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IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTHFIRST PHSP, INC. Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 20-179 C **COMPLAINT**

Plaintiff Healthfirst PHSP, Inc. ("Plaintiff" or "Healthfirst"), brings this action against the United States Government ("Defendant" or "Government") seeking damages and other relief for the Defendant's (1) violation of Section 1342 of the Patient Protection and Affordable Care Act ("Section 1342") and 45 C.F.R. § 153.510(b) ("Section 153.510"); and (2) breach of its risk corridors payment obligations under an implied-in-fact contract. In support of this action, Plaintiff states and alleges as follows:

NATURE OF ACTION

1. In March 2010, the Government enacted the Patient Protection and Affordable Care Act[1] and the Health Care and Education Reconciliation Act[2] (collectively, the "Affordable Care Act" or "ACA"). The ACA created a system of virtual "marketplaces" (or "exchanges") on which individuals and small groups could purchase Qualified Health Plans ("QHPs")[3] from participating insurance companies ("QHP issuers").

[1] Pub. L. No. 111-148 (Mar. 23, 2010), 124 Stat. 119.
[2] Pub. L. No. 111-152 (Mar. 30, 2010), 124 Stat. 1029.
[3] A QHP is a health plan that meets certain standards established by the Centers for Medicare & Medicaid Services ("CMS") in order to be sold to consumers through the exchanges.

2. Section 1342 of the ACA established the risk corridors program ("RCP"), under which QHP issuers (1) receive reimbursement from the Government if their losses exceed certain defined thresholds; and (2) pay the Government if their gains exceed similarly defined thresholds. By design, the RCP was effective for the first three years of the exchanges (benefit years 2014, 2015, and 2016).

3. The only significant precondition for the Government's payment obligations is the calculation of revenue and cost data submitted to CMS by QHP issuers.

4. At the end of 2014, the first year of the exchanges, a new Congress passed the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. No. 113-235) ("2015 Spending Rider") preventing CMS and its parent agency, the U.S. Department of Health & Human Services ("HHS")—responsible for administering the ACA—from using certain accounts to fund the obligated risk corridors payments for benefit year 2014. Congress included the same restriction in the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Rider") and Consolidated Appropriations Act, 2017 (Pub. L. No. 115-31) ("2017 Spending Rider," collectively, the "Spending Riders").

5. In 2014, 2015, and 2016, Plaintiff provided health insurance to its members on the exchange in New York.

6. CMS has conceded that Healthfirst is owed $75,523.98 under the RCP for benefit year 2014, $697,039.60 for benefit year 2015, and $6,891,430.55 for benefit year 2016 for Healthfirst's participation in the New York exchange.

7. The Government has made only partial payment toward its benefit year 2014 payment obligations to Healthfirst and no payment toward its benefit year 2015 and 2016 payment obligations to Healthfirst. Moreover, CMS has publicly stated in sub-regulatory

guidance that it will not make full payment under the RCP until a later—but as-of-yet undetermined—date, if at all.

8. By this lawsuit, Healthfirst seeks full payment of the risk corridors amounts owed to it by the Government under the ACA for benefit years 2014, 2015, and 2016.

JURISDICTION

9. This Court has jurisdiction over the subject matter of this action pursuant to the Tucker Act, 28 U.S.C. § 1491. The statutory cause of action giving rise to this Court's Tucker Act jurisdiction is Section 1342, a money-mandating statute that requires payment from the federal government to QHP issuers, like Plaintiff, that satisfy certain criteria. Section 153.510(b) is a money-mandating regulation that implements Section 1342 and thus also obligates payment from the federal government to QHP issuers that satisfy certain criteria.

10. In the alternative, the Contract Disputes Act, 41 U.S.C. §§ 7101 *et seq.*, a money-mandating statute, provides Plaintiff a cause of action that gives rise to this Court's jurisdiction pursuant to the Tucker Act.

11. This controversy is ripe because CMS has refused to pay Plaintiff the full amount Plaintiff is owed for 2014, 2015, and 2016 as required by Section 1342 and Section 153.510 and the parties' implied-in-fact contract.

PARTIES

12. Plaintiff, Healthfirst, is organized under the laws of New York with its principal place of business in New York, New York.

13. Healthfirst offers comprehensive health insurance benefits to individuals, families, and businesses.

14. In total, Healthfirst provided insurance coverage through QHPs to thousands of

individuals on the New York exchange during benefit years 2014, 2015, and 2016.

15. Healthfirst has aggressively pursued the ACA's goal of connecting the people in its service area to insurance coverage opportunities with the understanding that a broader base of insured is better for the individuals within the pool and the overall functioning of the marketplaces.

