Receipt number AUSFCC-6030359

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH CARE SERVICE CORPORATION, an Illinois Mutual Legal Reserve Company, doing business as BLUE CROSS BLUE SHIELD OF ILLINOIS, BLUE CROSS BLUE SHIELD OF MONTANA, BLUE CROSS BLUE SHIELD OF NEW MEXICO, BLUE CROSS BLUE SHIELD OF OKLAHOMA, and BLUE CROSS BLUE SHIELD OF TEXAS,

Plaintiff,

v.

UNITED STATES OF AMERICA acting through the UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES and CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Defendant.

No. 20-259 C

COMPLAINT

Contents

1. Plaintiff Health Care Service Corporation ("HCSC" or "Company"), doing business as Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Montana, Blue Cross Blue Shield of New Mexico, Blue Cross Blue Shield of Oklahoma, and Blue Cross Blue Shield of Texas, brings this complaint against Defendant United States of America, acting through the United States Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"). The Defendant has (1) refused to remit risk corridors payments owed and payable to HCSC under a federal money-mandating statute and its implementing regulations, and (2) breached its contracts with HCSC, proximately causing HCSC to suffer nearly $2 billion in damages. HCSC alleges as follows:

NATURE OF THE ACTION

2. When it enacted the sweeping healthcare reforms in the Patient Protection and Affordable Care Act (the "ACA"), Congress recognized that health insurers faced enormous financial risks and uncertainty if they participated in the new marketplace for health coverage created by the ACA. To guarantee Americans access to affordable health plans regardless of medical history, health insurers would have to depart from decades of established underwriting practices. For the first time, insurers would be prohibited from adjusting individual premiums based on an applicant's health status. Participating insurers would be required to price their health plans with little to no data about the health status and potential medical costs of their new (and previously uninsured) customers. And for the first time, health insurance products would be sold through federally regulated internet marketplaces or exchanges ("Exchanges"),[1] which would require insurers to implement a host of technological, personnel, and compliance changes

[1] The Exchanges are also known as American Health Benefit Exchanges. *See, e.g.*, 42 U.S.C. § 18031(b).

by the start of the ACA's inaugural benefit year, 2014. Given the uncertainties of this new market, with an unknown number of enrollees and limited information to price their products effectively, many health insurers initially declined to participate. But not HCSC.

3. From the beginning, HCSC agreed to support the ACA's vision of healthcare reform. It did so, in part, because Congress took steps to ensure that the government would share some (though not all) of the enormous financial risks of early participation in the Exchanges.

4. Recognizing it could not force health insurers to participate—and hoping to encourage them to *choose* to join the Exchanges—Congress adopted the ACA's "risk corridors" provision, 42 U.S.C. § 18062, which ensured that the federal government would share some of the risk borne by participating insurers in each of the first three years (2014–2016) of the Exchanges.

5. The ACA's risk corridors provision requires the federal government to pay a defined amount to a participating insurer if the insurer incurs greater-than-expected claims and health-quality-improving costs relative to premiums ("Excess Costs") and, conversely, to collect a defined amount from an insurer that incurs lower-than-expected claims and health-quality-improving costs relative to premiums ("Excess Gains"). By limiting the degree of an insurer's losses or gains when costs were difficult to predict, the risk corridors provision was intended to stabilize premiums during the initial years of healthcare reform. The contract between HCSC and the government incorporated that basic bargain, and HCSC reasonably expected the federal government to live up to its part of the deal.

6. Indeed, the ACA *mandated* that the federal government share Excess Costs with health insurers participating in the Exchanges, which, in the language of the statute, are known as issuers of Qualified Health Plans (or "QHPs"). The ACA is unequivocal that "for calendar years

2014, 2015, and 2016": (1) QHP issuers "shall participate" in the risk corridors program; (2) the Secretary of HHS "shall pay" for QHP issuers' greater-than-expected *costs*; and (3) QHP issuers, in turn, "shall pay" the Secretary for excess *gains*. 42 U.S.C. § 18062.

7. This statutory requirement was reinforced by HHS regulations. Throughout 2013—during the period when insurers were deciding whether to join the Exchanges—HHS publicly affirmed its commitment to pay issuers any risk corridors obligations in full. That same year, HHS issued a final rule that echoed the language of the statute, stating unambiguously that the Secretary "**shall make payment**" under the risk corridors provision to compensate for a fraction of large losses that may be incurred in the first benefit year—2014. The final rule emphasized the agency's commitment to prompt and full risk corridors payments to promote "greater payment stability," "protect against uncertainty in rate setting," and to limit "the extent of issuers' financial losses."

8. Relying on these statutory and regulatory mandates, HCSC entered into contracts with Defendant to issue QHPs on the Exchanges in 2014, 2015, and 2016. The language of those contracts reflected the parties' symmetrical obligations to make risk corridors payments. The contracts defined HCSC as an issuer of QHPs and incorporated by reference applicable provisions of the ACA and its accompanying regulations. As part of the contracting process, Defendant required HCSC to formally attest to its understanding of its obligations under the risk corridors provision as a QHP issuer, underscoring the parties' mutual understanding that the risk corridors payments were fundamental to the bargain. Having reached a binding agreement with the government, HCSC made good on its end of the bargain. It invested hundreds of millions of dollars to develop and sell new kinds of insurance products that conformed to the ACA's novel standards for coverage and to build, pay for, and expand a healthcare provider network on the

Exchanges. HCSC ultimately provided quality health insurance coverage and services through the Exchanges to over one-million ACA beneficiaries in five different states between 2014 and 2016.

9. But when the risk corridors bill came due, the Defendant balked. Although it has conceded repeatedly that it owes HCSC almost two billion dollars under the three years of the risk corridors program (*i.e.*, the portion of HCSC's losses for which the government was partly responsible), the government has failed to meet its obligations. Ignoring both the statute and its contracts with HCSC, as well as its prior regulatory pronouncements, Defendant has chosen to administer the risk corridors program in a "budget neutral" manner, meaning that the portion of HCSC's losses covered under the risk corridors formula can be paid only from other issuers' payments into the program. In other words, instead of spreading the risk between the government and health insurers as required by Congress, the government has reversed itself and taken the position that the risk corridors program spreads the risk *among insurers alone*. Defendant adopted this "budget neutral" payment criteria only *after* executing its first contracts with HCSC and only *after* HCSC had already covered the healthcare costs of more than one-million Americans who purchased policies through the Exchanges.

10. Specifically, CMS determined that if costs (*i.e.*, the risk corridors obligations owed by the Secretary to QHP issuers) exceed gains (*i.e.*, the risk corridors obligations owed by QHP issuers to the Secretary), it would pay issuers their risk corridors losses on a pro rata basis. In accordance with this decision, by the close of the three years of the risk corridors program, CMS had paid just pennies on the dollar—16.9%—of its total 2014 obligations, and none of its obligations for benefit years 2015 and 2016.

11. Defendant's refusal to meet its commitment is contrary to the text of the ACA, the government's own regulations, and the contractual representations made to entice issuers like HCSC to participate in the Exchanges at a time when doing so was most precarious and critical. Defendant's decision also unfairly and directly harms HCSC, depriving it of the funds necessary to cover significant losses that the government promised to share. HCSC is left to unexpectedly shoulder all of the losses incurred in the inaugural years of the Exchanges—far from the "stability," "certainty," and "orderly" payment Defendant promised when it contracted with HCSC. For the reasons set forth below, HCSC should be awarded a full and final judgment.

