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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

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U.S. COURT OF
FEDERAL CLAIMS

EMBLEMHEALTH, INC., HEALTH INSURANCE PLAN OF GREATER NEW YORK, INC., and CONNECTICARE BENEFITS, INC.,

Plaintiffs,

v.

THE UNITED STATES OF AMERICA,

Defendant.

No. 17-703 C

COMPLAINT

Plaintiffs EmblemHealth, Inc. and its subsidiaries Health Insurance Plan of Greater New York, Inc. ("HIP") and ConnectiCare Benefits, Inc. ("ConnectiCare") (collectively, "EmblemHealth") bring this action against the United States of America (the "Government") for money damages arising out of the Government's failure to make required payments to EmblemHealth under the risk corridors program mandated by § 1342 of the Patient Protection and Affordable Care Act, and implemented by the United States Department of Health and Human Services ("HHS" or "Department") and the Centers for Medicare and Medicaid Services ("CMS"), with respect to the 2015 and 2016 plan years.

JURISDICTION

1) This Court has jurisdiction over this action pursuant to the Tucker Act, 28 U.S.C. § 1491(a), which allows the United States Court of Federal Claims to hear claims for money damages against the United States "founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort."

Additionally, as discussed more fully herein, the risk corridors statute, the risk corridors regulation, and EmblemHealth's implied-in-fact contract with the Government, create a right to money damages.

PARTIES

2) EmblemHealth, Inc. is a not-for-profit New York corporation with its principal place of business at 55 Water Street, New York, New York 10041. EmblemHealth, Inc., through its health insurance subsidiaries – including HIP and ConnectiCare – provides medical and dental insurance plans in New York and Connecticut.

3) The Government is responsible for the ACA and the risk corridors program, including all related actions taken by the Department and CMS.

BACKGROUND

Introduction

4) The Patient Protection and Affordable Care Act, Pub. Law 111-148, as amended by the Health Care and Education Reconciliation Act, Pub. Law 111-152 ("ACA" or "Affordable Care Act"), significantly altered the regulation of health insurance coverage in the United States by imposing a new set of minimum federal standards for how health insurers (including EmblemHealth) developed, sold, and marketed commercial health insurance to both individuals and employers.

5) In particular, the ACA mandated the creation of health insurance marketplaces in every state (either operated by the particular state, or, in states that did not set up their own marketplace, by HHS). These marketplaces – also known as exchanges – are online platforms through which insurers sell Qualified Health Plans ("QHPs").

6) QHPs, which must meet certain minimum value and benefit design standards, are certified by the exchanges on a state-by-state basis. Insurers that issue QHPs are required to: (i) offer a variety of plans based on actuarial value, measured in metal-level tiers (*i.e.*, platinum, gold, silver, and bronze); (ii) cover federally-determined essential health benefits, as well as any additional state-mandated benefits; and (iii) charge premium rates that are approved by the state insurance regulator consistent with federal rate review requirements.

7) The ACA also imposed a new set of insurance market reforms that applied to individual and small group market coverage generally. These reforms had significant impacts on the way insurers priced and sold insurance products, and marked a stark departure from the pre-ACA regulatory regime.

8) The ACA's new federal rating rules prevented insurers from setting rates in the individual and small group insurance markets based on health status of the individuals seeking insurance. Rather, the new rules imposed a modified community rating requirement that limited rating factors to age, tobacco usage and whether coverage was for an individual or an individual and his or her family. Simultaneously, the ACA prohibited insurers from excluding coverage for pre-existing conditions.

9) Under this approach, insurers based the underlying rate on the total risk anticipated by the insurer for all individuals covered within a given market in a geographic area, *i.e.*, the single risk pool. Pre-existing condition exclusions had protected insurers from adverse selection (and the risk of higher than anticipated claims costs) caused by covering individuals who selected a certain plan or policy based on a disease or condition that would be more generously covered in a given plan.

