IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MAINE COMMUNITY HEALTH OPTIONS, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 16-967C Judge James F. Merow

PLAINTIFF'S MOTION FOR A PRETRIAL CONFERENCE TO ESTABLISH SCHEDULE FOR THE EXPEDITED DISPOSITION OF THIS ACTION

Plaintiff Maine Community Health Options ("Plaintiff" or "Health Options") now moves this Court pursuant to Rule 16(a)(1)-(3) and (6) to hold a pretrial conference at its earliest convenience to establish a briefing and argument schedule for the purposes of expediting the disposition of this matter, avoiding protracted procedural delays, discouraging unnecessary pretrial activities, and ruling on dispositive motions. Plaintiff is a non-profit health insurer and the requested relief could prove critical to Plaintiff's operating ability in the upcoming (2017) benefit year.

In support of this Motion, Health Options states as follows:

1. As detailed in its Complaint and recently filed Motion for Summary Judgment, Health Options is a non-profit issuer of qualified health plans, or QHPs, under the Affordable Care Act ("ACA"). Defendant the United States of America ("Government") owes Health Options $22,950,423 under Section 1342 of the ACA (the so-called Risk Corridors Program, or RCP), codified at 42 U.S.C. § 18062. Compl. ¶¶ 17, 66-67, 70, 76, 81.

2. The RCP, and the Government's financial obligations to Health Options arising under Section 1342, are central to Health Options' Complaint. Congress created the RCP specifically to induce health insurers to participate on the ACA's newly created health insurance "exchanges" or "Marketplaces" to help expand affordable health insurance coverage to millions of uninsured or underinsured Americans. The RCP is designed to work by mitigating the risk that insurers would have otherwise faced in trying to establish premiums for the vastly enlarged pool of health insurance enrollees in the context of a new and untested regulatory framework. Generally speaking, the RCP does this by requiring QHP issuers who realize lower-than-budgeted allowable costs in a benefit year to pay a portion of the savings to the Government while, conversely, requiring the Government to pay a portion of the overrun to QHP issuers that realize higher-than-expected allowable costs in the benefit year. Compl. ¶ 7.

3. Unlike traditional insurers, Health Options' dominant lines of business are the small group and individual markets that it accesses on the exchanges. Given its dedication to the delivery and service of individual and small group products, subject to the constraints and terms of the ACA, Health Options does not have sufficient revenue from the large group insurance market (*e.g.*, insurance sold to employers), like traditional insurers have, on which it can rely to offset the costs of operating in the untested waters of the exchanges. But for Health Options, there would have been only one carrier on Maine's individual Marketplace in 2014. Compl. ¶ 24.

4. Health Options answered the call of the ACA—it brought high-quality, affordable health insurance to the people of Maine and New Hampshire in 2014 and 2015. Since commencing business, Health Options has grown to become the largest writer of individual health insurance in the State of Maine. Compl. ¶ 24.

5. In its first year of operations, Health Options attracted over 80 percent of the exchange enrollment in Maine, enrolled 80 percent of the Ryan White (HIV/AIDS Program) patient population in Maine, and enrolled 89 percent of the New Hampshire Ryan White (HIV/AIDS Program) population. Compl. ¶ 27.

6. The assurances provided in Section 1342 of the ACA—reaffirmed by repeated pronouncements of the Centers for Medicaid and Medicare Services ("CMS"), the agency with the U.S. Department of Health and Human Services responsible for administering much of the ACA—were especially important in Health Options' rate-setting process because CMS requires CO-OPs like Health Options to maintain a higher level of capital than is otherwise required under the state insurance codes. Without the risk corridor program, Health Options would have charged higher premiums. *See* Compl. ¶ 43.

7. For obvious reasons, the RCP is only effective if the Government honors its financial obligations on an annual basis. The program would hardly be able to serve its purpose of mitigating risk and keeping premiums relatively low if, after incurring potentially millions of dollars in unbudgeted expenditures over a plan year, new and relatively small non-profit QHP issuers like Health Options—which lack substantial resources and were created directly in response to the ACA's call for creation of non-profit consumer sponsored CO-OP plans—could not timely collect the reimbursements owed to them by the Government pursuant to the statutory formula as soon as the plan's accounting for the preceding year was finalized establishing the amounts owed.