JURISDICTION AND VENUE

12. This is an action for damages and declaratory relief based on the violation of a money-mandating statute and for breach of contract under the Tucker Act, 28 U.S.C. § 1491.

13. This Court possesses subject matter jurisdiction over this action under 28 U.S.C. § 1491(a)(1), and venue is proper before the U.S. Court of Federal Claims because Plaintiff seeks damages from the United States in excess of $10,000.

THE PARTIES

14. Plaintiff is, and at all times mentioned herein was, an Illinois Mutual Legal Reserve Company, organized under the laws of Illinois, and an independent licensee of the Blue Cross and Blue Shield Association. Its principal place of business is 300 E. Randolph Street, Chicago, Illinois 60601.

15. Blue Cross Blue Shield of Illinois ("BCBS-IL") is, and at all times mentioned herein was, an unincorporated division of HCSC, headquartered at 300 E. Randolph Street, Chicago, Illinois 60601.

16. Blue Cross Blue Shield of Montana ("BCBS-MT") is, and at all times mentioned herein was, an unincorporated division of HCSC, headquartered at 560 N. Park Avenue, Helena, Montana 59604.

17. Blue Cross Blue Shield of New Mexico ("BCBS-NM") is, and at all times mentioned herein was, an unincorporated division of HCSC, headquartered at 5701 Balloon Fiesta Parkway NE, Albuquerque, New Mexico 87113.

18. Blue Cross Blue Shield of Oklahoma ("BCBS-OK") is, and at all times mentioned herein was, an unincorporated division of HCSC, headquartered at 1400 S. Boston Avenue, Tulsa, Oklahoma 74119.

19. Blue Cross Blue Shield of Texas ("BCBS-TX") is, and at all times mentioned herein was, an unincorporated division of HCSC, headquartered at 1001 E. Lookout Drive, Richardson, Texas 75082.

20. Defendant is, and was at all times relevant hereto, a governmental entity organized under federal law with the capacity to enter contracts, sue, and be sued. Defendant acted through CMS and HHS. HHS is, and at all times relevant hereto was, an agency of the United States, and is statutorily charged with administering and implementing the ACA. HHS is headquartered at 200 Independence Avenue, S.W., Washington, District of Columbia 20001. CMS is, and at all times relevant hereto was, an agency of the United States, operating as an instrumentality of HHS. CMS administers the Medicare program and works in partnership with state regulators to administer Medicaid and other programs, including implementation of the ACA. CMS is headquartered at 7500 Security Boulevard, Baltimore, Maryland 21244.

FACTUAL BACKGROUND

A. HEALTHCARE REFORM

21. On March 23, 2010, President Barack Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act. The following week, the president signed into law H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which amended H.R. 3590. Together, this legislation effected sweeping reforms to the national health insurance marketplace.

22. Among its reforms, the ACA required the establishment of Exchanges in each state for the purchase of insurance in the individual and small-group markets. *See* Pub. L. No. 111-148 § 1311(b), 124 Stat. 173–74. Health plans offered on the Exchanges must satisfy specific criteria set by CMS and, in some cases, state regulators. *See* 45 C.F.R. § 155.1000 (certification standards for QHPs). And CMS must approve QHPs offered through Exchanges operated by CMS. *See id*. To expand coverage and decrease costs for millions of Americans, the ACA enacted a set of insurance-market regulations that, effective January 1, 2014, barred health plans from denying coverage or charging higher premiums to individuals based on factors such as health status or gender (*i.e.,* "community rating" and "guaranteed issue" requirements). *See* 42 U.S.C. §§ 300gg (health insurance premiums), 300gg-1 (guaranteed availability of coverage).

23. Congress recognized that these groundbreaking reforms posed substantial financial risk to participating health insurers. Historically, insurers set premium rates annually based upon their past experience and anticipated costs related to their pool of enrollees. Health insurers, contemplating participation on the Exchanges in its initial years, faced significant uncertainty regarding, among other things, who would buy insurance through the new Exchanges, the volume of insurance that would be purchased, the medical history of enrollees,

and a host of other data points that typically inform premium rate-setting. *See* Congressional Research Service ("CRS"), *Information on the ACA Transitional Reinsurance Program*, 2–3 (Feb. 23, 2016), http://docs.house.gov/meetings/IF/IF02/20160415/104790/HHRG-114-IF02-20160415-SD003.pdf ("Insurers were faced with many questions at the start of health reform, such as whether young healthy individuals would sign up for insurance, or whether employers would choose to have their enrollees find insurance on the new marketplaces, or not.").

24. Moreover, because the central purpose of the ACA was to provide insurance for people who were previously uninsured, many new enrollees were expected to have untreated medical needs, chronic conditions, and other ailments requiring immediate and significant medical care at great cost. *See generally* Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (Aug. 2016), http://files.kff.org/attachment/Issue-Brief-Explaining-Health-Care-Reform-Risk-Adjustment-Reinsurance-and-Risk-Corridors; U.S. Government Accountability Office ("GAO"), Report to Congressional Requesters, *Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk*, 7 (Apr. 2015), http://www.gao.gov/assets/670/669942.pdf ("[P]reviously uninsured individuals who are most in need of health care may be more likely than others to purchase insurance during the transition, resulting in a pool of enrollees that have unknown and potentially higher medical costs than the broader population.").

B. THE RISK CORRIDORS PROGRAM

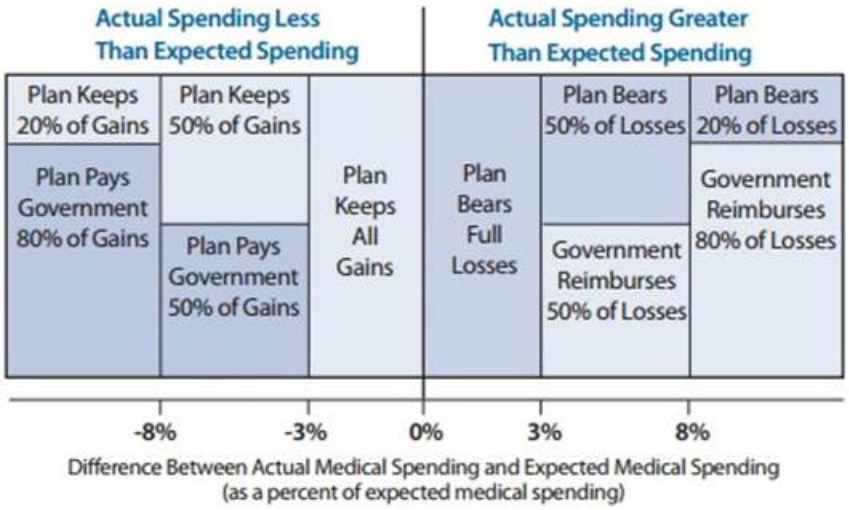
25. Defendant recognized that absent government intervention, health insurers would respond to this uncertainty by including a margin in their premium pricing to offset the potentially high cost of insuring new enrollees, especially during the early years of the Exchanges. *See* Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed.

Reg. 17220, 17221 (Mar. 23, 2012) ("Risk Corridors Standards Final Rule") ("To protect themselves from adverse selection, issuers may include a margin in their pricing (that is, set premiums higher than necessary) in order to offset the potential expense of high-cost enrollees."). This pricing strategy, in turn, would make the offered health plans less affordable and discourage enrollment in the new Exchanges, frustrating one of the primary purposes of the ACA.