10) To encourage healthy individuals – as well as those individuals who were previously unable to purchase adequate coverage for financial and/or medical history reasons – to purchase QHPs through an exchange, the ACA offered both advanced-payable premium tax credits ("APTCs"), and cost-sharing reductions. These programs subsidized the premium and cost-sharing for individuals whose income was at or below 400 percent of the federal poverty line and who were not enrolled in Medicaid. Coupled with penalties imposed on individuals who failed to acquire minimum health insurance coverage, the ACA sought to ensure that healthy individuals, not just sick individuals in need of insurance, would purchase individual coverage (thus spreading the risk more evenly across the community, preventing individual premiums from becoming overly expensive).

11) The populations targeted for enrollment in QHPs were generally individuals who had no group health plan coverage through their employers and limited access to individual coverage due to premium costs in excess of financial capacity to pay or due to medical histories that had rendered them unable to qualify for individual insurance prior to the ACA. While insurers and Congress understood that this newly insured population would have different claims experience than individuals covered in group or individual policies before the ACA, insurers had very little data on which to rely in setting premium rates for the new QHPs.

12) Congress anticipated that this lack of information could expose insurers to financial burdens solely as a result of offering QHPs in the marketplaces, and lead to insurers being overly conservative in setting rates (*i.e.*, seeking rates so high that individuals would not purchase them), undermining the ACA's goal of increasing coverage.

13) As a result, Congress included in the ACA three risk mitigation programs to spread market-wide insurable risk more smoothly across insurers and ensure that no single

insurer suffered disproportionate losses. These programs are: the permanent risk adjustment program, the temporary transitional reinsurance program, and the temporary risk corridors program.

14) The risk corridors program established under section 1342 mandated that the Department make payments to insurers whose claims cost in 2014, 2015, and 2016 was significantly more expensive than the amount of premium collected. Conversely, the statute mandated that insurers whose claims cost was significantly better than expected to make payments to the Department.

15) In light of the uncertainty in how to rate the new risk pool created through the market reforms and new incentives, the risk corridors program was designed to achieve two goals: (1) to protect insurers if they under-estimated risk; and (2) to prevent insurers from reaping a windfall if they over-estimated the risk. Despite the symmetry in the statutory language, these complimentary goals require that payments in and out of the program be viewed separately.

16) While the statute is clear that the Department must make payments to insurers that had worse than anticipated claims experience, and that insurers that had better than anticipated claims experience must make payments to the Department, nowhere does the statute condition payment by the Department on the receipt of sufficient funds from insurers.

17) In the middle of 2013 (prior to insurers offering QHPs for the first time in 2014), and before EmblemHealth contracted with the New York and Connecticut Exchanges, the Department affirmatively stated that insurers offering QHPs on exchanges would receive payments under the statute regardless of the amount of payments made by insurers who had better than expected claims experience, and that the risk corridors program was not required to

be budget neutral. This guarantee of payments was reaffirmed by the Department in 2014, when it indicated that, while it expected the risk corridors program to be budget neutral for 2014, it would ensure that all payments were made regardless of budget neutrality.

18) In March 2014, the Department changed its implementation approach – but not its contention that all payments would eventually be made – and announced that it would administer the program as budget neutral over the course of the three years of the program.

19) In September 2014, the Government Accountability Office ("GAO") issued a report regarding the availability of appropriations for risk corridors payments, and determined that only payments into the program and certain funds appropriated for CMS's management activities were available for risk corridors payments to insurers.

20) Subsequently, in December of 2014, Congress passed and the President signed into law an appropriations provision preventing the Department from using this otherwise available funding to make Risk Corridor Program payments for the entirety of fiscal year 2015. This limitation on the use of funds was thereafter extended for all of fiscal year 2016 through the present.

21) Nationally, claims costs for insurers offering QHPs in the small group and individual markets in 2014 far exceeded projections, resulting in massive outstanding risk corridors liabilities. In the 2014 plan year, $2.87 billion in risk corridors payments were owed, while the program collected only $362 million, or 12.6 percent of the total amount owed. In acknowledgement of this deficit, the Department announced that it would defer 87.4 percent of all amounts owed for 2014, with collections from the 2015 and 2016 plan years being used to satisfy remaining outstanding obligations from 2014 first. The Department also announced that all of the 2015 plan year collections will be used to satisfy 2014 plan year obligations, while

2016 plan year collections will first satisfy remaining 2014 obligations, and, if still available, then 2015 plan year obligations.

