effective Rate Review Programs was July 17, 2017, unless the State set an earlier

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[5] CMS, *State Effective Rate Review Programs*, https://tinyurl.com/y9guh6av.

[6] CMS, *Key Dates for Calendar Year 2016: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance* (Feb. 29, 2016), https://tinyurl.com/ybmszjba.

deadline. CMS set November 1, 2017 as the target date for States to post final rate increase information.[7]

46. As discussed below, Vermont regulators required BCBSVT to adhere to a more aggressive timeline, under which it had to submit its rate requests in May of the years in question.

G. Consistent With The ACA's Mandates, Vermont Requires Rate Review, Rate Approval, And Advance Certification Of QHPs.

47. In 2011, the Vermont Legislature passed "Act 48," which, among other things, created Vermont's ACA-mandated health benefit exchange—Vermont Health Connect. 2011 Vt. Acts & Resolves 48, § 4 (adding Vt. Stat. Ann. tit. 33, §§ 1801–32). Vermonters have been using VHC to buy health insurance beginning with the 2014 plan year. The Department of Vermont Health Access is responsible for operating VHC. Vt. Stat. Ann. tit. 33, § 1803(a).

48. As noted above, the ACA requires QHP issuers to make QHPs available, via an exchange, to both individuals and small groups. Beginning January 1, 2016, Vermont law has defined a small employer as "an entity which employed an average of not more than 100 employees on working days during the preceding calendar year." Vt. Stat. Ann. tit. 33, § 1811(a)(3)(B).

49. In creating its exchange and its QHP market, Vermont chose to require small groups—i.e., the employees of small employers—to purchase QHPs. Vt. Stat. Ann. tit. 33, §§ 1803(b)(2), 1811(b)(3). Vermont also chose to structure its QHP market as a merged risk pool that included both the individual and small-group markets, instead of treating each as a separate risk pool. At all times relevant to this action, including through calendar year 2018, insurers have been required to offer QHPs at the same premium rates for individuals and small groups.

[7] CMS, *Key Dates for Calendar Year 2017: Qualified Health Plan Certification in the Federally-facilitated Exchanges; Rate Review; Risk Adjustment, Reinsurance and Risk Corridors* (Apr. 13, 2017), https://tinyurl.com/ycevr7tv.

50. These state-specific policy choices for regulating the small-group market distinguish Vermont from most other states, and place its QHP issuers, including BCBSVT, at a unique disadvantage in the face of the federal government's decision to terminate the CSR payments.

51. Vermonters employed by small employers generally are not eligible for the ACA's premium tax credits, 26 C.F.R. § 1.36B-2, nor for cost-sharing reductions.

52. To be available on Vermont Health Connect, a QHP must have its rates approved pursuant to state law and be selected and certified by the Department of Vermont Health Access. The QHP must be certified in time to comply with all federal requirements and to allow the insurers and the State sufficient time to make the plans available to consumers for open enrollment.

53. To that end, each year the State establishes a timeline requiring that insurers file their rate requests by mid-May and that the plans and rates be submitted to the Department of Vermont Health Access for certification by mid-to-late August. The timeline also provides that the Department will select and certify QHPs by early September.[8]

54. This timeline requires the QHPs to be available for customer browsing on the Vermont Health Connect website before the open enrollment period begins. Indeed, BCBSVT sent out its initial consumer outreach mailing related to its 2018 QHPs on October 6, 2017. As a result, even attempting to change its 2018 QHPs, including the premiums, would have confused consumers, disrupted the VHC enrollment process, and imposed extreme operational burdens on BCBSVT.

[8] *See, e.g.*, Vermont Health Connect, *2018 Qualified Health Plan Certification Timeline* (Dec. 2016), https://tinyurl.com/y8qjglfe.

55. Vermont implemented the ACA's standards for health insurance rate review by charging another state entity, the Green Mountain Care Board (the "Board") with reviewing health insurance rate requests and thereby conducting the effective rate review program required by the ACA. Vt. Stat. Ann. tit. 18, § 9375(b)(6). Specifically, the Board must, within 90 days of receiving an issuer's rate filing, "determine whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State." *Id.* tit. 8, § 4062(a)(3); Green Mountain Care Bd. Rule 2.000, § 2.301(a).