26. The ACA's risk corridors provision established a temporary premium stabilization program that was intended to be in effect for the first three years of the Exchanges. 42 U.S.C. § 18062. To encourage participating insurers to set premiums for QHPs that were neither too high nor too low, the ACA created a system under which HHS makes payments to QHP issuers that incurred annual costs in excess of a specified percentage of premiums, and receives payments from QHP issuers that realized annual gains in excess of a specified percentage of premiums. *Id.* § 18062(b); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744, 13746 (Mar. 11, 2014) ("2015 Final Rule") ("Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that provides for the *sharing in gains or losses* resulting from inaccurate rate setting from 2014 through 2016 *between the Federal government and certain participating plans*.") (emphasis added).

27. Specifically, Section 1342(a) of the ACA provides that QHP issuers "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 1342(a), 124 Stat. 211 (Mar. 23, 2010) *codified at* 42 U.S.C. § 18062(a).

28. Section 1342(b)(1) provides that "the Secretary shall pay" to the QHP issuer a given amount to compensate for certain costs the plan incurs as a result of its allowable costs exceeding its premiums. *Id.* § 18062(b)(1). Section 1342(b)(2), in contrast, provides that a QHP issuer "shall pay to the Secretary" a given amount to account for certain gains the plan recognizes because the amounts it collects in premiums exceed its allowable costs. *Id.* § 18062(b)(2). The following chart from the American Academy of Actuaries graphically demonstrates this statutory obligation:



Source: American Academy of Actuaries. Fact Sheet: ACA Risk-Sharing Mechanisms – The 3Rs (Risk Adjustment, Risk Corridors, and Reinsurance) Explained. December 2013.

29. The risk corridors provision specifies a clear mandate to remit and collect payments, with defined parameters of payment, for the Secretary to follow. 42 U.S.C. § 18062(b)(1)(A) ("The Secretary shall provide under the [risk corridors] program that if . . . a participating plan's allowable costs for any benefit 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 . . . ."). Although the payment and receipt formulas are symmetrical, the text of the risk corridors provision does not cap total payouts or total receipts. *Id.* § 18062. Thus, by its terms, the statute could result in

no QHP issuer paying into the program, but *all* issuers receiving risk corridors payments. And conversely, it could also result in *all* issuers paying into the program, but *no* issuers receiving payments.

30. In short, the risk corridors program was not structured to operate in a budget-neutral fashion. *See* Congressional Budget Office ("CBO"), Cost Estimate re: H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation) (Mar. 20, 2010), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf (treating other provisions of the ACA as budget neutral for budget scoring purposes, without reference to risk corridors). As CMS's website explained, "[t]he temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 b*y having the Federal government share risk in losses and gains*." *See* CMS, Premium Stabilization Programs, www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html (emphasis added).

31. Further evidence for this conclusion comes from the ACA's direction to the Secretary to base the risk corridors program on an existing program in Medicare Part D, codified at 42 U.S.C. § 1395w-115. *See* 42 U.S.C. § 18062(a) ("Such program *shall be based* on the program for regional participating provider organizations under Part D of title XVIII of the Social Security Act.") (emphasis added); *see also* 42 U.S.C. § 1395w-115(e)(3). Like its sister provision in the ACA, the risk corridors provision under Part D is symmetrical, but not budget neutral. *See* 42 U.S.C. § 1395w-115(e)(2)(B); *see also* Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4306 (Jan. 28, 2005) ("These risk sharing arrangements are structured by the statute as symmetrical risk corridors, that is, agreements to share a portion of the losses or profits resulting from expenses above or below expected levels, respectively.").

32. On March 11, 2013, HHS issued the Notice of Benefit and Payment Parameters for 2014. This notice was the final rule for 2014 payments related to the risk corridors provision. *See generally*, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15410 (Mar. 11, 2013) ("2014 Final Rule").

33. In the 2014 Final Rule, HHS recognized that the risk corridors provision was designed to "provide issuers with greater payment stability as insurance market reforms are implemented and [to] facilitate increased enrollment." *Id.* at 15411. HHS reiterated that the risk corridors program "will protect against uncertainty in rate setting [by QHPs] by limiting the extent of issuers' financial losses and gains." *Id.* HHS also stated that "the premium stabilization programs (risk adjustment, reinsurance, and risk corridor) decrease the risk of financial loss that health insurance issuers might otherwise expect in 2014." *Id.* at 15414.

34. HHS also explicitly acknowledged in the 2014 Final Rule that the ACA risk corridors provision did *not* require budget neutrality and that the risk corridors program was designed to share risk between the health plans and the federal government: "The risk corridors program *is not statutorily required to be budget neutral*. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." *Id.* at 15473 (emphasis added).

C. CONTRACTING PROCESS TO OFFER HEALTH PLANS ON EXCHANGES

a. *Benefit Year 2014*

35. Following its representations regarding the risk corridors programs, on April 5, 2013, HHS issued a "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" (the "Letter to Issuers"), a true and correct copy of which is attached hereto as **Exhibit A**, soliciting health insurers to offer plans on the Exchanges and outlining the process for doing so. In the Letter to Issuers, HHS stated that it had "provided guidance on market-wide and QHP

certification standards, eligibility and enrollment procedures, and other Exchange-related topics in several phases." HHS advised issuers "to consult these materials in conjunction with the Letter to ensure full compliance with the requirements of the [ACA]." An appendix to the letter contained what HHS described as "the most relevant regulations and guidance documents" and included statutory and regulatory provisions governing the risk corridors program. (Ex. A at 1.)

36. The Letter to Issuers provided detailed instructions on the necessary steps issuers had to take to offer health plans on the Exchange. The Letter to Issuers explained the different processes for issuers operating on Federally-Facilitated Exchanges ("FFEs"), as opposed to those operating on State Partnership Exchanges ("SPEs"). For FFEs, CMS would conduct the review of health plans and make its own evaluations regarding plan approval. For SPEs, CMS would take recommendations from the state as to each plan and then decide whether to approve the plans as QHPs.

37. As detailed in the Letter to Issuers, the first step in the process was for issuers to submit a QHP Application. The Application consisted of a number of submissions detailing the issuer's operations and administrative information, as well as their plan offerings. The Letter to Issuers set a tentative date for submission of April 30, 2013 and provided a tentative timeline for the process. (Ex. A at 20.)

38. Significantly, the Letter to Issuers explained that the certification process would be completed with a "signed QHP Agreement," designed to "highlight and memorialize many of the QHP issuer's statutory and regulatory requirements and [to] serve as an important reminder of the relationship between the QHP issuer and CMS." (*Id*. at 23.)

39. On or around late April and early May 2013, HCSC submitted its QHP applications for each of the states in which HCSC operates.

40. The Letter to Issuers also required all applicants to submit Attestations in which issuers certified their ability to adhere to certain requirements set forth in the ACA and its implementing regulations: "The Affordable Care Act and the applicable Exchange regulations establish that health plans must meet a number of standards to be certified as qualified health plans (QHPs)." (Ex. A at 5.). A true and correct copy of the Attestations for each HCSC plan is attached hereto as **Exhibit B**.