22) The Department of Justice ("DOJ") has, in lawsuits similar to this, reiterated the Government's changed position that the program is required to be budget neutral over the three years of the program. Even if there was a valid basis to administer the program as budget neutral, the Department's regulation unfairly, arbitrarily, and without any basis in the statute forces insurers like EmblemHealth to subsidize payments to other insurers that were obligated for 2014, without any recovery to them in later years.

23) Consistent with its historical role as a health plan that has served the New York City area and surrounding communities for more than 75 years, EmblemHealth committed to seek QHP certification to sell coverage through exchanges in all states in which it offers health insurance coverage.

24) The QHPs were certified and EmblemHealth average membership totals for the three years of the program in New York were as follows:

Year	Individual Market	Small Group Market
2014	27,381	19,512
2015	22,765	16,437
2016	12,117	16,294

25) Average membership totals for the three years of the program in Connecticut, through ConnectiCare, were as follows:

Year	Individual Market	Small Group Market
2014	25,184	0

2015	36,519	0
2016	50,874	0

26) Under the risk corridors program, EmblemHealth neither owed nor was owed any funds for the 2014 plan year. For the 2015 plan year, circumstances, including higher than anticipated medical and pharmacy expenses, higher than expected risk adjustment program liability, as well as increases in individual market enrollment due to higher penalties under the ACA's individual mandate, resulted in EmblemHealth's claims cost in both the small group and individual markets exceeding projections. These circumstances resulted in risk corridors payments owed to EmblemHealth, for the New York market, in the amount of $3,645,672.92 for EmblemHealth's individual QHPs, and $17,504,832.79 for EmblemHealth's small group QHPs for 2015. While the final risk corridors payments for 2016 will not be finalized until the second half of 2017, EmblemHealth estimates that it will be owed roughly $28,600,000.00 in risk corridors payments for the 2016 plan year for individual and small group plans offered in the New York market. Additionally, EmblemHealth estimates that the government will owe it roughly $20,400,000.00 in risk corridors payments for the 2016 plan year for individual plans offered in the Connecticut market.

27) To date, the Defendant has made no risk corridors payments for obligations owed to EmblemHealth for 2015.

28) By failing to make any payments to EmblemHealth for the 2015 plan year and lacking any funding source for payments to issuers for the 2016 plan year, Defendant has breached both its statutory duty to EmblemHealth to make risk corridors payments to insurers, and its contractual obligation to EmblemHealth to provide certain payments in exchange for

EmblemHealth participating in the ACAs exchanges by offering QHPs. This failure deprives EmblemHealth of roughly $70 million owed for plans offered in the New York and Connecticut markets, under the terms of the ACA, its implementing regulations, and the implied contract between EmblemHealth and the Government to offer QHPs in satisfaction of the Government's statutory requirement to do so.

The Affordable Care Act

29) The Affordable Care Act adopted broad-based structural changes to the manner in which the federal government and, as a result, state governments regulated the sale of health insurance. The ACA included significant new substantive requirements, the so-called market reforms, which set federal floors that insurers must meet in order to legally sell health insurance. *See* ACA §§ 1001, 1201 (amending the Public Health Service Act (the "PHSA")). The ACA also included new incentives for previously uninsured individuals to purchase insurance in the form of tax credits and cost-sharing reductions. *See* ACA §§ 1401, 1402, and 1412. Additionally, the ACA required that the states establish health benefit exchanges to facilitate the sale of insurance, and that the Secretary develop minimum standards for both the exchanges and the certification of QHPs sold through the exchanges. ACA § 1311(b) and (c).

30) Among the market reforms, insurers were: precluded from relying on individuals' medical history in setting premium rates (PHSA § 2701); required to guarantee sale of coverage to individuals and small groups (PHSA § 2702); and prohibited from imposing pre-existing conditions exclusions (PHSA § 2704). In combination, these three provisions created a great deal of uncertainty for insurers in the setting of premium prices, as insurers would be covering both individuals (through the guaranteed issue requirement) and conditions (through the pre-existing conditions provision) for which they had little actuarial experience or data to rely.