56. Consistent with the State's QHP certification timeline discussed above, the Board typically receives rate requests for QHPs in mid-May and issues its decisions in mid-August.

H. The Government Decided To Discontinue The CSR Payments To Insurers After BCBSVT's 2018 Rates Were Set And Its QHPs Were Finalized And Ready For Consumers.

57. Neither Congress nor the executive branch took action to discontinue the CSR payments prior to state and federal deadlines for rate review and plan certification for the 2018 plan year.

58. In spring 2017, Congress was continuing its work on an overdue appropriations bill for fiscal year 2017 (which began months earlier, on October 1, 2016). Congress typically does not pass appropriations legislation until after the start of the federal fiscal year on October 1. For example, for fiscal years 2011 through 2016, not a single appropriations act was passed prior to October 1.

59. For fiscal year 2017, the Consolidated Appropriations Act was passed on May 4, 2017 and became law on May 5, 2017. *See* Pub. L. No. 115-31, 131 Stat. 135 (2017). Nothing in that Act restricts funding for CSR payments.

60. Shortly before Congress passed the 2017 appropriations bill, House Speaker Paul Ryan stated publicly that it would not include a specific line-item appropriation for cost-sharing reductions because the CSR payments are made separately by the Administration. "CSRs, we're not doing that," Speaker Ryan told reporters. "That is not in the appropriation bill. That's something separate that the administration does."[9] Speaker Ryan's statement confirms that the ACA requires these payments whether or not Congress specifically includes a line-item appropriation and that Congress has not taken action to stop the payments.

61. Congress has not yet acted on appropriations legislation for fiscal year 2018.

62. Congress has never repealed or amended the ACA's cost-sharing reduction provision.

63. Congress has never repealed or amended the ACA's permanent appropriation to prevent its use as authority for making cost-sharing reduction payments.

64. Congress has never included any language in appropriations or other bills preventing HHS, CMS or the Treasury from accessing certain funds or accounts to make CSR payments.

65. Congress has never repealed or amended the ACA's cost-sharing reduction provision so as to change the federal government's obligation to make CSR payments to QHP issuers.

66. Congress has never repealed or amended the ACA's permanent appropriation to prevent its use as authority for making cost-sharing reduction payments.

[9] Paige Winfield Cunningham, *House Republicans look to Trump to fund Obamacare subsidies. They used to sue Obama over this*, Wash. Post (Apr. 26, 2017), https://tinyurl.com/ybkdynsn.

67. However, on October 12, 2017, HHS announced that it would stop making CSR payments immediately "until a valid appropriation exists."[10] The decision rested on the Department of Justice's conclusion that the premium tax credits and CSR payments are distinct programs, and the permanent appropriation in 31 U.S.C. § 1324 only funded the premium tax credits.[11]

I. The Government's Refusal To Pay The CSR Amounts Due And Owing Has Caused BCBSVT Substantial Harm.

68. Pursuant to the state and federal requirements discussed above, BCBSVT's rates and plan designs for its 2017 and 2018 QHPs were fixed before the federal government decided to terminate the CSR payments. The 2017 QHPs were fixed during the fall of 2016, and the rates and plan designs for BCBSVT's 2018 QHPs were fixed on or before September 29, 2017, the deadline DVHA set to complete validation of the plans in the Vermont Health Connect computer systems.

69. The actuarial calculations that supported both BCBSVT's proposed rates and the final rates approved by the Green Mountain Care Board assumed that the federal government would continue to make cost-sharing reduction payments as required by the ACA.

70. Shortly after the federal government terminated the CSR payments, Green Mountain Care Board Chair Kevin Mullin confirmed that the Board would not allow premium increases for 2018 plans in order to address the termination.[12]

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[10] *See* Memorandum from Acting Sec'y Eric Hargan to Seema Verma re Payments to Issuers for Cost-Sharing Reductions (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[11] *Id.* at 2–5 (Letter from Atty. Gen. Jefferson Sessions to Sec'y of Treasury and Acting Sec'y of HHS (Oct. 11, 2017)).

[12] Erin Mansfield, *Federal Upheaval Won't Change 2018 Health Care Premiums*, VTDigger (Oct. 24, 2017), https://tinyurl.com/yar3pj7s.