41. The Attestations specifically required each applicant to "attest[] that it will adhere to the risk corridor standards and requirements set by HHS as applicable for (a) risk corridor data standards and annual HHS Notice of Benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 C.F.R § 153.510); and (b) remit charges under the circumstances described in 45 C.F.R. § 153.510(c)." (*See, e.g.*, Ex. B at 6.) The Attestations, therefore, incorporated the regulations mandating annual risk corridors payments to QHP issuers participating in the Exchanges.

42. On May 7, 2013, BCBS-NM submitted its Attestations to the New Mexico Division of Insurance ("NMDOI").[2]

43. On May 7, 2013, BCBS-IL submitted its Attestations.

44. On May 1, 2013, BCBS-OK submitted its Attestations.

45. On May 2, 2013, BCBS-TX submitted its Attestations.

46. On May 14, 2013, BCBS-MT submitted its Attestations.

[2] BCBS-NM submitted these Attestations directly to NMDOI, the entity administering the New Mexico state exchange, because New Mexico had opted to operate its own health insurance exchange. Though NMDOI worked with CMS to certify QHPs, BCBS-NM submitted additional documentation to NMDOI.

47. QHP applicants were also required to submit proposed rates for approval, as well as a memorandum detailing their reasoning and justifications for the proposed rate. *See* 45 C.F.R. § 154.215(b)(3), (f).

48. Each Actuarial Memorandum certified, based on certain assumptions outlined in the Memorandum, that "the proposed rates would be adequate if the assumptions [were] realized." The Actuarial Memorandum explained that "[i]n the best of circumstances, there is inherent uncertainty in health insurance pricing assumptions," and that the new regulatory framework created by the ACA "introduce[d] unprecedented risk and uncertainty into the rate development process." The risk corridors program—which would help to defray the Company's losses in the event that these "unprecedented risks" were realized—was material to HCSC's decision to participate in the Exchanges in 2014, 2015 and 2016.

49. HCSC submitted its final proposed rates to CMS (or the relevant state regulator) on September 5, 2013.

50. On September 9, 2013, CMS sent email correspondence (the "Plan Confirmation Email") to each HCSC plan informing it that CMS (or the relevant state regulator) had reviewed and approved each of the QHPs. A true and correct copy of the Plan Confirmation Email for each HCSC plan, with personal confidential information redacted, is attached hereto as **Exhibit C**.

51. Each Plan Confirmation Email expressly conditioned CMS's approval based on "the information contained in [HCSC's] application." (*See, e.g.*, *id*. at 6.) Each Plan Confirmation Email then asked HCSC to confirm its agreement to offer each proposed plan on the relevant Exchange. (*See, e.g.*, *id*. at 4.)

52. On September 11, 2013, HCSC confirmed its agreement to offer the proposed plans on the Exchanges in a "Final Issuer Email" for each HCSC plan. A true and correct copy of the Final Issuer Email for each HCSC plan, with personal confidential information redacted, is attached hereto as **Exhibit D**.

53. Each Plan Confirmation Email attached a form Qualified Health Plan Issuer ("QHPI") Agreement and instructed HCSC to complete, sign, and return the QHPI Agreement no later than September 11, 2013. (*See, e.g.*, Ex. C at 4.) A true and correct copy of the fully executed QHPI Agreement for each HCSC plan is attached hereto as **Exhibit E.**

54. The QHPI Agreements noted that the relationship between the parties was founded on the ACA and its related regulations: "Section 1301(a) of the Affordable Care Act ('ACA') provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish." (*See, e.g.*, Ex. E at 1.)

55. The QHPI Agreements stated that each contract was entered "in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge." (*Id*.)

56. Among other points, the QHPI Agreements memorialized the parties' commitment to a monthly "reconciliation process" through which amounts owed between the parties would be transmitted: "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) *with respect to offering of QHPs*, including the following types

of payments: APTC [advance payment of tax credits], advance payments of CSRs, and payment of Federally-facilitated Exchange user fees." (*See, e.g.*, *id.* at 5 (emphasis added).)

57. The QHPI Agreements reflect the understanding that HCSC was a contractor to Defendant. For example, each agreement required HCSC to "assume ultimate responsibility" for any services and functions "that are assigned or *subcontracted*," and ensure that any "subcontractor . . . will perform all functions in accordance with all applicable requirements." (*See, e.g.*, *id*. at 7 (emphasis added).)

58. The QHPI Agreements are "governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws, statutes or rules." (*See, e.g.*, *id*. at 8.) Those laws and regulations include the ACA and the regulations codified thereunder, including those specifically governing the risk corridors program. *See, e.g.*, 42 U.S.C. §18062(a); 45 C.F.R. § 153.510(d).

59. BCBS-IL signed and submitted its QHPI Agreement, dated September 9, 2013. (Ex. E.)

60. BCBS-MT signed and submitted its QHPI Agreement, dated September 9, 2013. (*Id.*)

61. BCBS-NM signed and submitted its QHPI Agreement, dated September 9, 2013. (*Id.*)

62. BCBS-TX signed and submitted its QHPI Agreement, dated September 9, 2013. (*Id.*)

63. BCBS-OK signed and submitted its QHPI Agreement, dated September 9, 2013. (*Id.*)

64. Each QHPI Agreement was signed by Jeffrey Tikkanen, the President of Retail Markets for HCSC. (*See, e.g.*, *id*. at 9.)

65. On September 25, 2013, CMS sent a separate email to HCSC regarding each of the states in which it operates confirming that the application process had been completed. A true and correct copy of each "Final Confirmation Email" for each HCSC plan, with personal confidential information redacted, is attached hereto as **Exhibit F.**

66. Each Final Confirmation Email listed the QHPs that had been certified for the 2014 benefit year. (*Id*. at 2–3.) Through each Final Confirmation Email, CMS accepted each of HCSC's offers to make health plans available on the Exchanges.

67. James Kerr, Acting Deputy Director, Operations, for CMS's Center for Consumer Information & Insurance Oversight ("CCIIO"),[3] and Troy Trenkle, Director and CMS Chief Information Officer for CMS's Office of Information Services, with authority to bind the government in contract, executed the QHPI Agreements on September 23, 2013 with BCBS-IL, BCBS-MT, BCBS-TX, and BCBS-OK. (*See, e.g.*, Ex. E at 10.) The contracts were effective that same day. (*Id*. at 5.)

68. On September 9, 2013, BCBS-NM executed a contract related to its QHP offerings on the New Mexico exchange. BCBS-NM's contract with CMS was substantially similar to the other HCSC contracts with CMS, and it included identical protocols for conducting electronic transactions and managing personally identifiable information on CMS's Data Services Hub as well as an identical governing law provision. (*See* Ex. E.)

[3] The CCIIO is charged with implementing and enforcing many of the ACA's new rules governing the insurance market, in particular developing and implementing policies and rules governing State-based Exchanges, overseeing the operations of State-based Exchanges, and administering Exchanges in States that elect not to establish their own.

69. In addition, on or about September 25, 2013, CMS sent each HCSC plan countersigned copies of its respective QHPI Agreement.

b. *Benefit Years 2015 and 2016*

70. As benefit year 2014 was underway, HCSC and CMS engaged in a similar negotiation process, culminating in CMS's acceptance of HCSC's plan offerings and execution of QHPI Agreements for benefit year 2015. The following year, HCSC and CMS once again repeated this process, culminating in plan offerings and executed QHPI Agreements for benefit year 2016.