31) The ACA also imposed a mandate on individuals who failed to maintain minimum essential coverage, either through their employer, enrolling in a governmental program, or purchasing coverage on the commercial markets. 26 U.S.C. § 5000A(a).

32) The addition of incentives for lower-income individuals to purchase insurance further exacerbated the knowledge gap for insurers as more previously uninsured individuals were expected to purchase QHP coverage. Congress incentivized purchase of coverage for individuals with income at or below 400 percent of the federal poverty level through the premium tax credits paid directly to the insurer to reduce the premium cost to the individual. *See* ACA § 1412 and 26 U.S.C. § 36B. For lower income individuals, Congress provided cost-sharing reductions which significantly increased the value of coverage for individuals whose income was at or below 400 percent of federal poverty. ACA § 1402(c). Like the APTCs, the generosity of the cost-sharing subsidy increases for individuals at lower incomes. Since individuals are only eligible for the subsidies if they purchase coverage sold through the exchanges, the ACA was designed to drive the previously uninsured population into the QHPs sold through exchanges.

33) The regulations implementing the ACA's exchange provisions make clear that insurers that offer QHPs on an exchange will receive payment for tax credits for qualified individuals under 26 U.S.C. § 36B. *See* 45 C.F.R 156.460. An insurer will receive those payments after submitting a notice to the exchange that a qualified individual is enrolled, and the insurer has reduced the premium amount to reflect the APTC, notified the exchange of the reduction, and included the amount of the APTC and the remaining premium in the billing statement to the enrollee. *Id*. at § 156.460(a).

34) Similarly, insurers that sell cost-sharing reduction eligible QHPs to eligible individuals will receive payments directly from the government in the amount of payments made by the insurer to the provider. 45 C.F.R. § 156.430(b).

35) The establishment of Exchanges and QHP standards was another essential aspect of the Secretary's role in implementing the Affordable Care Act. Indeed, if the Secretary determined that a state-exchange did not meet federal standards, the Secretary was required to operate an exchange on behalf of the state. ACA § 1321(c).

36) Congress anticipated that this drastic change in the regulation of insurance, and the claims experience of this previously uninsured population, would render accurate premium pricing by insurers extremely difficult, particularly in the first three years in which the new rules applied. Because this new regulation of the health insurance markets created significant uncertainty for insurers, Congress enacted three risk-mitigation programs (transitional reinsurance, risk corridors, and risk adjustment) designed to ensure that risk was spread fairly across insurers and the marketplace. These programs were primarily focused on: (i) encouraging insurers to participate in the exchanges and fulfill the statutory mandate for the federal and state governments to offer QHPs; and (ii) creating sufficient safeguards that insurers would not set overly-conservative premium rates, thus defeating the ACA's purpose of expanding coverage opportunities.

37) The reinsurance program and the risk adjustment program were both, by their terms limited, in the amount of funding available for insurers.

38) For the reinsurance program, Congress specified that the Secretary was to collect a fixed sum amount spread across health insurers and group health plans on a per capita basis in each of the three plan years. ACA § 1341(b)(3)(B)(iii) and (iv) (setting aggregate collection

amounts for 2014, 2015, and 2016 at $12,000,000,000, $8,000,000,000, and $5,000,000,000, respectively). These funds were to be used, in part, to fund reinsurance payments to insurers who covered "high-risk individuals" in the individual market generally. ACA § 1341(b)(2). Importantly, Congress designed this program to be run by the states, but with the federal government serving as a default in the event a state failed to elect to implement the provision. ACA § 1321(c)(1).

39) The risk adjustment program was designed to equalize actuarial risk across plans in the small group and individual markets. ACA § 1343(a). Payments under this program were designed to be relative to the market risk, and therefore limited to amounts collected. *Id.* Specifically, a plan would only receive a payment if the actuarial risk of the enrollees in the plan for a year was higher than the actuarial risk of all enrollees in all plans and coverages in the state. ACA § 1343(a)(2). Similarly, plans would only pay into the program if the actuarial risk of their enrollees was less than that of all enrollees in all covered plans and coverages in the state. ACA § 1343(a)(1). Again, this program was to be run by the state, and was designed to be (and has been implemented as) a budget neutral program, *i.e., payments made by the program are limited in amount to the payments made into the program.*

The Risk Corridors Program

40) The third of these risk mitigation programs – the risk corridors program – gives rise to this lawsuit. Section 1342 of the ACA mandates that the Department establish the risk corridors program – and, pursuant to it, make prescribed payments to insurers to partially compensate them for certain losses attributable to their participation in the exchanges.