8. Across the country, more than half of the non-profit insurers operating in the exchanges have failed. Health Options is fighting to continue to fulfill its mission of increasing

the accessibility of healthcare coverage to individuals who traditionally lacked sufficient coverage, despite the Government's wrongful withholding of funds. However, Health Options was forced to withdraw from the New Hampshire individual market beginning in 2017, due in part to the Government's decision to withhold approximately $23 million due under the RCP. Mot. Summ. J. at 9, Nov. 3, 2016.

9. CMS has conceded that the Government owes Health Options $211,217 under the RCP for benefit year 2014. In addition, Health Options is owed $22,739,206 for benefit year 2015. To date, the Government has paid Health Options only 12.6 percent of what it owes for 2014, and has paid nothing toward its 2015 obligation to Health Options. Compl. ¶ 17, 18, 70.

10. It is the Government's position that it is not obligated to pay Health Options the amounts owing under the RCP for 2014 and 2015, at least not yet, and maybe not at all.

11. The Government's refusal to honor its RCP obligations is what prompted Health Options to file this lawsuit. But at stake is more than the vindication of Health Options' legal claim—at stake potentially is the existence of Health Options as a going concern. Recouping the amounts due and owing from the Government under the RCP for benefit years 2014 and 2015 is absolutely critical to Health Options' financial health. Lewis Decl. ¶ 6.

12. Moreover, time is of the essence. As of the time of the filing of this Motion, enrollment for benefit year 2017 has opened. The fact of the matter, however, is that Health Options is thinly capitalized and, as such, effectively has no capital cushion to withstand any significant future turbulence and maintain its competitive position in the market. As it is, Health Options' 25.5 percent premium increase for 2017 was a direct response to its inability to tolerate

any negative results in 2017, and the Government's refusal to honor its RCP payment obligations caused a higher increase than would otherwise have been necessary. Lewis Decl. ¶ 7.

13. Because of the urgency presented by the dire straits in which the Government's refusal to pay its RCP obligations has placed Health Options, Health Options filed not only its Complaint but also its Motion for Summary Judgment prior to the Government filing a responsive pleading in this matter. It is also why Health Options strongly opposes the Government's effort to stay this case.

14. In its Reply in support of an indefinite stay of this case, the Government characterizes Health Options' Motion for Summary Judgment as "stale." Reply at 4. It is not clear what the basis for the Government's statement is. The motion is not stale. Rather, the Government seems to suggest that (1) the Department of Justice is too busy to handle this case; and (2) *this Court* need not bother adjudicating *Health Options'* case because other judges of the Court of Federal Claims are considering similar cases brought by other plaintiffs. The Government ignores the point that, as a threshold matter, it has the burden to demonstrate a "pressing need" for the stay, which it has not done. The Government also suggests that it is not trying to deny Health Options' day in court, but merely "ensure[] that day is both informed and efficient." Reply at 3 n.3. That suggestion is erroneous and should be rejected out of hand. The entire point of the requested stay is to require Health Options' rights to be determined by the outcomes of other cases. That is not proper grounds for a stay.

15. The Government has not demonstrated the need for more time to respond—it expressly agreed to a 45-day extension to respond to the Complaint (giving it a total of 111 days), and cannot now claim insufficient time. In fact, counsel for Government specifically

requested the November 28 due date (which was slightly more than 45 days), and counsel for Plaintiff agreed to this request. The Government does not even attempt to dispute that it could readily file the same motion to dismiss it has filed in other cases in this Court, before or after November 28.

16. For the reasons stated above, Health Options now seeks the Court's assistance in establishing a schedule that will facilitate the expedited disposition of this matter and eliminate unnecessary proceedings and protracted litigation.

17. Counsel for Plaintiff conferred with Defendant's counsel prior to filing this motion, and is authorized to state that Defendant's counsel opposes this motion.

Dated: November 17, 2016

Respectfully submitted,

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