

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

INDEPENDENT HEALTH BENEFITS)
CORPORATION,)
)
Plaintiff,)
)
v.)
)
THE UNITED STATES OF AMERICA,)
)
Defendant.)
)

Case No. 20-163 C

COMPLAINT

Plaintiff Independent Health Benefits Corporation (“Plaintiff” or “Independent Health”), by and through its undersigned counsel, brings this action against Defendant, the United States of America (“Defendant,” “United States,” or “Government”), and alleges the following:

INTRODUCTION

1. Independent Health brings this Complaint to recover money damages owed by the Government for calendar years 2015 (“CY 2015”) and 2016 (“CY 2016”), for violations of the mandatory risk corridors payment obligations Defendant owes to Independent Health’s qualified health plans (“QHPs”), that are prescribed in Section 1342 of the Patient Protection and Affordable Care Act (“ACA”) and its implementing federal regulations; and for breach of the implied-in-fact contracts between Defendant and Plaintiff regarding such risk corridors payments.

2. Congress’ enactment in 2010 of the ACA marked a major reform in the United States health care market.

3. The market reform guaranteed availability of health care to all Americans, and prohibited health insurers from using factors such as health status, medical history, preexisting conditions, gender, and industry of employment to set premium rates or deny coverage.

4. The ACA introduced scores of previously uninsured or underinsured citizens into the health care marketplace, creating great uncertainty for health insurers, including Plaintiff, that had no previous experience or reliable data to meaningfully assess the risks and set the premiums for this new population of insureds under the ACA.

5. Congress, recognizing such uncertainty for health insurers and the potential increased premiums that would come with that uncertainty, included three premium-stabilization programs in the ACA to help protect health insurers against risk selection and market uncertainty, including the temporary federally administered risk corridors program, which mandated that the Government pay health insurers annual risk corridors payments based on a statutorily prescribed formula to provide health insurers with stability as insurance market reforms began.

6. Under the statutory parameters of the risk corridors program, the Government shared the risk with QHPs – such as Plaintiff’s – associated with the new marketplace’s uncertainty for each of the temporary program’s three years: 2014, 2015 and 2016. If the amount a QHP collected in premiums in any one of those years exceeded its medical expenses by a certain target amount, the QHP was required to make a payment to the Government. If annual premiums fell short of this target, however, Congress required the Government to make risk corridors payments to the QHP in an amount prescribed by a formula in Section 1342.

7. The temporary risk corridors program was designed to ease the transition between the old and new health insurance marketplaces and help stabilize premiums for consumers.

8. The United States has admitted in writing its obligations to pay the full amount of risk corridors payments owed to Independent Health for CY 2015, and CY 2016, totaling at least \$15,887,180.59, but Defendant has failed to pay the full amount due. Instead, the Government has not paid any of the total amount due for CY 2015 or CY 2016, asserting that the Government's obligation to make full payment to Independent Health is limited by available appropriations, even though no such limits appear anywhere in the ACA or its implementing regulations or in Independent Health's contracts with the Government.

9. Independent Health, on the other hand, honored its obligation to remit its full and timely risk corridors collection charges to the Government.

10. Although the United States has repeatedly acknowledged its obligation to make full risk corridors payments to Independent Health, it has failed to do so in breach of its statutory, regulatory and contractual obligations. This Complaint seeks monetary damages from the Government of at least \$15,887,180.59, which represents the amount of unpaid risk corridors payments Defendant has admitted is owed to Plaintiff for CY 2015 and CY 2016.

JURISDICTION AND VENUE

11. This Court has jurisdiction over this action and venue is proper in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1), because Plaintiff brings claims for monetary damages over \$10,000 against the United States founded upon the Government's violations of a money-mandating Act of Congress, a money-mandating regulation of an executive department, and an implied-in-fact contract with the United States.

12. The actions and/or decisions of the Department of Health and Human Services (“HHS”) and the Centers for Medicare & Medicaid Services (“CMS”) at issue in this lawsuit were conducted on behalf of the Defendant United States within the District of Columbia.