41) The risk corridors program was limited to insurers that offered QHPs, and – unlike the reinsurance and risk adjustment programs – was not designed to be limited to

collections by the Department. Rather, the risk corridors program was designed to share the risk of these newly-covered populations between the Government and insurers like EmblemHealth.

42) Section 1342 provides, in relevant part:

> **(a) In general**
>
> The Secretary ***shall establish and administer*** a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall participate in a payment adjustment system*** based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.
>
> **(b) Payment methodology**
>
> **(1) Payments out**
>
> The Secretary ***shall provide under the program established under subsection (a)*** that if—
>
> **(A)** a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, ***the Secretary shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> **(B)** a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, ***the Secretary shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> **(2) Payments in**
>
> The Secretary ***shall provide under the program established under subsection (a)*** that if—
>
> **(A)** a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, ***the plan shall pay to the Secretary*** an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> **(B)** a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, ***the plan shall pay to the Secretary*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062 (emphases added).

43) Congress's unflagging use of the word "shall" in § 1342, without placing any contingencies or discretion on the mandated payments (other than that plans must have the requisite gains or losses), stands in stark contrast to the language in the other risk mitigation programs. As such, the text of section 1342 obligates the Department to make payments to insurers under the terms of § 1342(b)(1) – just as it obligates insurers to make payments to the Department under the terms of § 1342(b)(2).

44) Similarly, regulations issued by the Department and CMS also make clear that these payments are mandatory:

> (b) HHS payments to health insurance issuers. ***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.
>
> (c) Health insurance issuers' remittance of charges. ***QHP issuers must remit*** charges to HHS in the following amounts, under the following circumstances:
>
> > (1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and
> >
> > (2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

45 C.F.R. § 153.510 (emphases added).

45) In eventually promulgating guidance with respect to the risk corridors program, the Department and CMS repeatedly acknowledged that which is obvious on the face of the statute: "The temporary risk corridors program permits ***the Federal government and QHPs to share in profits or losses*** resulting from inaccurate rate setting from 2014 to 2016," HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,121 (Dec. 7, 2012) (emphasis added), and "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 . . . ." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013) (emphasis added).

46) Nor was there any misunderstanding that these payments would be made in a prompt manner. The Department and CMS indicated that "[a] QHP issuer must remit charges to HHS within 30 days after notification of such charges," 45 C.F.R. § 153.510(d), and that "payment deadlines should be the same for HHS and QHP issuers." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,238 (Mar. 23, 2012).

47) In March 2014 – that is, ***after*** the risk corridors program began – the Department announced its intention to "implement this program in a budget neutral manner." HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014). The Department further elaborated that it would not outright refuse to pay its statutory obligations, but would delay doing so: "[I]f 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 [and] . . . collections received for the next year will . . . be used to pay off the payment reductions issuers experienced in the previous year." CMS, Risk Corridors and Budget Neutrality (Apr. 11, 2014).

48) Of course, if, as the Department of Justice has subsequently contended in defense of other lawsuits similar to this, the program is truly budget neutral, then payments into the program would have to be capped by the amount of payments out of the program. Although this factual situation did not arise, there is equally little support in the statute for the application of true budget neutrality as there is for the Government's current position capping payments to insurers at the amount paid in by insurers.

49) Then, in December 2014, Congress passed the Consolidated and Further Continuing Appropriations Act of 2015, which prohibited CMS from using CMS Program funding sources to make payments under the risk corridors program. Pub. L. 113-235 (Dec. 16, 2014), § 227; *see also* Consolidated Appropriations Act, 2016, Pub. L. 114-113 (Dec. 18, 2015), § 225 (same).