16. Defendant is the Government, acting at times through CMS or HHS. Unless otherwise noted, references in this Complaint to CMS include HHS where applicable.

FACTUAL ALLEGATIONS

A. The Affordable Care Act Established a "Risk Corridors" Program With Two-Way Payment Obligations.

17. The ACA represented a major shift in healthcare regulation and coverage in the country. It ushered in a host of market-wide reforms and requirements affecting the private health insurance industry. Among other things, the ACA addressed the scope of covered services, availability of coverage, renewability of coverage, out-of-pocket costs for consumers, pricing, and other coverage determinants. The ACA limits health insurance product variation and restricts pricing and underwriting practices. The ACA also guarantees issuance and renewability of coverage.

18. In addition to creating the exchanges "to bring together buyers and sellers of insurance, with the goal of increasing access to coverage," the ACA requires individuals to purchase coverage if they are not otherwise insured. The law then also creates a system of federal subsidies to offset the cost of coverage. These features dramatically increased the number of individuals—many previously uninsured—purchasing health insurance.

19. The ACA requires health plans in the individual and small group markets to cover many benefits without any added cost to the insured. Because QHP issuers had insufficient data

to reliably predict the needs and associated costs of the newly insured, QHP issuers would have had difficulty setting premiums at affordable rates under normal market conditions.

20. To encourage insurance companies to enter the exchanges and offer plans at affordable premiums, and to minimize the risks posed to them by doing so in light of the uncertainties about the newly insured, the ACA set up three marketplace premium stabilization programs, commonly referred to as the "Three Rs": a permanent risk adjustment program, a transitional reinsurance program, and a temporary "risk corridors" program. These premium stabilization programs were designed to mitigate the risks posed by an untested regulatory framework. Both the reinsurance and risk corridors programs were in effect for each of the 2014, 2015, and 2016 benefit years (a "benefit year" is the calendar year for which a health plan provides coverage for health benefits). The risk adjustment program is a permanent program.

21. Section 1342 of the Affordable Care Act, as codified at 42 U.S.C. § 18062, created the RCP. In relevant part that Section states:

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

> more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.

Pub. L. No. 111-148, § 1342 (emphases added). In addition to these "payments out," Section 1342 also requires QHP issuers to pay amounts to HHS if the plans' actual costs are less than its targeted costs ("payments in"). *Id.* § 1342(b)(2). For both the "payments out" and "payments in" provisions, the terms "allowable costs" and "target amount" are defined by the statute. *Id.* § 1342(c). Thus, the RCP specifically guarantees that if an insurer's allowable costs "for any plan year" exceed the target amount, HHS "shall pay to the plan" a portion of such excess allowable costs pursuant to the statutory formula. Conversely, plans that incur allowable costs below the target amount in the benefit year are obligated to pay a portion of their realized savings to the Government.

22. The RCP is required by statute to be modeled on the risk corridors program enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act, signed into law in 2003 (*i.e.*, Medicare Part D), also administered by HHS and CMS on an annual, non-budget neutral basis. *See* 42 C.F.R. § 423.336.

23. HHS implemented the RCP in the Code of Federal Regulations at 45 C.F.R. § 153.510. In relevant part, Section 153.510 states:

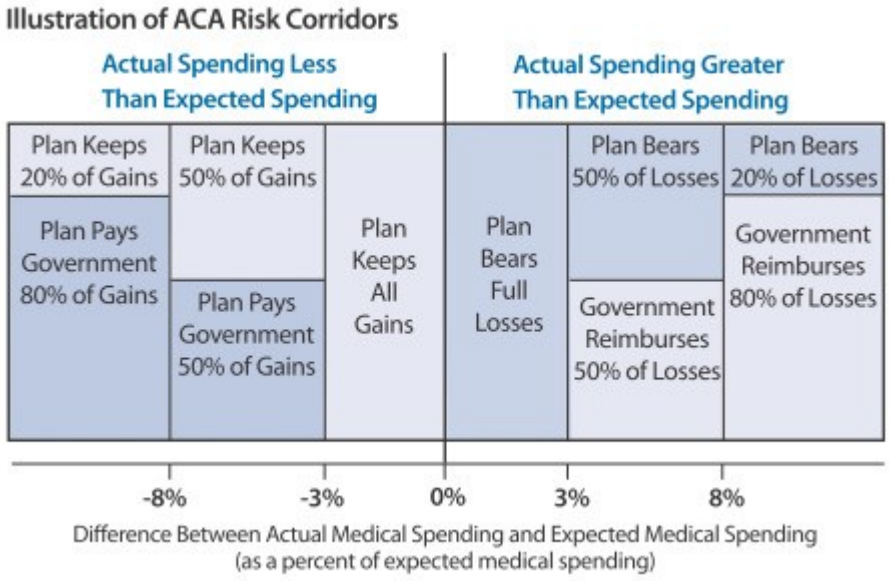
> (b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
>
> > (1) When a QHP's allowable costs ***for any benefit year*** are more than 103 percent but not more than 108 percent of the target amount, ***HHS 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.