PARTIES

13. Plaintiff Independent Health Benefits Corporation is a not-for-profit health plan located in Buffalo, New York. Independent Health is duly authorized to issue health insurance coverage in New York and participated and offered QHPs on the Health Insurance Marketplaces in New York for CY 2014, CY 2015, and CY 2016, and each year through the present.

14. Defendant is THE UNITED STATES OF AMERICA. HHS and CMS are agencies of the Defendant United States of America.

FACTUAL ALLEGATIONS

Congress Enacts the Patient Protection and Affordable Care Act

15. Congress' enactment in 2010 of the ACA, Public Law 111-148, 124 Stat. 119, marked a historic shift in the United States health care market.

16. Through the ACA, Congress aimed to increase the number of Americans covered by health insurance and decrease the cost of health care in the U.S., and included a series of interlocking reforms designed to expand coverage in the individual and small group health insurance markets. The market reforms guaranteed availability of health care to all Americans, and prohibited health insurers from using factors such as health status, medical history, preexisting conditions, gender, or industry of employment to set premium rates or deny coverage.

17. The ACA provides that "each health insurance issuer that offers health insurance coverage in the individual or [small] group market in a State must accept every employer and individual in the State that applies for such coverage." 42 U.S.C. § 300gg-1(a).

18. The ACA also generally bars insurers from charging higher premiums on the basis of a person's health. *See* 42 U.S.C. § 300gg.

19. Through the ACA, Congress created competitive statewide health insurance marketplaces – the ACA Exchanges – that offer health insurance options to consumers and small businesses.” Section 1311 of the ACA establishes the framework for the Exchanges. *See* 42 U.S.C. § 18031.

20. Plaintiff voluntarily participated and offered QHPs in the ACA Marketplace in New York after satisfying the state-level operator of the New York ACA Exchange that it should be certified as a QHP, from January 1, 2014 (the first day of the ACA Exchanges) through the present. For each of those years, Independent Health’s premiums were submitted to and approved by the state’s insurance regulator in the spring and/or summer of the previous year (e.g., spring and/or summer of 2013 for CY 2014).

21. Upon the Government’s and/or the state-level operator’s evaluation and certification of Plaintiff’s QHPs, Plaintiff was required to provide a package of “essential health benefits” on the ACA Exchanges on which they voluntarily participated. 42 U.S.C. § 18021(a) (1).

22. In deciding to become and continue as a QHP issuer in New York, Independent Health understood and believed that in exchange for complying with numerous obligations imposed on QHPs, the Government would comply with many reciprocal obligations imposed on it – including the obligations to make full and timely risk corridors payments to eligible QHPs, like Independent Health’s. The Government, however, unlawfully has failed to do so, as detailed below.

The ACA’s Premium-Stabilization Programs

23. The three premium-stabilization programs created by Congress in the ACA – temporary reinsurance and risk corridors programs to give insurers payment stability as insurance market reforms began, and an ongoing risk adjustment program that makes payments

to health insurance issuers that cover higher-risk populations (*e.g.*, those with chronic conditions) to more evenly spread the financial risk borne by issuers – began in CY 2014. These three premium-stabilization programs are known as the “3Rs.”

24. Congress’ overarching goal of the 3Rs premium-stabilization programs, along with other Exchange-related provisions and policies in the ACA, was to make affordable health insurance available to individuals who previously did not have access to such coverage, and to help ensure that every American has access to high-quality, affordable health care by protecting consumers from increases in premiums due to health insurer uncertainty. *See, e.g.*, 42 U.S.C. § 18091(2)(I)-(J) (stating that one of the goals of the ACA was “creating effective health insurance markets”).

25. Congress also strived to provide certainty and protect against adverse selection in the health care market (when a health insurance purchaser understands his or her own potential health risk better than the health insurance issuer does) while stabilizing premiums in the individual and small group markets as the ACA’s market reforms and Exchanges began in 2014.

26. Of the 3Rs, this Complaint addresses only the temporary, three-year risk corridors program, which began in CY 2014 and expired at the end of CY 2016, and was a “Federally administered program.” 77 FR 17219, 17221 (Mar. 23, 2012), attached hereto at Exhibit 01.