71. Like the process for benefit year 2014, BCBS-NM, BCBS-IL, BCBS-OK, BCBS-TX, and BCBS-MT each submitted Attestations in both 2015 and 2016. A true and correct copy of the 2015 Attestations for each HCSC plan is attached hereto as **Exhibit G.** A true and correct copy of the 2016 Attestations for each HCSC plan is attached hereto as **Exhibit H**.

72. Through the 2015 and 2016 Attestations, HCSC again agreed to comply with several terms related to the ACA and its implementing regulations; to create a compliance plan; to comply with rate requirements; to adhere to rules for enrollment of insureds; to be bound by certain regulations governing user fees; and to report to the Exchanges the data and information required by HHS. (*See* Ex. G; Ex. H.)

73. Like the process for benefit year 2014, HCSC submitted and CMS returned countersigned QHPI Agreements to BCBS-NM, BCBS-IL, BCBS-OK, BCBS-TX, and BCBS-MT, each dated October 29, 2014 for benefit year 2015, and each dated October 8, 2015 for benefit year 2016. A true and correct copy of the fully executed 2015 QHPI Agreement for each HCSC plan is attached hereto as **Exhibit I.** A true and correct copy of the fully executed 2016 QHPI Agreement for each HCSC plan is attached hereto as **Exhibit J**.

74. The 2015 and 2016 QHPI Agreements again noted that the relationship between the parties was founded on the ACA and its implementing regulations: "Section 1301(a) of the Affordable Care Act ('ACA') provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish." (*See, e.g.,* Ex. I at 1; Ex. J at 1.)

75. The 2015 and 2016 QHPI Agreements again described each HCSC plan: "QHPI is an entity licensed by an applicable State Department of Insurance ('DOI') as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs." (Ex. I at 1; Ex. J at 1.)

76. The 2015 and 2016 QHPI Agreements again stated that they were entered "in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge." (Ex. I at 1; Ex. J at 1.)

77. The 2015 and 2016 QHPI Agreements again memorialized the parties' commitment to a monthly "reconciliation process" through which amounts owed between the parties would be transmitted: "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) *with respect to offering of QHPs*, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees." (*See, e.g.*, Ex. I at 5; Ex. J at 5 (emphasis added).)

78. The 2015 and 2016 QHPI Agreements again reflected the understanding that HCSC was a contractor of Defendant. For example, each version of the Agreement required

HCSC to "assume ultimate responsibility" for any services and functions "that are assigned or *subcontracted*," and ensure that all "subcontractors . . . will perform all functions in accordance with all applicable requirements." (*See, e.g.*, Ex. I at 7; Ex. J at 7 (emphasis added).)

79. The 2015 and 2016 QHPI Agreements again specified that they are "governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws, statutes or rules." (*See, e.g.*, Ex. I at 7; Ex. J at 8.) Those laws and regulations include the ACA and the regulations codified thereunder, including those specifically governing the risk corridors program. *See, e.g.*, Pub. L. No. 111-148, § 1342(a); 42 U.S.C. §18062(a); 45 C.F.R. § 153.510(d).

D. DEFENDANT REVERSES ITSELF ON SIGNIFICANT HEALTH EXCHANGE POLICY

80. Enrollment in HCSC's QHPs for the 2014 benefit year started on October 1, 2013, and continued for six months. During the 2014 benefit year, HCSC enrolled over one million insureds. HCSC's QHPs provided health insurance coverage effective January 1, 2014.

81. Because HCSC chose to participate in the Exchanges in all five states where it operated, and because HCSC operated these plans in compliance with its QHPI Agreements, Defendant received the full benefit of its bargain and was able to fulfill its statutory mission of implementing the Exchange program.

82. During the process of launching the new Exchanges, however, Defendant forced QHPs to accommodate a variety of changing policy pronouncements. For example, in late 2013, one month before open enrollment for 2014 was set to begin, Defendant announced a new transitional policy whereby insurance policies that did not comply with the ACA, but were in

force prior to 2014, could be renewed. *See* CMS Letter to State Insurance Commissioners (Nov. 14, 2013) ("Transitional Policy Letter"), https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf.

83. This transition policy (also known as "Grandmothering") was announced after HCSC had finalized 2014 premiums for new, ACA-compliant policies, and submitted its plans to CMS for approval. The effect of this new transition policy was that issuers would be enrolling a less-healthy risk pool than originally forecast because many previously insured individuals would choose to stay with their prior plans, increasing the percentage of previously uninsured individuals seeking coverage through the Exchanges. These previously uninsured enrollees were likely to consume more health care services than the individuals who elected to renew their non-compliant ACA plans. Several months later, on March 5, 2014, HHS further disrupted the market when it extended until October 2016 the period that health insurers could renew policies that failed to comply with the ACA's mandates, which further inhibited HCSC's ability to accurately forecast the risk pool for the 2015 benefit year. *See* CMS Bulletin: Extended Transition to Affordable Care Act-Compliant Policies, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/transition-to-compliant-policies-03-06-2015.pdf.

84. The added uncertainty created by these policy changes made prompt and orderly risk corridors payments all the more essential for QHP issuers that had decided to enter the Exchanges in 2014. In the Transitional Policy Letter, CMS acknowledged that the new policy "was not anticipated by health insurance issuers when setting rates for 2014," but assured state insurance commissioners and issuers alike that the "risk corridors program should help ameliorate unanticipated changes in premium revenue." *Id*. at 3.

E. DEFENDANT RETROACTIVELY IMPOSES BUDGET NEUTRALITY ON THE RISK CORRIDORS PROGRAM.

85. On January 17, 2014, the president signed an appropriations bill funding, among other agencies, CMS. That appropriation provided CMS with $3.6 billion to carry out its duties. It contained no restriction on the funds available for CMS to satisfy its obligations under the ACA's risk corridors provision. Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5, 374 (2014). Despite CBO's original estimate that the risk corridors program would turn an $8 billion profit for the government, by March 4, 2014, Defendant had reassessed its position. Perhaps taking into account the costs it had imposed on issuers through policies such as Grandmothering, the president's original budget proposal for fiscal year 2015 included a $5.5 billion request for risk corridors payments. A true and correct copy of an excerpt of the government's Fiscal Year 2015 budget proposal reflecting this $5.5 billion request is attached hereto as **Exhibit K**.

86. Just one week later, well after HCSC had set premiums for the 2014 benefit year, Defendant changed the rules under which the risk corridors program would operate. On March 11, 2014, HHS indicated for the first time that it administer the risk corridors program in a *budget neutral* manner by adjusting certain details in the risk corridors payments formula until risk corridors payments balanced risk corridors collections. *See* 2015 Final Rule, 79 Fed. Reg. at 13787 ("We intend to implement this program in a budget-neutral manner, and may make future adjustments, either upward or downward to this program . . . to the extent necessary to achieve this goal.") (the "2015 Final Rule").[4]

[4] This variance was repeated in the rule on Exchange and Insurance Market Standards for 2015 and Beyond, published on March 21, 2014. 79 Fed. Reg. 15808, 15822.