(Emphases added.)

24. HHS mandated certain data reporting requirements and deadlines applicable to QHP issuers. 45 C.F.R. §§ 153.510, 153.530. Under the RCP, after HHS verifies the QHP issuers' data submissions, HHS must pay the insurers based on their plans' excess expenses (one amount for expenses greater than 103 percent and another amount for expenses greater than 108 percent of each QHP issuer's target amount).

25. The QHP issuers' and the Government's respective risk corridors payment obligations pursuant to Section 1342 are graphically depicted in the following chart from the American Academy of Actuaries:



26. The Government's payments out under the RCP are not subject to the payments in, and vice versa. The statute does not create a single account to service both payments in and payments out. Nor does the statute provide that the RCP must be budget neutral. The statute is clear that the Government will share in the losses for plans with higher than anticipated costs.

Accordingly, if all plans experienced higher than anticipated costs, the Government would be obligated to make payments even though there would be no payments in from insurers.

27. The purpose of the RCP—in conjunction with the other of the Three Rs—was to induce health insurer participation in the health insurance exchanges by mitigating their risk of loss. The program could not serve that purpose if, after incurring potentially millions of dollars in unbudgeted expenditures over a benefit year, QHP issuers could not depend on the Government to make timely reimbursements owed under Section 1342. The ACA would have failed to attract sufficient entrants into the marketplaces because the investment would have been too risky (reducing competition and increasing premiums). HHS's timely and complete payment to plans under the RCP is integral to realizing Congress's intent to stabilize premiums.

B. QHP Issuers Participated in Exchanges and Set Prices in Reliance on the RCP.

28. As noted above, the ACA's health insurance exchanges became operational for the 2014 benefit year. For Healthfirst to participate that year, it had to submit its premiums to the Government by May 2013. In September 2013, Healthfirst entered into a QHP Issuer Agreement with CMS, and its commitment to participate in the marketplace was fixed and irrevocable. Healthfirst, like its fellow QHP issuers, entered the exchanges with the express understanding—based on the plain text of Section 1342 and its implementing regulations set forth above—that if it qualified for reimbursement under the statutory formula, it would receive the payments owed. Prior to the launch of the exchanges in 2014, the Government gave no indication that it would subsequently refuse to make risk corridors payments or hold payments due for a particular benefit year until a later and indefinite date.

29. Health insurers had relied on the statutorily mandated RCP, as well as the other premium stabilization programs, in setting their premiums for 2014, 2015, and 2016. It was not

until October 2015, long after health insurers had set premiums for the last year of the RCP, that the Government first indicated that it would pay only 12.6 percent of its obligations under the RCP for the 2014 benefit year. CMS, "Risk Corridors Payment Proration Rate for 2014" (Oct. 1, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf; CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf ("2014 Payment Memo"). Similarly, it was not until September 2016 that CMS first indicated that it anticipated that "no funds would be available at this time for 2015 benefit year risk corridors payments." CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF ("Sept. 2016 Memo"). CMS then stated in November 2016 that it would not pay *any* portion of its obligations under the RCP for the 2015 benefit year. CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (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 ("2015 Payment Memo"). CMS similarly indicated in November 2017 that it would not pay any portion of its obligations under the RCP for the 2016 benefit year. CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year" (Nov. 18, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf ("2016 Payment Memo"). CMS has repeatedly indicated that it will not make full payment under the RCP.

C. The Risk Corridors Program Was Contravened After Enactment.

30. The Government impeded its administration of the ACA despite its express and binding obligations.

31. The first such step was in March 2014, when HHS unexpectedly took the position in its annual Payment Rule that the RCP would be administered in a "budget neutral" manner. The Payment Rule is an annual rulemaking articulating the payment policies and requirements for participation in the ACA marketplaces. The preamble to the 2015 Payment Rule stated:

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

79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014).

32. Then, in April 2014, CMS issued a statement asserting:

> 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.

CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf ("April 2014 Memo").