27. By enacting the risk corridors program through Section 1342 of the ACA, Congress recognized that, due to uncertainty about the population entering the ACA Exchanges during the first few years of Exchange operation, health insurers would not be able to predict their risk accurately, and that their premiums may reflect costs that are ultimately lower or higher than predicted. *See* 76 FR 41929, 41931 (July 15, 2011), attached hereto at Exhibit 02; 77 FR 73118, 73119 (Dec. 7, 2012), attached hereto at Exhibit 03 (“The risk corridors program … will

protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.”).

28. While the risk adjustment and reinsurance programs were designed to share risk *between* health plans, Congress designed the risk corridors program to share risk between insurers *and the Government*. See 77 FR 73118, 73121 (Dec. 7, 2012), Ex. 03 (“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.” (emphasis added)).

29. The risk corridors program applied only to participating plans, like Independent Health’s, that agreed to participate on the ACA Exchanges, accepted all of the responsibilities and obligations of QHPs as set forth in the statute and implementing regulations, and were certified as QHPs at the discretion of CMS and/or the state-level operators of the ACA Exchanges in accordance with CMS regulations. All insurers that elected to enter into agreements with the Government to become QHPs were required by Section 1342(a) of the ACA to participate in the risk corridors program.

30. The financial protections that Congress provided in the 3Rs statutory premium-stabilization programs, including the mandatory annual risk corridors payments, provided QHPs with the security – backed by federal law and the full faith and credit of the United States – to become participating health insurers in their respective states’ ACA markets, at considerable cost to the QHPs, despite the significant financial risks posed by the uncertainty in the new health care markets.

31. Since the launch of the ACA Exchanges in 2014, Independent Health participated as a QHP issuer on the ACA Exchanges in New York and continues to participate on New York ACA Exchange today serving over 21,000 members.

32. Independent Health agreed to participate in the New York ACA Exchange based on the understanding that the United States would honor its statutory, regulatory, and contractual commitments regarding, *inter alia*, the 3Rs, including the temporary risk corridors program.

33. The Government has failed to hold up its end of the bargain, necessitating the filing of this lawsuit.

The ACA's Risk Corridors Payment Methodology

34. Under the ACA's risk corridors program, the federal government shares risk with QHP health insurers annually in "calendar years 2014, 2015, and 2016," 42 U.S.C. § 18062(a), attached hereto at Exhibit 04, by collecting charges from a health insurer if the insurer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and by making payments to the insurer if the insurer's QHP premiums fall short by a certain amount. *Id.* at §18062(b).

35. In this manner, "[r]isk corridors create a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers." 76 FR 41929, 41942 (July 15, 2011), Ex. 02.

36. Through ACA Sections 1342(b)(1) and (2), Congress established the payment methodology and formula for the risk corridors "payments in" and "payments out."

37. The text of Section 1342(b) states:

(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(b), Ex. 04.

38. To determine whether a QHP in any year must pay into, or receive payments from, the Government under the risk corridors program, HHS compared allowable costs (essentially, claims costs subject to adjustments for health care quality, health IT, annual risk adjustment payments and charges, and annual reinsurance payments) and the target amount – the difference between a QHP's earned premiums and allowable administrative costs.

39. Pursuant to the Section 1342(b) formula, each year from CY 2014 through CY 2016, QHPs with allowable costs that were less than 97 percent of the QHP's target amount were required to remit charges for a percentage of those cost savings to HHS, while QHPs with allowable costs greater than 103 percent of the QHP's target amount were to receive payments from HHS to offset a percentage of those losses. None of these payments was contingent upon collections.

40. The risk corridors program did not require the Government to reimburse insurers for 100 percent of their losses in a calendar year, nor did the program require insurers to remit 100 percent of their gains to the Government in a calendar year.

41. Section 1342(b)(1) prescribes the specific payment formula from HHS to QHPs whose costs in a calendar year exceed their original target amounts by more than three percent.

42. Section 1342(b)(1)(A) requires that if a QHP's allowable costs in a calendar year are more than 103 percent, but not more than 108 percent, of the target amount, then "the Secretary [of HHS] shall pay" to the QHP an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount.

43. Section 1342(b)(1)(B) further requires that if a QHP's allowable costs in a calendar year are more than 108 percent of the target amount, then "the Secretary [of HHS] shall pay" to the QHP 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.