71. Because BCBSVT's final premium rates had been set by state law before the federal government terminated the cost-sharing reduction payments and the Green Mountain Care Board disclaimed any willingness to consider a rate increase, BCBSVT could not have raised its premiums for its 2018 QHPs.

72. Even if BCBSVT could have sought regulatory approval for a rate increase, notwithstanding the Board's stated objections, any increase in premiums would have applied to all purchasers of its QHP plans, including employees of small employers and others who do not qualify for ACA premium tax credits. As described above, Vermont, unlike other states, merged its individual and small-group markets into a single risk pool. Insurers may only offer QHPs at the same premiums for all participants in the merged risk pool. Therefore, in contrast to insurers in other states, BCBSVT could not raise premiums for its 2017 or 2018 QHPs in a way that restricted the premium increase to individuals who also qualify for premium tax credits.

73. Further, any attempt by BCBSVT to seek regulatory approval for a rate increase after the federal government terminated the cost-sharing reduction payments would have been time-consuming, expensive, burdensome, and disruptive for BCBSVT, VHC, and consumers. Given the regulatory process for rate review, which includes actuarial review, public input, and participation by the Vermont Office of the Health Care Advocate, any decision by the Board would have come after open enrollment began and likely after the policy year began on January 1, 2018. That means that consumers would have been evaluating and choosing plans without any certainty as to their cost, and with the potential for unknowable retroactive rate increases.

74. Moreover, had BCBSVT taken the extraordinary step of requesting a rate increase for its 2018 QHPs, despite the Board's publicly stated position and the burdens such an increase would impose on consumers, the Board would almost certainly have denied the request. Given

Chair Mullin's public statements and the Board's statutory charge to promote affordable rates, such a request had virtually no chance of succeeding.

75. Additionally, Vermont's unique merged risk pool market structure means that, even in the extremely unlikely event the Board had permitted BCBSVT to raise its 2018 QHP premium rates, that increase would have caused the subset of Vermonters who had to buy QHPs but were ineligible for tax credits or CSR benefits (essentially, members of small groups) to pay unexpectedly higher premiums.

76. Such premium increases would have also substantially burdened Vermont consumers who are not eligible for premium tax credits or cost-sharing reductions by effectively forcing them to pay (through those premium increases) for the cost-sharing reductions that the federal government is supposed to fund.

77. In sum, BCBSVT could not use premium increases to cover its 2018 CSR outlays while holding consumers harmless, as most insurers around the country were able to do.

78. Finally, the fact that BCBSVT could not have increased its premiums for the 2018 plan year is confirmed by the state-law changes that were necessary to restructure the Vermont market for plan year 2019. The Vermont Legislature changed Vermont law to allow the Green Mountain Care Board to authorize insurers, "[i]n the event that federal cost-sharing reduction payments to insurers are suspended or discontinued," to create "reflective silver plans" similar to the silver-level QHPs offered on Vermont Health Connect, and to offer those plans for sale to "individuals and employees of small employers." *See* 2018 Vt. Acts & Resolves 88, § 5 (adding Vt. Stat. Ann. tit. 33, § 1813(a)(1)). Second, it requires the Green Mountain Care Board to "ensure" that the rates for silver-level QHPs being sold on Vermont Health Connect "include funding to

offset the loss of the federal cost-sharing reduction payments," and that the reflective silver plans do not include such funding. *See id.* (adding Vt. Stat. Ann. tit. 33, § 1813(a)(2)).

79. BCBSVT has already suffered, and will continue to suffer, severe financial harm as a result of the government's refusal to make the CSR payments. BCBSVT has provided, and continues to provide, all required notifications and information to CMS regarding the cost-sharing reductions BCBSVT has provided to its QHP enrollees. HHS requires QHP issuers to submit that information monthly via an electronic template. BCBSVT has submitted and will continue to submit all such information in a timely manner.

80. Based on the information submitted by BCSBVT, the federal government sends BCBSVT a monthly payment report stating the amount of the advance payment due and owing to BCBSVT.

81. Based on the information BCBSVT has received from the federal government to date, the federal government owes BCBSVT $4,613,449.52 for unpaid advance CSR payments. That amount will increase every month that the federal government fails to make a payment.