33. These statements—in the form of sub-regulatory guidance, not subject to public notice and comment—were directly at odds with the statements of HHS during its rulemaking. HHS never raised during the rulemaking on its Section 1342 implementing regulation (which was promulgated on March 23, 2012) that it would administer the RCP in a budget-neutral manner, or even that the statute permitted it to do so. 77 Fed. Reg. 17,220, 17,220-17,252 (Mar.

23, 2012). HHS's 2014 statements radically departed from what the ACA intended and its plain text requires, as well as what its implementing regulation reflected: the RCP was enacted without regard to annual budget neutrality. Indeed, in the preamble to its 2014 Payment Rule, issued March 11, 2013, HHS conceded as much, stating that "[t]he risk corridors program is not statutorily required to be budget neutral." 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013). Further, Congress stated expressly in Section 1342 that the RCP was to be based on the Medicare Part D risk mitigation program, which is not budget neutral. *See* GAO, Report 15-447 (April 2015) at 14, *available at* http://www.gao.gov/assets/680/670161.pdf ("For the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions.").

34. The Government's attempt to impose budget neutrality is not permitted by law. Neither Section 1342 nor Section 153.510 provide that the risk corridors payments made to QHP issuers (*i.e.*, payments out) will come from the pot of payments made to the Government by other insurers (*i.e.*, payments in). Nor does either provision contemplate permitting the Government to postpone payments that are owed until the following year's collections are accounted for, or until some undetermined date in the future, if ever.

D. <u>Congress Did Not Amend Section 1342.</u>

35. Through the Spending Riders, Congress restricted CMS and HHS from using certain accounts to fund the obligated risk corridors payments through appropriations riders. Specifically, the Spending Riders prevented CMS from using the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, as well as funds transferred from other accounts funded by the Spending Riders, to the CMS Program Management account for fiscal years 2015, 2016, and 2017.

36. The QHP issuers on the whole incurred almost $2.9 billion in losses that the Government was required to reimburse under Section 1342. Over $2.5 billion of that mandatory amount was not paid due to the 2015 Spending Rider.

37. The QHP issuers on the whole incurred even greater compensable losses in 2015 and 2016 that CMS has not paid, and will not pay, as a result of the 2016 and 2017 Spending Riders.

38. The 2015 Spending Rider's prohibition on the use of certain funds did not eliminate the use of all funds in the CMS Program Management account, such as fees received by HHS for the federally facilitated exchanges. It also did not apply to years other than the fiscal year ending September 30, 2015. Most notably, Congress *did not amend Section 1342 to require budget neutrality or to alter the underlying risk corridors obligations of the Government.*

39. Moreover, the 2015 Spending Rider was enacted on December 16, 2014, nearly a year after Plaintiff began offering insurance on the New York exchange and approximately 18 months after it had submitted rates for regulatory approval. Faced with this new development, Plaintiff continued to abide by its obligations to the Government and its insureds, but received little immediate guidance as to what would happen with the risk corridors payments.

40. On November 19, 2015, Defendant stated that "HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter ***as a fiscal year 2015 obligation of the United States Government for which full payment is required***." 2014 Payment Memo. The statement was extraordinary in that the agency (1) *conceded* that it owed Plaintiff and other QHP issuers payment under the RCP, (2) *refused* to pay the amounts due, and (3) offered instead to pay "12.6 percent" of what is owed with a vague promise to pay more at some indeterminate point in the future.

41. In December 2015, Congress passed the 2016 Spending Rider. As in the 2015 Spending Rider, the 2016 Spending Rider prohibited CMS from using trust funds and other accounts to fund risk corridors payments for the fiscal year ending September 30, 2016. But, like the 2015 Spending Rider, *it did not amend Section 1342 to require budget neutrality or alter the underlying risk corridors obligations of the Government*.

42. On September 9, 2016, CMS issued a memorandum reiterating that 2015 risk corridors payments were an obligation of the United States Government for which full payment to Plaintiff and other issuers is required. Sept. 2016 Memo. That memorandum was followed by testimony of CMS Acting Administrator Andrew Slavitt before the House Energy and Commerce Committee on September 14, 2016. Among other things, Mr. Slavitt stated without equivocation that, notwithstanding the lack of an appropriation to fund the payments due insurers under Section 1342, it was "*an obligation of the federal government*" to remit full payment to insurers.[4]

43. In a letter dated September 20, 2016 to HHS Secretary Sylvia Burwell, the Chairman and members of House Energy and Commerce Committee took issue with the positions expressed by CMS and Acting Administrator Slavitt, and demanded production by CMS of certain information and documents, including: (1) the basis for CMS's viewpoint that the Government is obligated "to make insurers whole," (2) the names of agency officials involved in discussions with Department of Justice about "risk corridors" litigation, and (3) CMS's position on the use of the Judgment Fund to settle the Government's Section 1342

[4] *See* Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20, 2016), *available at* https://energycommerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and.

obligations.[5]

44. The letter to Secretary Burwell was followed by letters sent by the same House Committee on or around October 4, 2016 to the chief executives of each of the QHP issuers that had, as of that date, filed complaints against the Government in the Court of Federal Claims seeking recovery of the risk corridors payments owed to them.