50) Notwithstanding these appropriations riders, the Department and CMS continued to (correctly) acknowledge that "the Affordable Care Act requires the Secretary to make full payments to issuers," HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015), and that any "amounts that remain unpaid . . . [are an] obligation of the United States Government for which full payment is required." Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015); Risk Corridors Payments for 2015 (Sept. 9, 2016) (same).

EmblemHealth's QHPs

51) Congress's enactment of the ACA, the Department and CMS's regulations implementing the ACA, and numerous other written and oral communications by the Government, the Department, and CMS conditioned a variety of benefits – including APTCs,

cost-sharing subsidies, risk adjustment and risk corridors – on insurers agreeing to participate in the exchanges.

52) EmblemHealth accepted this offer to provide QHPs by participating in exchanges in New York and Connecticut.

53) In particular, EmblemHealth entered into an agreement with the New York Department of Health to offer QHPs on the New York State Health Insurance Exchange (the "New York Exchange") on July 31, 2013. *See* Agreement between Department of Health and Health Insurance Plan of Greater NY (the "NY Agreement"). The term of the NY Agreement runs from October 1, 2013 (the first day of open enrollment for the 2014 plan year, and the first open enrollment for which the exchanges were intended to be operational) through December 31, 2018, thus covering the entirety of the risk corridors program.

54) The NY Agreement required EmblemHealth to offer QHPs for the entire period and to meet all applicable requirements, including those imposed on insurers by the regulations implementing the risk corridors program. *See generally*, NY Agreement at § III(b) and (c). The NY Agreement also barred EmblemHealth from making modifications to the QHP standardized benefits or cost-sharing structures, unless required by state or federal law. *Id.* at § III(c)(3).

55) Moreover, the NY Agreement, consistent with federal regulatory requirements, required that EmblemHealth submit annual premium rate and form filings. *Id*. at § V(A)(2). Importantly, the NY Agreement permitted EmblemHealth to terminate the NY Agreement, and subsequently not offer QHPs, only if EmblemHealth notified "the Exchange of circumstances causing the CONTRACTOR to be ***unable to perform activities and services required under this AGREEMENT.***" *Id.* § X(F) (emphasis added).

56) Similarly, on September 30, 2013, EmblemHealth entered into an agreement with the Connecticut Health Insurance Exchange ("Access Health CT") to offer QHPs in Connecticut. *See* Agreement Between the Connecticut Health Insurance Exchange d/b/a Access Health CT and ConnectiCare Benefits, Inc. (the "CT Agreement"). The term of the CT Agreement ran from October 1, 2013 through December 31, 2015. The parties agreed to a written amendment of the CT Agreement (the "Amendment") effective January 1, 2016 through December 31, 2017. *See* Amendment at Preamble. The amended CT Agreement covers the entirety of the risk corridors program.

57) The CT Agreement required EmblemHealth to offer QHPs in Connecticut for the term of the Agreement and to comply with "all State and Federal laws and regulations applicable to the performance of" EmblemHealth's obligations, which necessarily include the risk corridors regulations. *See* CT Agreement at Sec. 3.24(A). The CT Agreement also specified that the Exchange, and not EmblemHealth, would "define a cost sharing and benefit design for each standard plan, which may be amended from time to time as deemed necessary by the Exchange." *See* CT Agreement at Sec. 3.2(B).

58) Consistent with federal regulatory requirements, the CT Agreement required that EmblemHealth submit annual rate filings to the Connecticut Department of Insurance. *Id.* at Sec. 3.1(E)(1). EmblemHealth submitted rates for review by the New York Department of Financial Services and the Connecticut Insurance Department consistent with the ACA's market reforms for the 2014 plan year. Those rates were filed and approved as follows:

	Filed	Approved
HIP Individual On Exchange	April 29, 2013	July 26, 2013
HIP Individual Off Exchange	May 29, 2013	August 29, 2013

HIP Small Group Off Exchange	May 29, 2013	August 29, 2013
ConnectiCare Individual On Exchange	May 20, 2013	August 5, 2013

59) EmblemHealth considered a number of relevant factors in setting rates. Specifically, EmblemHealth considered the costs of medical and pharmaceutical supplies and therapies for the current insured population, morbidity rates for the uninsured population, medical and pharmacy trends, provider network costs, changes in benefit levels, expected risk adjustment payments, expected reinsurance program payment, cost-sharing subsidies, administrative expenses, and taxes and fees.