44. Alternatively, Section 1342(b)(2) sets forth the amount of the annual risk corridors charges that must be remitted to HHS by QHPs whose costs in a calendar year are more than three percent below their original target amounts.

45. Section 1342(b)(2)(A) requires that if a QHP's allowable costs in a calendar year are less than 97 percent, but not less than 92 percent, of the target amount, then "the plan shall pay to the Secretary [of HHS]" an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs.

46. Section 1342(b)(2)(B) requires that if a QHP's allowable costs in a calendar year are less than 92 percent of the target amount, then "the plan shall pay to the Secretary [of HHS]"

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.

47. Through this risk corridors payment methodology, QHPs keep all gains and bear all losses that they experience within three percent of their target amount for a calendar year, and the Government does not share in the risk. For example, a QHP that has a target amount of \$10 million in a given calendar year will not pay a risk corridors charge or receive a risk corridors payment if its allowable charges range between \$9.7 million and \$10.3 million for that calendar year.

48. HHS and CMS provided specific examples of risk corridors payment and charge calculations beyond the three percent threshold – published in the Federal Register dated July 15, 2011, at 76 FR 41929, 41943 – which illustrate risk corridors payments the Government must pay under different allowable cost, target amount, and gain and loss scenarios. *See* 76 FR 41929, 41943 (July 15, 2011), Ex. 02.

49. The American Academy of Actuaries provided an approximate illustration of the risk corridors payment methodology – excluding the charge or payment of 2.5 percent of the target amount for gains or losses greater than eight percent – as follows:

Illustration of ACA Risk Corridors					
Actual Spending Less Than Expected Spending			Actual Spending Greater Than Expected Spending		
Plan Keeps 20% of Gains	Plan Keeps 50% of Gains	Plan Keeps All Gains	Plan Bears Full Losses	Plan Bears 50% of Losses	Plan Bears 20% of Losses
Plan Pays Government 80% of Gains	Plan Pays Government 50% of Gains			Government Reimburses 50% of Losses	Government Reimburses 80% of Losses
-8%	-3%	0%	3%	8%	

Source: American Academy of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms* (2013), available at http://actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf, attached hereto at Exhibit 05.

Independent Health Decides to Offer QHPs on the New York ACA Exchange

50. In deciding to apply to offer QHPs on the New York ACA Exchange, Independent Health relied upon HHS' commitments to make full risk corridors payments annually to QHPs as required in Section 1342 of the ACA regardless of whether risk corridors payments to QHPs are actually greater than risk corridors charges collected from QHPs for a particular calendar year.

51. Independent Health made its full mandatory risk corridors charge remittances to the Government under Section 1342 for CY 2014 before the end of CY 2015, for Plaintiff's allowable-cost gains of more than three percent of their target amounts in the New York ACA Individual Market and Small Group Market.

52. In contrast, despite the fact that Independent Health experienced significant allowable cost losses in the New York ACA markets in CY 2015 and in CY 2016, requiring the

Government to make full annual risk corridors payments to Independent Health for each of those years, the Government failed to do so and made no risk corridors payments at all to Independent Health for CY 2015 and/or CY 2016.

HHS' Risk Corridors Regulations

53. Congress directed HHS to administer the risk corridors program enacted in Section 1342. *See* 42 U.S.C. § 18062(a), Ex. 04. The HHS Secretary formally delegated authority over the Section 1342 risk corridors program to the CMS Administrator on August 30, 2011. *See* 76 FR 53903, 53903-04 (Aug. 30, 2011), attached hereto at Exhibit 06. That delegation recognized that the ACA risk corridors program was statutorily required to be “based on” the Medicare Part D risk corridors program. *Id.* By authority of this delegation from the HHS Secretary, CMS issued implementing regulations for the risk corridors program at 45 C.F.R. Part 153.

54. In 45 C.F.R. § 153.510, CMS adopted a risk corridors calculation “for calendar years 2014, 2015, and 2016,” 45 C.F.R. § 153.510(a), that is mathematically identical to the statutory formulation in Section 1342 of the ACA, using the identical thresholds and risk-sharing levels specified in the statute. *See* 45 C.F.R. § 153.510, attached hereto at Exhibit 07.