87. The 2015 Final Rule was the first articulation by CMS of a budget-neutrality payment criterion for the risk corridors program, and it was announced years after the ACA was passed. *See Protecting Americans from Illegal Bail-outs and Plan Cancellations Under the President's Health Care Law: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce,* 113th Cong. 41 (2014) (statement of Rep. Gus Bilirakis, Member, Subcomm. on Health ("When the rules for the risk corridors were published in 2011, the administration was willing to pay more in risk corridors than they collected. They have subsequently changed to a budget neutral position."). This change in policy was not included in the proposed rule, and therefore was not subject to public comment. *Compare* HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72322, 72350 (Dec. 2, 2013) ("2015 Proposed Rule") *with* 2015 Final Rule, 79 Fed. Reg. at 13787. In response to this policy shift, the American Academy of Actuaries explained that a "budget neutrality policy … would change the basic nature of the risk corridor program retroactively . . . from one that shares risk between issuers and CMS to one that shares risk between competing issuers." April 21, 2014 AAA Letter to CMS, at 3.

88. On April 11, 2014—nearly one year after the Final Rule for the 2014 benefit year took effect—CMS issued an informal guidance document entitled "Risk Corridors and Budget Neutrality," which is a two-page frequently-asked-questions, or "FAQ." One question and answer read in pertinent part:

> **Question 1**: . . . HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?
>
> **Answer 1**: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, 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. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Risk Corridors and Budget Neutrality FAQ at A1.

89. This informal "FAQ" announced, for the first time, that CMS might withhold portions of the annual risk corridors payments to which QHP issuers were entitled. Notably, CMS stated in the "FAQ" as follows: "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program. However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program." *Id*. at A2.

90. The "FAQ" did not offer a textual basis in the statute for this interpretation or offer an explanation for the departure from the 2014 Final Rule's disavowal of budget neutrality in the risk corridors program.

91. The guidance promised in the FAQ came on November 26, 2014, when HHS published its proposed rule relating to the Notice of Benefit and Payment Parameters for the 2016 benefit year. *See* 79 Fed. Reg. 70674 (Nov. 26, 2014) ("2016 Proposed Rule"). In the preamble to the 2016 Proposed Rule, HHS confirmed its obligation to make full risk corridors payments. *Id.* But HHS indicated that, if the program results in a net payment from HHS to issuers, it would pay QHPs only if there was available funding left from other programs. *See id.* at 70700 (Nov. 26, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary

to make full payments to issuers. In the unlikely event that risk corridors collections, including any potential carryover from the prior years, are insufficient to make risk corridors payments for the 2016 benefit year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.").

F. CONGRESS RESTRICTS DEFENDANT'S USE OF CERTAIN FUNDING SOURCES TO SATISFY DEFENDANT'S RISK CORRIDORS PAYMENT OBLIGATIONS.

92. As 2014 drew to a close and HCSC duly performed its obligations under its agreements, Congress attempted to block certain sources of payments that had been suggested in the November 2014 Proposed Rule.

93. On December 16, 2014, after the completion of contract negotiations between HCSC and HHS for the 2015 benefit year, Congress passed, and the president signed, a continuing resolution funding the government for fiscal year 2015. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (hereinafter "the Act"). The Act prohibited the use of funds from the fiscal year 2015 appropriation for the Medicare trust fund or CMS's Program Management Account to make risk corridors payments to QHP issuers. *Id*. § 227, 128 Stat. at 2491 ("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 corridor).").

94. The Act neither amended nor repealed Section 1342. Thus, while Congress may have restricted the funding sources from which HHS could pay its risk corridors obligations, it left untouched Defendant's statutory obligation to make full risk corridors payments on an annual basis.

G. DEFENDANT CONTINUED TO REPRESENT THAT FULL RISK CORRIDORS PAYMENTS WOULD BE MADE.

95. In January and March of 2015, the CBO stated that it "estimates that payments and collections will offset each other in each year, resulting in no net budgetary effect." CBO, *The Budget and Economic Outlook: 2015 to 2025*, 117 (Jan. 2015), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/49892-Outlook2015.pdf; CBO, *Updated Budget Projections: 2015 to 2025*, 16 (Mar. 2015), http://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-Updated_Budget_Projections.pdf.

96. Subsequently, on July 21, 2015, Kevin Counihan, the Chief Executive Officer of the Health Insurance Marketplace at CMS, wrote to state insurance commissioners who were then in the process of approving and setting insurance rates for the 2016 benefit year. A true and correct copy of Counihan's letter to state insurance commissioners is attached hereto as **Exhibit L**.

97. With respect to the risk corridors provision, Counihan wrote: "CMS remains committed to the risk corridors program. As stated in our final payment notice for 2016, 'We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.'" (*Id.* at 2.) CMS encouraged state insurance commissioners to take into account and assume full risk corridors payments when deciding whether to approve QHP issuers' proposed premium rates for the 2016 benefit year. (*Id.*) ("We believe these payments should be taken into account before decisions are made on final rates . . . [and] we ask that you consider these findings as you work to finalize rates for the 2016 benefit year.")

H. DEFENDANT FAILS TO REMIT FULL RISK CORRIDORS PAYMENTS TO HCSC.

98. On July 31, 2015, HCSC submitted to CMS its applications for risk corridors payments and supporting data, as required by its contract and applicable regulations. Plaintiff submitted the following amounts for the 2014 benefit year:

HCSC Plans	2014 Risk Corridors Payments Due
Illinois	$197,172,058.30
Montana	$ 24,011,955.69
New Mexico	$ 6,566,900.60
Oklahoma	$ 53,892,185.62
Texas	$294,308,352.40
Total	**$575,951,452.62**

99. On October 1, 2015, CMS announced that for benefit year 2014, QHP issuers had collectively requested $2.87 billion in risk corridors payments, but QHP issuers would only pay CMS $362 million collectively in risk corridors charges. CMS, *The Three Rs: An Overview* (Oct. 1, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html. As a consequence of that shortfall, CMS indicated it would follow the procedure it had outlined in its "FAQ" and remit only a pro rata share of 12.6% of each request. CMS indicated that shortfalls from 2014 risk corridors payments would be satisfied in 2016 from risk corridors collections following the 2015 benefit year. CMS acknowledged, however, that it would "explore other sources of funding, subject to the availability of appropriations[]" if the risk corridors program netted a shortfall by the end of the entire three-year period. *Id.*

100. On October 9, 2015, CMS directly communicated with HCSC regarding risk corridors payments for 2014. *See* CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015), https://www.cms.gov/CCIIO/Programs-and-

Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf. It set forth the risk corridors payments owed and paid for Plaintiff:

HCSC Plans	2014 Risk Corridors Payments Due HCSC	2014 Risk Corridors Payments Paid to HCSC
Illinois	$197,172,058.28	$ 24,878,907.14
Montana	$ 24,011,955.69	$ 3,029,796.52
New Mexico	$ 6,566,900.60	$ 828,602.75
Oklahoma	$ 53,892,185.62	$ 6,800,044.05
Texas	$294,308,352.43	$ 37,135,435.09
Total	**$575,951,452.62**	**$ 72,672,785.55**

101. The CMS letter concluded: "I wish to reiterate to you that the Department of Health and Human Services (HHS) recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States Government for which full payment is required."

102. On November 19, 2015, CMS reiterated in a letter to all QHP issuers, including HCSC, that the remaining balance beyond its 12.6% payment was a "fiscal year 2015 obligation of the United States Government for which full payment is required." A true and correct copy of this letter to all QHP issuers is attached hereto as **Exhibit M**.