45. In May 2017, Congress passed the 2017 Spending Rider prohibiting CMS from using trust funds and other accounts to fund risk corridors payments for the fiscal year ending September 30, 2017. But, like the other Spending Riders, *it did not amend Section 1342 to require budget neutrality or alter the underlying risk corridors obligations of the Government.*

E. The Government Conceded that it Owes Substantial Amounts to Plaintiff.

46. Section 1342 of the ACA requires the Government to reimburse Healthfirst for higher-than-expected allowable costs incurred as a result of its participation in the New York marketplace pursuant to the statutory formula, just as Section 1342 requires Healthfirst or any other QHP issuer to pay CMS for lower-than-expected allowable costs. To date, however, CMS has stated publicly in sub-regulatory guidance that it will not make full payment under the RCP. In addition, in public court filings the Government has asserted that it has no obligation to make risk corridor payments in excess of collections. *E.g.*, Def.'s Mot. Dismiss and Opp. to Pl.'s Mot. Partial Summ. J. at 8-10, 31, *Montana Health CO-OP v. United States*, No. 16-1427C (Fed. Cl. Jan. 10, 2017), ECF No. 17.

[5] House of Representatives & Committee on Energy and Commerce, Letter to the Honorable Sylvia Burwell (Sept. 20, 2016), *available at* https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/letters/20160920HHS.pdf.

47. On November 19, 2015, CMS conceded that as a result of the RCP, it owes Healthfirst $75,523.98 for benefit year 2014. 2014 Payment Memo. The calculations are separated into individual market and small group market.

48. On November 18, 2016, CMS conceded that as a result of the RCP, it owes Healthfirst $697,039.60 for benefit year 2015. 2015 Payment Memo. The calculations are separated into individual market and small group market.

49. On November 15, 2017, CMS conceded that as a result of the RCP, it owes Healthfirst $6,891,430.55 for benefit year 2016. 2016 Payment Memo.

50. CMS has conceded that under the RCP, Plaintiff is owed $75,523.98 for Healthfirst's participation in the state-based New York marketplace for benefit year 2014, $697,039.60 for participation in the same marketplace for 2015, and $6,891,430.55 for benefit year 2016.

51. On or about December 1, 2015, CMS made an initial payment of $8,180.13 to Healthfirst for benefit year 2014, which amounts to approximately 10.8 percent of the total it conceded it owed Healthfirst. Since its initial payment, CMS made additional payments to Healthfirst amounting to $4,431.96. In total, Healthfirst has received $12,612.09—or approximately 16.7 percent—of the amount CMS concedes that it owes Healthfirst for benefit year 2014.

52. On September 9, 2016, HHS stated that all benefit year 2015 collections would be used to pay outstanding liabilities for the 2014 benefit year. Sept. 2016 Memo. Similarly, on November 15, 2017, HHS stated that all benefit year 2016 collections would be used to make additional payments toward 2014 benefit year. 2016 Payment Memo. In other words, no payments would be made for the 2015 or the 2016 benefit year.

F. The Government Refuses to Pay Amounts It Owes Plaintiff For 2014 Risk Corridors Payments.

53. On September 25, 2013, Plaintiff and the New York State Department of Health[6] fully executed a QHP Issuer Agreement for Plaintiff's participation in the New York exchange, effective until December 31, 2018. The parties subsequently entered into a Trading Partner Agreement, for Plaintiff's participation on the exchange for benefit year 2014.[7]

54. Consistent with CMS regulations and the QHP Issuer Agreement, Plaintiff began selling QHPs to consumers on the exchange in or around November 2013, with coverage effective January 1, 2014.

55. Pursuant to its obligations under the ACA and 45 C.F.R. §§ 153.500 *et seq.*, Plaintiff complied with its statutory requirements throughout the year and submitted all required data for the risk corridors calculations by the statutory deadline of July 31, 2015. *See* 45 C.F.R. § 153.530(d).