60) For the 2015 rate filing, which occurred in April/May 2014, no data regarding claims experience was available for the new population of enrollees covered under EmblemHealth's ACA-compliant plans.

61) At all relevant times, EmblemHealth has materially complied with applicable laws and regulations governing its participation in the New York and Connecticut Exchanges, and the NY and CT Agreements, respectively.

62) EmblemHealth offered QHPs to individuals throughout the three years of the risk corridors program in both New York and Connecticut and has, to the best of its current knowledge and understanding, materially satisfied all the requirements imposed on insurers under both ACA section 1342 of the Affordable Care Act and the regulations implementing that provision, *see* 45 C.F.R. § 153.500, *et. seq.*, as well as the NY and CT Agreements. EmblemHealth has not been advised to the contrary by federal or state regulators.

Insurers' Experience Under the Risk Corridors Program

63) On November 19, 2015, CMS issued a memorandum that detailed the nationwide, and insurer-specific, results of the risk corridors program for the 2014 plan year. *See* Risk Corridors Payments and Charge Amount for Benefit Year 2014, CMS (Nov. 19, 2015) *available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf*. CMS reaffirmed an earlier statement that, for 2014, $2.87 billion in risk corridors payments had been requested by insurers, and that only $362 million in risk corridors charges against insurers had been levied. As a result of the Defendant's budget-neutral implementation approach, CMS stated that insurers who requested payments would only receive 12.6 percent of the requested amount, a pro-rata adjustment based on the amounts charged to insurers. The memorandum reaffirmed that risk corridors charges levied against insurers would be paid in full.

64) On September 9, 2016, CMS issued a memorandum detailing preliminary data for risk corridors payments for the 2015 plan year. Risk Corridors Payments for 2015, CMS (Sept. 9, 2016) *available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF*. While specific data on the amount of risk corridors obligations owed by the Government to individual insurers was not included in this memorandum, CMS did make clear that all 2015 collections for the program would be used to satisfy outstanding 2014 plan year obligations. CMS also invited insurers who were owed risk corridors obligations to begin discussing settlement of these outstanding claims.

65) On October 7, 2016, EmblemHealth submitted a letter to the Department of Justice making a demand for the 2015 payment amount in a final effort to avoid litigation over the risk corridors obligations.

66) On November 18, 2016, CMS issued a memorandum that detailed the insurer-specific risk corridors payments and charges for the 2015 plan year. Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, CMS (Nov. 18, 2016) *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf. That memorandum states that the Government owes the Health Insurance Plan of Greater New York $3,645,672.92 in individual market risk corridors payments and $17,504,832.79 in small group market risk corridors payments.

67) The total collections for the 2015 plan year by the Government are roughly $95,000,000.00, an amount that leaves over $2 billion in outstanding obligations that have not been satisfied for the 2014 plan year alone. To date, no payments have been made on the Government's obligations for the 2015 plan year.

68) EmblemHealth continued to offer QHPs through state-based exchanges in both New York and Connecticut for the 2016 plan year consistent with its obligations under both the NY Agreement and the CT Agreement. While those data will not be verified by CMS until later in 2017, EmblemHealth estimates that it will be owed roughly $49 million in risk corridors payments across both states.

69) Based on the limited risk corridors collections paid to the Government by insurers for the 2015 plan year, the remaining outstanding balance of 2014 payments owed, the fact that the Government has administered the risk corridors program as being budget-neutral over the three-year course of the program, and the lack of available appropriations, the Government currently owes EmblemHealth $21,150,505.71 for the 2015 plan year and there is no reasonable expectation that the government will make that payment, even at the end of the three-year

program. Similarly, no payments are reasonably expected for the roughly $49,000,000.00 in obligations for the 2016 plan year.

70) Alternatively, if the Government's obligations to EmblemHealth could be limited to funds available under a budget-neutral risk corridors program, EmblemHealth would be entitled to pro rata payments for the 2015 and 2016 plan years based on the amount of money the Government received for each of those respective plan years (*i.e.*, the Government may not further reduce the money EmblemHealth is entitled to for the 2015 and 2016 plan years to provide extra payments owed to other insurers for the 2014 plan year).