82. In short, BCBSVT cannot and will not walk away from its legal obligations, reflected in its 2017 and 2018 QHPs' premiums, to implement the ACA's cost-sharing reduction mechanism, especially given the CSR program's intended beneficiaries: low-income Vermonters. Basic fairness dictates that the government cannot be permitted to do so.

COUNT I

Claim for Money Damages under
42 U.S.C. § 18071(c) and 42 U.S.C. § 18082(c)(3)

83. Plaintiff BCBSVT re-alleges and incorporates paragraphs 1–82 as if fully set forth herein.

84. BCBSVT is an issuer of qualified health plans for purposes of the ACA.

85. Under the ACA, BCBSVT is required to reduce the cost-sharing obligations of its eligible insureds as set forth in 42 U.S.C. § 18071 and 45 C.F.R. § 156.410.

86. At all relevant times, BCBSVT has provided, and continues to provide, the required notice to HHS of its cost-sharing reductions.

87. The ACA expressly obligates the federal government to reimburse BCBSVT in an amount equal to the cost-sharing reductions. 42 U.S.C. § 18071(c)(3)(A).

88. The ACA expressly obligates the federal government to make "periodic and timely" payments to reimburse BCBSVT for the cost-sharing reductions. 42 U.S.C. § 18071(c)(3)(A).

89. Both the ACA and its implementing regulations require the federal government to make regular advance CSR payments to BCBSVT, equal to the full amount of cost-sharing reductions that BCBSVT provides to its eligible insureds. 42 U.S.C. § 18082(c)(3); 45 C.F.R. § 156.430.

90. The federal government has not eliminated or altered its mandate that issuers of QHPs provide cost-sharing reductions to eligible insureds.

91. Congress has not eliminated, limited, or altered the money-mandating statutory and regulatory obligations that require the federal government to reimburse issuers of QHPs for the CSR discounts issuers provide to eligible insureds, nor made those obligations subject to the availability of appropriations.

92. The federal government has not made any CSR payments to BCBSVT since beginning of October 2017.

93. HHS publicly stated in its October 12, 2017 announcement that HHS will no longer make CSR payments to QHP issuers, including BCBSVT.

94. The federal government's failure to make CSR payments to BCBSVT is a violation of federal law, including 42 U.S.C. § 18071 and 45 C.F.R. § 156.430.

95. Each month, HHS acknowledges the amount of unpaid CSR payments that it owes to BCBSVT.

96. Based on the information BCBSVT has received from HHS to date, the federal government owes BCBSVT $4,613,449.52 for unpaid advance CSR payments. That amount increases every month that the federal government fails to make a payment.

97. BCBSVT is entitled to damages for all unpaid cost-sharing reduction payments.

98. As a result of the federal government's violation of 42 U.S.C. § 18071(c) and 42 U.S.C. § 18082(c)(3), and of the relevant implementing regulations, BCBSVT has been damaged in the amount of at least $4,613,449.52 as of the filing of this Complaint, together with interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT II

Claim for Money Damages for Breach of Implied Contract

99. Plaintiff BCBSVT re-alleges and incorporates paragraphs 1–98 as if fully set forth herein.

100. BCBSVT entered into a valid implied-in-fact contract with the federal government for plan years 2017 and 2018, whereby BCBSVT agreed to offer qualified health plans through the Vermont exchange and the federal government agreed to make full and timely CSR payments to BCBSVT.

101. The federal government's offer to make full and timely cost-sharing reduction payments to insurers who agreed to issue qualified health plans on the exchanges was clear and unambiguous, as evidenced by statute, including Section 1402 of the ACA; implementing regulations adopted by HHS, including 45 C.F.R. § 156.430; HHS and CMS statements; the federal

government's consistent practice of making full and timely cost-sharing reduction payments for over three-and-a-half years; and these and other actions by HHS and CMS officials who had authority to bind the federal government.

102. BCBSVT accepted the federal government's offer by agreeing to issue qualified health plans on the Vermont exchange and accepting and complying with the federal government's requirements for issuers of qualified health plans.