56. On October 1, 2015, HHS announced that funds paid by QHP issuers into the RCP (payments in) would be sufficient to cover only 12.6 percent of the Government's risk corridors payment obligations (payments out). CMS, "Risk Corridors Payment Proration Rate for 2014" (Oct. 1, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf. Based on the Government's own official calculation, QHP issuers generated $362 million in risk corridors gains for the Government, but QHP issuers suffered $2.87 billion in compensable risk corridors losses. *Id.* The 12.6 percent that HHS anticipated could initially

[6] New York has a State-based Exchange (SBE), which is operated by the New York State Department of Health. States who wish to operate a SBE must submit a declaration letter to CMS for approval.

[7] The parties executed a TPA for each benefit year.

be paid reflected a prorated distribution of the $362 million received from the insurers that were required to make payments in to the Government for the 2014 benefit year.

57. As a result, although CMS conceded that Healthfirst is entitled to $75,523.98 from the RCP for the 2014 benefit year, the agency has paid only $12,612.09 of this amount (including its initial payment and its subsequent payments).

58. With respect to its partial payments for benefit year 2014, HHS stated that it was "recording those amounts that remain[ed] unpaid following [its] 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which full payment is required." 2014 Payment Memo.

59. HHS's unilateral decision to pay only a small fraction of the amounts that it owes contradicts the express language of Section 1342, which states that if a plan's allowable costs "for any ***plan year***" exceeds the target amount, the Secretary "***shall pay to the plan***" the amounts set forth in the ACA. The implementing regulations at 45 C.F.R § 153.510 expressly reiterate when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the amounts set forth in the ACA.

60. HHS stated that "[t]he risk corridors payments for program year 2014 [would] be paid in late 2015. The remaining 2014 risk corridors claims will be paid out of 2015 risk corridors collections, and if necessary, 2016 collections." 2014 Payment Memo. HHS concluded that in the event of a shortfall for the 2016 program year, HHS "***will explore other sources of funding for risk corridors payments, subject to the availability of appropriations***. This includes working with Congress on the necessary funding for outstanding risk corridors payments." *Id.* HHS has, therefore, refused to pay an "obligation of the United States Government for which full payment is required," and seeks to leave its payment of this debt

open-ended.

61. The Government, by refusing to meet its payment obligations under the RCP in violation of Section 1342, abrogates its responsibility with respect to one of the key features of the ACA, *i.e.*, providing market-stabilization in the new exchanges.

62. The Government's refusal to pay money due under the RCP gives rise to significant financial difficulties. Healthfirst has established itself as a community leader in healthcare, and through its programs changed the lives of millions of Americans. Withholding risk corridors payments defeats the very purpose of the RCP: mitigation of the risk that QHP issuers like Healthfirst otherwise confronted by agreeing to provide affordable health coverage to all Americans on the exchanges, as Congress intended.

G. The Government Refuses to Pay Amounts It Owes Plaintiff For 2015 Risk Corridors Payments.

63. Consistent with CMS regulations and the QHP Issuer Agreement, Plaintiff began selling QHPs to consumers in the New York exchange on or about November 15, 2014, with coverage effective January 1, 2015.

64. As it did in relation to its 2014 risk corridors payments, Plaintiff complied with its statutory requirements and submitted to HHS all data required by the ACA demonstrating that Healthfirst experienced higher-than-expected allowable costs under the RCP for benefit year 2015, entitling Healthfirst to payment by HHS in the amount of $697,039.60.

65. Yet again, however, HHS has stated that it will not make full payment as required by the ACA for benefit year 2015. Similar to the 2015 Spending Rider, the 2016 Spending Rider prevents CMS and HHS from making risk corridors payments from certain funding sources. As a result, HHS has indicated that it will continue to administer the RCP in a "budget neutral" manner and will use any funds received from QHP issuers for the 2015 risk corridors results to

first pay down the $2.5 billion shortfall from 2014.

H. The Government Refuses to Pay Amounts It Owes Plaintiff For 2016 Risk Corridors Payments.

66. Consistent with CMS regulations and the QHP Issuer Agreement, Plaintiff began selling QHPs to consumers on the New York exchange on or about November 15, 2015, with coverage effective January 1, 2016.

67. Plaintiff complied with its statutory requirements and submitted to HHS all data required by the ACA demonstrating that Healthfirst experienced higher-than-expected allowable costs under the RCP for benefit year 2016, entitling Healthfirst to payment by HHS in the amount of $6,891,430.55.