COUNT I

Violations of Statutory and Regulatory Mandates to Make Payments

71) EmblemHealth re-alleges and incorporates by reference the allegations set forth in ¶¶ 1- 70 above, as if fully rewritten herein.

72) ACA § 1342 and 45 C.F.R. § 153.510 obligate the Government to pay QHPs specified percentages of "allowable costs" incurred by the QHPs above the "target amount."

73) EmblemHealth has satisfied all requirements for participation in the risk corridors program and met all conditions for payment of risk corridors obligations for the 2015 and 2016 plan years.

74) Despite doing so, payments to EmblemHealth under the risk corridors program have not been made – and it is clear that, under the existing legal and regulatory framework, the payments to which EmblemHealth is entitled will not be made.

75) The Government's obligations under ACA § 1342 and 45 C.F.R. § 153.510 have not – and, at this point, may not – be repealed in whole or in part.

76) Accordingly, full payments to EmblemHealth are required for the 2015 and 2016 plan years.

77) In the alternative, since the Government has and will receive *some* money from insurers under the risk corridors program for the 2015 and 2016 plan years, EmblemHealth is – at a minimum – entitled to a *pro rata* share with respect to each individual plan year. Yet, the Government has indicated it will use this money to first pay out remaining balances owed to insurers for the 2014 plan year, in further violation of ACA § 1342 and 45 C.F.R. § 153.510.

COUNT II

Breach of Implied-in-Fact Contract

78) EmblemHealth re-alleges and incorporates by reference the allegations set forth in ¶¶ 1 - 77 above, as if fully rewritten herein.

79) EmblemHealth entered into an implied-in-fact contract with the Government, under which – in consideration for EmblemHealth's participation in the exchanges – EmblemHealth was and is entitled to risk corridors payments.

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

81) EmblemHealth's compliance with its obligations under ACA § 1342, 45 C.F.R. § 153.510 and other relevant statutory and regulatory provisions constituted acceptance of the Government's offer.

82) Both EmblemHealth and the Government's actions evinced an intent to be bound by the terms of this implied-in-fact contract.

83) The Government's failure to make required risk corridors payments constitutes a material breach of this implied-in-fact contract.

84) The Government's announced policies with respect to the disbursement of risk corridors payments further constitute an anticipatory breach of this implied-in-fact contract.

85) Accordingly, full payments (or in the alternative pro rata annual payments) to EmblemHealth are required for the 2015 and 2016 plan years.

COUNT III

Taking Without Just Compensation

86) EmblemHealth re-alleges and incorporates by reference the allegations set forth in ¶¶ 1 - 85 above, as if fully rewritten herein.

87) EmblemHealth has a vested property interest in the approximately $70,150,000 owed to it by the Government (or, in the alternative, the amount of money EmblemHealth would be entitled to if the Government made risk corridors payments on a *pro rata* basis with respect to each individual plan year).

88) The Government's actions, as set forth in this Complaint and related official pronouncements, constitute an unjustified deprivation and taking of EmblemHealth's property for public use without just compensation, in violation of the Fifth Amendment of the United States Constitution.

89) Accordingly, EmblemHealth is entitled to just compensation for the Government's taking of approximately $70,150,000 (or, in the alternative, the amount EmblemHealth would have received on a *pro rata* basis for plan years 2015 and 2016).

PRAYER FOR RELIEF

WHEREFORE, EmblemHealth requests this Court to enter judgment in its favor and against the Government with respect to Counts I, II and/or III, and order the following relief:

a. Award EmblemHealth money damages it is or will be entitled to under the risk corridors program, which EmblemHealth estimates to be approximately $70,150,000;

b. Award EmblemHealth such additional damages and other relief (including declaratory relief) available under applicable law;

c. Award EmblemHealth pre- and/or post-judgment interest to the greatest extent permitted by law;

c. Award EmblemHealth costs and attorneys' fees to the greatest extent permitted by law; and

d. Award EmblemHealth any and all further relief that this Court may deem just and proper.

Dated: May 26, 2017

Respectfully submitted,

GROOM LAW GROUP, CHARTERED

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