55. Specifically, 45 C.F.R. § 153.510(b) prescribes the method for determining risk corridors payment amounts that QHPs “will receive”:

(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.

56. By this regulation, the Government intended that HHS “will pay” and QHPs “will receive” risk corridors payments in “an amount equal to” the risk corridors calculation “[w]hen” it is determined that a QHP qualifies for risk corridors payments – not some fraction of that amount at some indeterminate future date, or never at all.

57. Furthermore, 45 C.F.R. § 153.510(c) prescribes the circumstances under which QHPs “must remit” charges to HHS, as well as the means by which HHS will determine those charge amounts:

(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.

58. Nowhere does 45 C.F.R. § 153.510 make payments to QHPs contingent upon collections received.

59. The payment methodology provisions at 45 C.F.R. § 153.510(a) to (c) were adopted by HHS in final rulemaking on March 23, 2012, after a notice-and-comment period. *See* 77 FR 17219, 17251 (Mar. 23, 2012), Ex. 01.

60. In the preceding July 15, 2011 proposed rule, CMS and HHS stated regarding risk corridors payment deadlines that:

HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a

payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers.

76 FR 41929, 41943 (July 15, 2011), Ex. 02.

61. In the final rulemaking of March 23, 2012, HHS responded to comments received supporting the 30-day payment deadline to QHPs, and stated that it “plan[ned] to address the risk corridors payment deadline in the HHS notice of benefit and payment parameters.” 77 FR 17219, 17239 (Mar. 23, 2012), Ex. 01. HHS reiterated, however, that:

While we did not propose deadlines in the proposed rule, we … suggested … that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. *QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.*

Id. (emphasis added).

62. This was HHS’ final administrative construction and interpretation regarding the deadline for HHS’ risk corridors payments to QHPs; it never “address[ed] the risk corridors payment deadline in the HHS notice of benefit and payment parameters.” *Id.*

63. Following a notice-and-comment period, CMS published a final rule on March 11, 2013, adopting, among other things, the 30-day deadline for a QHP to remit risk corridors charges to the Government. 78 FR 15409, 15531 (Mar. 11, 2013), attached hereto at Exhibit 08. This resulted in 45 C.F.R. § 153.510 being amended by adding the following subsection:

(d) *Charge submission deadline.* A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

64. HHS also adopted a final rule on March 11, 2013, amending 45 C.F.R. § 153.530 by adding subsection (d), imposing the annual requirement that “[f]or each benefit year, a QHP issuer must submit all information required under this section by July 31 of the year following the benefit year.” *Id.*

65. While CMS never imposed in the implementing regulations a specific deadline for HHS to tender full risk corridors payments to QHPs whose allowable costs in a calendar year are greater than 103 percent of the QHP's target amount, the Government also never contravened its earlier public statements that the deadline for the Government's payment of risk corridors payments to QHPs should be identical to the deadline for a QHP's remittance of charges to the Government. *See* 76 FR 41929, 41943 (July 15, 2011), Ex. 02; 77 FR 17219, 17238 (Mar. 23, 2012), Ex. 01.

66. Independent Health relied upon these statements by HHS and CMS in the Federal Register in deciding to agree to become, and continue to act as, a QHP issuer in New York, and accept the obligations and responsibilities of a QHP issuer, believing that the Government would pay the full risk corridors payments owed to it within 30 days, or shortly thereafter, following a determination that Independent Health experienced losses sufficient to qualify for risk corridors payments under Section 1342 of the ACA and 45 C.F.R. § 153.510.

67. Nothing in Section 1342 or 45 C.F.R. Part 153 limits the Government's obligation to pay QHPs the full amount of risk corridors payments due based on appropriations, restrictions on the use of funds, or otherwise.

68. The United States should have paid Independent Health the full CY 2015 risk corridors payments due by the end of CY 2016, and the full CY 2016 risk corridors payments due by the end of CY 2017, but failed or refused to do so as required under Section 1342 of the ACA and 45 C.F.R. § 153.510.