68. However, HHS has yet again indicated that it will not make full payment as required by the ACA for benefit year 2016. The 2017 Spending Rider prevents CMS and HHS from making risk corridors payments from certain funding sources. HHS has not modified its position that it will continue to administer the RCP in a "budget neutral" manner.

69. Despite the clear statutory mandate and its own multiple admissions of its obligations to the contrary, HHS has stated that it will not make timely and complete payment to QHP issuers.

* * * * *

70. Regardless of HHS's statements that it will manage the RCP in a "budget neutral" manner, and regardless of the Spending Riders limiting the availability of certain funds to make payments owed to QHP issuers under the RCP, the Government's obligations under the ACA RCP *have never been amended.* Section 1342 mandates payment to QHP issuers under certain conditions *without regard to budget neutrality*, and for the very purpose of stabilizing the market by mitigating annual losses of participating plans. Notwithstanding *subsequent* agency

pronouncements, *made only after QHP issuers such as Healthfirst entered the market*, CMS's implementing regulation (Section 153.510) reflects the mandatory nature of the payments without regard to budget neutrality.

Plaintiff relied upon the RCP when it entered and performed on the ACA exchanges and when it designed and priced its 2014, 2015, and 2016 plans. At the end of benefit year 2014, Plaintiff was *owed* money based on its participation in the individual market. HHS paid only a small fraction of the total that was due. The remainder in the amount of $62,911.89 is owed and presently due. Similarly, the $697,039.60 in losses sustained in the RCP for benefit year 2015 and $6,891,430.55 in losses sustained in the RCP for benefit year 2016, are owed and presently due to Plaintiff under the express terms of Section 1342 of the ACA. By this lawsuit, Plaintiff seeks the immediate payment in full of risk corridors receivables for the 2014, 2015, and 2016 benefit years, so that it can continue to offer affordable health products.

CLAIMS FOR RELIEF

COUNT I

(Violation of Statutory and Regulatory Mandate to Make Payments)

71. Plaintiff re-alleges and incorporates the preceding paragraphs as if fully set forth herein.

72. As part of its obligations under Section 1342 of the ACA and its obligations under 45 C.F.R. § 153.510(b), the Government is required to pay any QHP issuer certain amounts exceeding the target costs they incurred in 2014, 2015, and 2016.

73. Plaintiff is a QHP issuer under the ACA and, based on its adherence to the ACA and its submission of allowable costs and target costs to CMS, satisfies the requirements for payment from the United States under Section 1342 of the ACA and 45 C.F.R. § 153.510(b).

74. The Government has failed, without justification, to perform as it is obligated under Section 1342 of the ACA and 45 C.F.R. § 153.510(b), and has affirmatively stated that it will not do so.

75. The Government's failure to provide timely payments to Plaintiff is a violation of Section 1342 of the ACA and 45 C.F.R. § 153.510(b), and Plaintiff and has been harmed by these failures.

COUNT II

(Breach of Implied-In-Fact Contract to Make Payments)

76. Plaintiff re-alleges and incorporates by reference the preceding paragraphs as if fully set forth herein.

77. Plaintiff entered into a valid implied-in-fact contract with the Government regarding the Government's obligation to make full and timely risk corridors payments to Plaintiff in exchange for Plaintiff's agreement to become a QHP issuer and participate in the New York exchange.

78. Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's repeated admissions regarding their obligation to make risk corridor payments were made or ratified by representatives of the Government, including, but not limited to, Kevin Counihan, Director of Consumer Information and Insurance Oversight ("CCIIO") and CEO of the Health Insurance Marketplaces; Andrew Slavitt, Acting Administrator of CMS; or other CMS officials, all of whom who had actual authority to bind the Government. Section 1342, CMS's implementing regulations, and the repeated admissions by agency officials with authority to bind the Government constitute a clear and unambiguous offer by the Government to make full and timely risk corridor payments to health insurers, including

Plaintiff, that agreed to participate as QHP issuers in the ACA marketplaces and were approved as certified QHP issuers by the Government at the Government's discretion. This offer evidences a clear intent by the Government to contract with Plaintiff.

79. Plaintiff accepted the Government's offer by agreeing to become a QHP issuer, accepting the obligations, responsibilities, and conditions the Government imposed on QHP issuers under the ACA, *inter alia*, 45 C.F.R. §§ 153.10 *et seq*. and 155.10 *et seq.*, and proceeding to provide health insurance on the New York exchange. Plaintiff satisfied and complied with its obligations and conditions which existed under the implied-in-fact contract.

80. The Government's agreement to make full and timely risk corridor payments was a significant factor material to Plaintiff's decision to participate in the marketplaces for these states.