103. BCBSVT offered qualified health plans on the Vermont exchange for policy years 2017 and 2018 and otherwise met its obligations under the implied-in-fact contract.

104. The implied-in-fact contract is supported by mutual consideration. BCBSVT provided a benefit to the federal government by offering qualified health plans on the Vermont exchange, a market in which BCBSVT provides coverage to approximately 80% of participating insureds. By offering qualified health plans on the Vermont exchange, BCBSVT's performance of the implied-in-fact contract served the ACA's goal of ensuring access to affordable health insurance coverage. The federal government's offer to reimburse BCBSVT for cost-sharing reductions, and to do so through a system of timely and periodic advance payments, provided a significant benefit to BCBSVT by enabling it to act as a conduit for providing the ACA's CSR benefit to eligible policyholders.

105. Because as an issuer of qualified health plans, BCBSVT would be obligated to provide cost-sharing reductions to eligible insureds, the federal government's agreement to make full and timely cost-sharing reduction payments was a material factor in BCBSVT's decision to offer qualified health plans on the Vermont exchange.

106. The federal government waited to announce its decision to stop making cost-sharing reduction payments until after BCBSVT had complied with federal and state deadlines for

rate review and approval and after the State of Vermont had selected and certified BCBSVT's qualified health plans for sale on Vermont Health Connect.

107. The federal government waited to announce its decision to stop making cost-sharing reduction payments until after BCBSVT had committed to offering qualified health plans on the Vermont exchange.

108. The federal government's conduct, in promising to make cost-sharing reduction payments to issuers of qualified health plans, including BCBSVT; promulgating regulations that implemented the legal requirement to make those payments; and actually making those payments for over three-and-a-half years, was a significant factor in inducing BCBSVT to offer qualified health plans on certain terms in the Vermont exchange.

109. The federal government repeatedly acknowledged and confirmed its obligation to make cost-sharing reduction payments to issuers of qualified health plans, through regulations, guidance, public statements, and litigating positions, all made or ratified by government officials with express or implied authority to bind the federal government.

110. The federal government has not eliminated or altered its mandate that issuers of qualified health plans provide cost-sharing reductions to eligible insureds.

111. Congress has not eliminated, limited, or altered the money-mandating statutory and regulatory obligations that require the federal government to reimburse issuers of qualified health plans for the cost-sharing reductions issuers provide to eligible insureds, nor made those obligations subject to the availability of appropriations.

112. The federal government's failure to make cost-sharing reduction payments to BCBSVT is a material breach of the implied-in-fact contract, and BCBSVT has suffered damages as a result.

113. BCBSVT is entitled to damages of at least $4,613,449.52 for all unpaid cost-sharing reduction payments due and owing as of the filing of this Complaint, together with any other losses actually sustained as a result of the federal government's breach, reliance damages, interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT III

Claim for Money Damages for Unconstitutional Taking without Just Compensation in Violation of the Fifth Amendment

114. Plaintiff BCBSVT re-alleges and incorporates paragraphs 1–113 as if fully set forth herein.

115. Through the actions described in this Complaint, the federal government has effected a deprivation and taking of BCBSVT's property for public use without just compensation, in violation of the Fifth Amendment to the U.S. Constitution.

116. BCBSVT has a vested property interest in its statutory, regulatory, and contractual rights to receive statutorily-mandated cost-sharing reduction payments. BCBSVT had a reasonable investment-backed expectation of receiving the full and timely payments payable to them under express statutory and regulatory mandates, based on its implied-in-fact contracts with the federal government, 42 U.S.C. § 18071(c), HHS's implementing regulations (45 C.F.R. § 156.430), HHS's practice of making those payments for over three and a half year, litigating positions taken by the federal government, and public statements and guidance from HHS and CMS.

117. By its conduct in halting cost-sharing reduction payments in October 2017, the federal government deliberately interfered with and deprived BCBSVT of its investment-based expectation to receive cost-sharing reduction payments. After making those payments for three-and-a-half years and defending that practice in litigation, the federal government halted the payments in October 2017.

118. The federal government did not eliminate or alter its mandate that issuers of qualified health plans provide cost-sharing reductions to eligible insureds.