103. For benefit year 2015, CMS required QHP issuers to submit data for risk corridors payments by August 1, 2016. CMS, *Medical Loss Ratio and Risk Corridors Data Submission Deadline for the 2015 Benefit Year* (July 26, 2016), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/RC-MLR-FAQ-072616.pdf; *see also* 45 C.F.R. § 153.530(d). HCSC submitted estimates of risk corridors expected payments and charges for 2015 as required by its contract and applicable regulations. The amounts anticipated by HCSC were as follows:

HCSC Plans	2015 Risk Corridors Payments Due
Illinois	$ 291,495,530.60
Montana	$ 43,068,108.88
New Mexico	$ 18,627,474.95
Oklahoma	$ 119,431,219.80
Texas	$ 622,460,036.59
Total	**$1,095,082,370.82**

104. On September 9, 2016, HHS "announc[ed] preliminary information about risk corridors for the 2015 benefit year." It again limited risk corridors payments to risk corridors collections, warning that it "anticipate[d] that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments," without paying anything for the 2015 benefit year. Significantly, HHS again "recognize[d] that the Affordable Care Act requires the Secretary to make full payments to issuers" and promised to "record risk corridors payments due as an obligation of the United States Government for which full payment is required." CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF.

105. On November 18, 2016, CMS announced that it had only collected $95.3 million in risk corridors payments for benefit year 2015 and confirmed that all of its collections would be "used to pay a portion of the government's balance" from the 2014 benefit year. *See* CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf.

106. For benefit year 2016, CMS required QHP issuers to submit data for risk corridors payments by July 31, 2017. CMS, *Medical Loss Ratio and Risk Corridors Training Information for the 2016 MLR Reporting Year* (May 9, 2017),

https://www.cms.gov/CCIIO/Resources/Training-Resources/Downloads/Issuer_2016_MLR_Training_Memo.pdf; *see also* 45 C.F.R. § 153.530(d). HCSC submitted estimates of risk corridors expected payments and charges for 2016 as required by its contract and applicable regulations. HCSC estimated the following amounts due under the risk corridors program:

HCSC Plans	2016 Risk Corridors Payments Due
Illinois	$115,870,451.92
Montana	$ 34,407,521.02
New Mexico	$ 2,884,412.08
Oklahoma	$ 58,224,758.14
Texas	$167,878,594.37
Total	**$379,265,737.53**

107. On November 13, 2017, CMS announced that it had only collected $27 million in risk corridors payments for benefit year 2016 and confirmed that all of its collections would be "used to make additional payments toward 2014 benefit year payment balances." *See* CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

108. After Defendant remitted all of its payments towards the amount owed for the 2014 benefit year, the amount due and payable to HCSC at the close of the risk corridors program is as follows:

HCSC Plans	Outstanding 2014 RC Payments	Outstanding 2015 RC Payments	Outstanding 2016 RC Payments	*Total Outstanding RC Payments*
Illinois	$164,154,707	$ 291,495,531	$ 115,870,452	*$571,520,690*
Montana	$19,991,045	$ 43,068,109	$ 34,407,521	*$97,466,675*
New Mexico	$5,467,244	$ 18,627,475	$ 2,884,412	*$26,979,131*
Oklahoma	$44,867,696	$ 119,431,220	$ 58,224,758	*$222,523,647*
Texas	$245,025,091	$ 622,460,037	$ 167,878,594	*$1,035,363,722*
Total	**$479,505,784**	**$1,095,082,371**	**$ 379,265,738**	***$1,953,853,892***[5]

CLAIMS FOR RELIEF

Count I

Violation of Statutory and Regulatory Mandates to Remit Risk Corridors Payments

109. Plaintiff incorporates by reference as if set forth fully herein the allegations set forth above.

110. As part of its obligations under the ACA, HHS is required to "establish and administer a program of risk corridors for calendar years 2014, 2015 and 2016." 42 U.S.C. § 18062(a). The ACA states that HHS "*shall*" create this risk corridors program for each of the listed calendar years. *Id.* (emphasis added).

111. The ACA further provides that "the Secretary *shall* pay" to an issuer of a QHP a given amount to compensate for certain losses the plan incurs as a result of its allowable costs exceeding its premiums. 42 U.S.C. § 18062(b)(1) (emphasis added). This payment formula

[5] Figures may not add to the amount in the "Total" row due to rounding.

contains no restriction conditioning the Defendant's obligation on the availability of appropriations.

112. The Final Rule governing the risk corridors program for the 2014 benefit year also establishes that risk corridors payments are mandatory, notwithstanding the availability of appropriations. This Rule states that "QHP issuers *will* receive payment from HHS in the following amounts, under the following circumstances: (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount." 45 C.F.R. 153.510(b) (emphasis added).

113. Plaintiff is a QHP, and was certified as such by HHS through CMS, and it has operated on the Exchanges through all of 2014, 2015, and 2016.

114. Plaintiff satisfied the requirements established by Section 1342 of the ACA, and as a result, Defendant is legally obligated to make the payments required by Section 1342.

115. Defendant's refusal to remit to Plaintiff the full amount of the risk corridors payments owed for 2014, 2015, and 2016 violates the ACA and its implementing regulations.

116. Defendant has failed and refused, without justification, to perform its statutory obligations.

117. Defendant has violated its statutory obligations by refusing to remit the full risk corridors payments owed to Plaintiff as required by 42 U.S.C. § 18062 and 45 C.F.R. § 153.510(b).

118. Defendant's violation of the ACA and its implementing regulations proximately caused Plaintiff to suffer monetary damages.

Count II

Breach of Express Contract

119. Plaintiff incorporates by reference as if set forth fully herein the allegations set forth above.

120. The documents exchanged between HCSC and CMS during the QHP qualification processes for 2014, 2015, and 2016 together constitute a valid and enforceable written contract between Plaintiff and Defendant. The parties' mutual intent to include all these documents is supported by an email from Defendant to Plaintiff, which conditioned Defendant's agreement on the accuracy of the information contained in Plaintiff's applications to offer QHPs on the Exchanges.

121. Defendant solicited bids to participate in the Exchanges through its "Letter to the Issuers." (Ex. A.)

122. The documents that Plaintiff submitted in response to Defendants' solicitation constituted an offer to contract with Defendant to include its health insurance plans on the Exchanges.

123. Defendant accepted Plaintiff's offer to contract through an email confirming that each of Plaintiff's plans would be included on the Exchanges and delivering the counter-signed QHPI Agreements. (Exs. E, F.)

124. The government representatives who bound Defendant to this contract, James Kerr (Acting Deputy Director, Operations, Center for Consumer Information & Insurance oversight (CMS)) and Tony Trenkle (Director and CMS Chief Information Officer, Office of Information Services (CMS)), had actual authority to do so. In addition, Defendant evidenced its

acceptance of Plaintiff's offer to contract through official CMS email. At all times relevant here, Defendant's representatives had the actual authority to and did bind HHS to these contractual commitments.

125. The QHPI Agreements "memorialize" the contractual relationship between Plaintiff and Defendant. (Ex. A at 23.)

126. The parties mutually exchanged consideration to support the QHPI Agreements. In consideration, Plaintiff and Defendant agreed to abide by the ACA. As further consideration, Plaintiff expended hundreds of millions of dollars providing affordable healthcare to over one million Americans in benefit year 2014, satisfying an essential part of Defendant's regulatory mandate under the ACA. Plaintiff also undertook to develop and sell new kinds of insurance products that conformed to the ACA's novel standards for coverage on the Exchanges, thereby enabling Defendant to fulfill its statutory mandate. Plaintiff also built, paid for, and expanded a health care provider network on the Exchanges. Defendant committed to mitigating Plaintiff's risk of participating in the Exchanges during the early years of the ACA through the ACA's premium stabilization programs, including a commitment to make any risk corridors payments in full that were required by the statute and regulations. Defendant also committed to administering the Exchanges in conformity with the ACA.