81. The parties' mutual intent to contract is further confirmed by the parties' conduct, performance and statements following Plaintiff's acceptance of the Government's offer, including the Plaintiff's commitment to the QHP Issuer Agreement each year, and the Government's repeated assurances that full and timely risk corridor payments would be made and would not be subject to budget limitations. *See, e.g.*, 78 Fed. Reg. at 15,473.

82. The implied-in-fact contract was also supported by mutual consideration: The RCP's protection from uncertain risks and new market instability was a real benefit that significantly influenced Plaintiff's decision to agree to become a QHP issuer and participate in the New York exchange. Plaintiff, in turn, provided a real benefit to the Government by agreeing to become a QHP issuer, complying with the obligations and conditions of the QHP Issuer Agreements, and participating in these marketplaces, as adequate insurer participation was crucial to the Government achieving the overarching goal of the ACA exchange programs—to

guarantee the availability of affordable, high-quality health insurance coverage for all Americans by protecting consumers from increases in premiums due to health insurer uncertainty.

83. The Government induced Plaintiff to participate in the New York exchange for benefit year 2014 by including the RCP in Section 1342 of the ACA and its implementing regulations, by which the Government committed to help protect health insurers financially against risk selection and market uncertainty.

84. The Government repeatedly acknowledged its commitments to share risk with QHP issuers and its obligations to make full and timely risk corridors payments to qualifying QHP issuers through its conduct and statements to the public and to Plaintiff and other similarly situated QHP issuers, made or ratified by representatives of the Government who had express or implied actual authority to bind the Government. *See, e.g.*, 77 Fed. Reg. at 17,238.

85. The Government also induced Plaintiff to commit to the New York exchange for benefit years 2015 and 2016 during and after HHS and CMS's announcement in 2014 of their intention to implement the RCP in a budget neutral manner, by repeatedly giving assurances to QHP issuers, including Plaintiff, that risk corridors collections will be sufficient to cover all of the Government's risk corridors payments, and that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, April 2014 Memo ("We anticipate that risk corridors collections ***will be sufficient*** to pay for all risk corridors payments.") (emphasis added); 79 Fed. Reg. 30,240, 30,260 (May 27, 2015) ("***In the unlikely event of a shortfall*** for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, ***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations.") (emphases added).

86. HHS and CMS acknowledged and published the full risk corridors payment

amount of $75,523.98 that the Government concedes it owes Plaintiff for benefit year 2014. *See* 2014 Payment Memo.

87. HHS and CMS also acknowledged the full risk corridors payment amount of $697,039.60 that the Government concedes it owes Plaintiff for benefit year 2015. *See* 2015 Payment Memo.

88. HHS and CMS similarly acknowledged the full risk corridors payment amount of $6,891,430.55 that the Government concedes it owes Plaintiff for benefit year 2016. *See* 2016 Payment Memo.

89. Because Plaintiff accepted the Government's unilateral offer by beginning performance in or around the fall preceding each benefit year, Congress's *subsequent* failure to appropriate sufficient funds for risk corridor payments in the Spending Riders did not extinguish the Government's contractual obligation to make full and timely risk corridor payments to Plaintiff. This contractual obligation survives and is enforceable regardless of whether the Court believes that the Spending Riders modified or repealed Section 1342 of the ACA. Once the contract became binding, the Government was—and remains—liable to make full payment to Plaintiff. Plaintiff is entitled to full payment of $62,911.89 for benefit year 2014, $697,039.60 for benefit year 2015, and $6,891,430.55 for benefit year 2016.

90. The Government's failure to make full and timely risk corridor payments to Plaintiff is a material breach of the implied-in-fact contract, and Plaintiff has been damaged by this failure. Plaintiff therefore brings a claim for damages of $7,651,382.04 against the Government founded upon the Government's violation of an implied-in-fact contract.

PRAYER FOR RELIEF

Plaintiff requests the following relief:

A. That the Court award Plaintiff monetary relief in the amounts to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b): $62,911.89 (for benefit year 2014), $697,039.60 (for benefit year 2015), and $6,891,430.55 (for benefit year 2016).

B. That the Court award pre-judgment and post-judgment interest at the maximum rate permitted under the law;

C. That the Court award such court costs, litigation expenses, and attorneys' fees as are available under applicable law; and

D. That the Court award such other and further relief as the Court deems proper and just.

Dated: February 20, 2020

Respectfully submitted,

/s/ Stephen McBrady

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CERTIFICATE OF SERVICE

I certify that on February 20, 2020, a copy of the forgoing complaint was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

/s/ Stephen McBrady
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