119. Congress has not eliminated, limited, or altered the money-mandating statutory and regulatory obligations that require the federal government to reimburse issuers of qualified health plans for the cost-sharing reductions issuers provide to eligible insureds, nor made those obligations subject to the availability of appropriations.

120. BCBSVT has been and remains obligated by federal law to provide cost-sharing reductions to eligible insureds but has been unlawfully and unconstitutionally deprived of its vested property interest in receiving reimbursement of those cost-sharing reductions from the federal government.

121. BCBSVT is entitled to receive just compensation for the federal government's taking of its property in the amount of at least $4,613,449.52 as of the filing of this Complaint plus interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT IV

Claim for Money Damages for Breach of the Implied Covenant of Good Faith and Fair Dealing

122. Plaintiff BCBSVT re-alleges and incorporates paragraphs 1–121 as if fully set forth herein.

123. Every contract, express or implied, imposes upon each party a duty of good faith and fair dealing in its performance and enforcement.

124. The duty of good faith and fair dealing is implied in contracts with the federal government.

125. The duty of good faith and fair dealing includes a duty not to interfere with the other party's performance and a duty not to act so as to destroy the reasonable expectations of the other party regarding the fruits of the contract.

126. The duty of good faith and fair dealing is a part of the implied contracts between BCBSVT and the federal government for plan years 2017 and 2018.

127. BCBSVT had a reasonable expectation that the federal government would honor its statutory and contractual obligation to make periodic and timely cost-sharing reduction payments for plan years 2017 and 2018.

128. BCBSVT relied on the expectation of those payments as an important part of the consideration for its implied contracts with the federal government for plan years 2017 and 2018.

129. The federal government had a duty to act so as not to destroy the reasonable expectations of BCBSVT regarding the fruits of the implied contracts for plan years 2017 and 2018.

130. By failing to make the cost-sharing reduction payments, the federal government has interfered with, injured, or destroyed, BCBSVT's right to receive the benefits of the implied contracts, in violation of the breach of the covenant of good faith and fair dealing.

131. The federal government breached the implied covenant of good faith and fair dealing by, at a minimum, promising through legislation to reimburse insurers for the cost-sharing reductions; promising through duly adopted regulations to reimburse insurers for the cost-sharing reductions; and halting the payments to insurers in October 2017 without eliminating or altering BCBSVT's obligation to make the cost-sharing reductions for its insureds.

132. As a direct and proximate result of the federal government's breach of the covenant of good faith and fair dealing, BCBSVT has been damaged in the amount of at least $4,613,449.52

as of the filing of this Complaint, together with any losses actually sustained as a result of the federal government's breach, reliance damages, interest, costs of suit, and such other relief as this Court deems just and proper.

PRAYER FOR RELIEF

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

(1) For Count I, awarding damages sustained by BCBSVT in the amount of at least $4,613,449.52 as of the filing of this Complaint, subject to proof at trial, and as may be further supplemented during the course of this action, as a result of Defendant's violation of 42 U.S.C. §§ 18071(c), 18082(c)(3), and 45 C.F.R. § 156.410.

(2) For Count II, awarding damages sustained by BCBSVT in the amount of at least $4,613,449.52 as of the filing of this Complaint, subject to proof at trial, and as may be further supplemented during the course of this action, as a result of the federal government's breaches of the implied contracts, together with any other losses actually sustained as a result of the Defendant's breach, and reliance damages.

(3) For Count III, awarding to BCBSVT just compensation for the federal government's taking of its property, in the amount of at least $4,613,449.52 as of the filing of this Complaint, subject to proof at trial, and as may be further supplemented during the course of this action.

(4) For Count IV, awarding damages sustained by BCBSVT in the amount of at least $4,613,449.52 as of the filing of this Complaint, subject to proof at trial, and as may be further supplemented during the course of this action, as a result of the federal government's breaches of

the implied covenant of good faith and fair dealing, together with any other losses actually sustained as a result of the Defendant's breach, and reliance damages.

(5) awarding BCBSVT all available interest, including, but not limited to, post-judgment interest.

(6) awarding BCBSVT all available attorneys' fees and costs.

(7) awarding BCBSVT any other relief that the Court deems just and proper.

Respectfully submitted,

Dated: March 9, 2018

By: /s/ Michael Donofrio
Michael Donofrio

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