127. Defendant repeated this process and reiterated its commitments and obligations for benefit years 2015 and 2016.

128. Plaintiff has fully performed its duties under its contracts with Defendant.

129. Defendant's contracts with Plaintiff incorporate the ACA, including the risk corridors provision and related regulations.

130. These QHPI Agreements define HCSC as a QHP issuer, and QHP issuers are required by Section 1342 of the ACA to participate in the risk corridors program. *Id.*; 42 U.S.C. § 18062(a).

131. The Financial Management Attestations provide that applicants "will be bound by . . . Federal payments related to the . . . risk corridor programs," and include a specific reference to 45 C.F.R. § 153.510. (*See, e.g.*, Ex. B at 6.)

132. Plaintiff's agreements with Defendant require Defendant to remit risk corridors payments that are due and payable to Plaintiff under the ACA for benefit years 2014, 2015, and 2016, in full, as part of its monthly reconciliation process for payments and collections. (*See, e.g.*, Ex. E at 5.)

133. Defendant breached its contracts with Plaintiff by, among other things, failing to fully pay risk corridors payments owed to Plaintiff for the 2014, 2015, and 2016 benefit years.

134. Defendant's breach of its express contracts with Plaintiff proximately caused Plaintiff to suffer monetary damages.

Count III

Breach of Implied Contract

135. Plaintiff incorporates by reference as if set forth fully herein the allegations contained in the paragraphs above.

136. In the alternative, Plaintiff and Defendant entered into an implied-in-fact contract that risk corridors payments due under the statutory formula detailed in ACA § 1342 and its implementing regulations would be remitted in the years in which they became due and payable.

137. The terms of the offer and acceptance were unambiguously specified in the ACA and its implementing regulations.

138. Defendant's intent to contract is demonstrated by the ACA, the implementing regulations, and Defendant's repeated representation of the risk corridors program as one intended to provide protection for participating QHP issuers, like Plaintiff, by: stabilizing participating premiums, offsetting early losses, and removing uncertainty in rate setting. Further, Defendant consistently represented that the risk corridors provision was intended to "provide issuers with greater payment stability as insurance market reforms are implemented [and] to facilitate increased enrollment" and to "protect against uncertainty in rate setting [by QHPs] by limiting the extent of issuers' financial losses and gains." 2014 Final Rule, 78 Fed. Reg. at 15411.

139. Defendant's intent to contract is also demonstrated by its negotiations over Plaintiff's final plan list and its approval of Plaintiff's submissions, including the Attestations.

140. Throughout the contracting process, Defendant repeatedly confirmed its understanding that the 2014, 2015, and 2016 contracts required "full payment" of the risk corridors amounts. This intention was consistent with Plaintiff's understanding of the 2014, 2015, and 2016 QHPI Agreements.

141. Additionally, Defendants first announced that full payments would not be made in November 2015, ***after*** the contracts for 2014, 2015, and 2016 were formed. A unilateral statement made after the contracts were formed could not alter their terms.

142. Plaintiff's intent to contract is demonstrated by its submissions to Defendant, including the Attestations.

143. Based on Defendant's solicitation to insurers, Plaintiff offered to provide specific health plans on the Exchanges, and Defendant accepted. Plaintiff's offer and Defendant's acceptance is demonstrated by Plaintiff's participation directly with CMS and HHS in the

implementation of the risk corridors program. Plaintiff's offer and Defendant's acceptance is further demonstrated by the parties' mutual execution of the QHPI Agreements.

144. In consideration, Plaintiff and Defendant agreed to abide by the Act. As further consideration, Plaintiff expended hundreds of millions of dollars providing affordable health insurance to millions of Americans in benefit years 2014, 2015, and 2016, satisfying an essential part of Defendant's regulatory mandate under the ACA. Plaintiff undertook to develop and sell new kinds of insurance products that conformed to the ACA's novel standards for coverage on the Exchanges, thereby enabling Defendant to fulfill its statutory mandate. Plaintiff also built, paid for, and expanded a health care provider network on the Exchanges. Defendant committed to mitigating Plaintiff's risk of participating in the Exchanges during the early years of the ACA through the ACA's premium stabilization programs, including a commitment to pay risk corridors payments in full. Defendant also committed to administering the Exchanges in conformity with the ACA.

145. The government representatives who bound the government to this implied-in-fact contract, James Kerr (Acting Deputy Director, Operations, Center for Consumer Information & Insurance oversight (CMS)) and Tony Trenkle (Director and CMS Chief Information Officer, Office of Information Services (CMS)), had actual authority to do so. In addition, Defendant evidenced its acceptance of Plaintiff's offer to contract through official CMS email. At all times relevant here, Defendant's representatives had the actual authority to and did bind HHS to these contractual commitments.

146. At all times relevant here, Plaintiff fully performed its contractual obligations.

147. Defendant breached its contractual obligations by failing to promptly remit full risk corridors payments owed to Plaintiff for benefit years 2014, 2015, and 2016.

148. Defendant's breach of its implied contract with Plaintiff proximately caused Plaintiff to suffer monetary damages.

Count IV

Breach of the Implied Covenant of Good Faith and Fair Dealing

149. Plaintiff incorporates by reference as if set forth fully herein the allegations contained in the paragraphs above.

150. The September 2013, October 2014, and October 2015 contracts between Defendant and Plaintiff regarding the issuance of QHPs included an implied duty of good faith and fair dealing. This duty precludes Defendant from acting so as to destroy Plaintiff's "reasonable expectations of the other party regarding the fruits of the contract." *Centex Corp. v. United States*, 395 F.3d 1283, 1304 (Fed. Cir. 2005).

151. In contracting with Defendant to offer QHPs on the Exchanges, Plaintiff reasonably expected that it would receive the full amount of risk corridors payments owed to it under the Act, regardless of the risk corridors payments that CMS collected from other QHP issuers.

152. Plaintiff's expectations were based on the mandatory payment provisions of the ACA, as well as HHS's rules and guidance documents reiterating both that payment would be made and the premium stabilization purposes of the risk corridors program.

153. Defendant has breached the implied covenant of good faith and fair dealing by, among other actions, (1) unilaterally determining after these agreements were executed that CMS would make risk-corridor payments in a "budget neutral fashion"; and thereby (2) limiting the risk corridors payments to Plaintiff for the 2014, 2015, and 2016 benefit years to only a fraction of the amounts owed under the ACA.

154. Defendant's breach of this duty of good faith and fair dealing has proximately caused Plaintiff to suffer monetary damages.

PRAYER FOR RELIEF

Plaintiff prays that this Court:

A. Award damages for the outstanding risk corridors payments still due to HCSC for the 2014, 2015, and 2016 benefit years, in an amount to be proven at trial;

B. Award HCSC its costs and expenses and any interest allowable by law; and

C. Award such further and additional relief as is just and proper.

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Respectfully submitted,

By: /s/ K. Lee Blalack II

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