Plaintiff's Plans Were Accepted and Approved as QHPs

69. Based on Congress' statutory commitments set forth in the ACA, including, but not limited to, Section 1342 and the risk corridors program, as well as on the Government's

statements and conduct regarding its risk corridors obligations, Plaintiff agreed to offer QHPs on the New York ACA Exchange, and to enter into QHP Agreements with the state-level operator of the New York ACA Exchange, after the state-level operator had exercised its discretion to certify Plaintiff as a QHP in New York.

70. Independent Health executed a QHP Agreement with the New York State Department of Health (“NYSDOH”), the state-level operator of the ACA Exchange in New York (the “New York Health Benefit Exchange” or “New York ACA Exchange”) on August 7, 2013. *See* New York ACA QHP Agreement, attached hereto at Exhibit 09. Independent Health’s QHP Agreement with NYSDOH was effective from October 1, 2013 until December 31, 2018. Among other things, Independent Health’s QHP Agreement required as a term and condition of QHP certification that Independent Health “have a process in place to comply with the standards related to the Risk Adjustment, Reinsurance and Risk Corridors program pursuant to 45 C.F.R Part 153.”

71. Independent Health’s plans were certified as QHPs by NYSDOH for CY 2014 in August 2013, and were recertified by NYSDOH annually in August or September of each year thereafter. *See* NYSDOH Certifications, attached hereto at Exhibit 10. Independent Health’s plans participated as QHPs in New York each year from CY 2014 to the present.

72. Congress mandated that “the Secretary shall pay” risk corridors payments to eligible QHPs like Independent Health’s under 42 U.S.C. § 18062(b). Had Independent Health known that the Government would fail to fully and timely make the risk corridors payments owed to Independent Health – reneging on the Government’s assurances that “[t]he risk corridors program … will protect against uncertainty in rates for [QHPs] by limiting the extent of issuer losses and gains,” 77 FR 73118, 73119 (Dec. 7, 2012), Ex. 03, then Independent Health’s annual

premiums on the New York ACA Exchange on which it voluntarily participated would necessarily have been higher than actually charged, as a result of the increased risks in the Marketplace.

73. The Government's promised risk-sharing mandated through the risk corridors program was a significant factor in Independent Health's decision to agree to become a QHP issuer and undertake the many responsibilities and obligations required for Independent Health to participate in the ACA Exchanges.

**HHS' and CMS' Interpretation of The Government's
Section 1342 Risk Corridors Payment Obligations**

74. Between Congress' enactment of the ACA in 2010 and the 2013 commitment of QHPs, including Independent Health's, to the ACA Exchanges, HHS and CMS repeatedly and publicly acknowledged and confirmed to Independent Health and other QHPs the Government's statutory and regulatory obligations to make full and timely risk corridors payments to eligible QHPs.

75. HHS and CMS continued making statements recognizing the Government's full and annual risk corridors payment obligations through September 2016.

76. These repeated public statements by HHS and CMS were made or ratified by representatives of the Government who had actual authority to bind the United States, including, but not limited to, the HHS Secretary and Kevin J. Counihan, the CMS official designated as the Chief Executive Officer of the ACA Health Insurance Marketplaces and Director of CMS's Center for Consumer Information and Insurance Oversight ("CCIIO"), which regulates health insurance at the federal level. *See CMS Leadership, Center for Consumer Information and Insurance Oversight, Kevin Counihan, <https://www.cms.gov/About>*

CMS/Leadership/cciio/Kevin-Counihan.html (last visited Jan. 12, 2017), attached hereto at Exhibit 11 (Mr. Counihan's job description).

77. Independent Health relied on these repeated public statements by HHS and CMS to assume and continue its QHP issuer status, including its continued participation in the New York ACA Exchange each year from CY 2014 through CY 2016.

78. On July 11, 2011, HHS issued a fact sheet on HealthCare.gov stating that under the risk corridors program, “[f]rom 2014 through 2016” – “qualified health plan issuers with costs greater than three percent of cost projections will receive payments from HHS to offset a percentage of those losses.” HealthCare.gov, *Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment* (July 11, 2011), attached hereto at Exhibit 12.

79. In the same July 11, 2011 fact sheet, HHS stated that “[r]isk corridors create a mechanism for sharing risk for allowable costs between the Federal government and qualified health plan issuers.” *Id.*

80. On July 15, 2011, in a proposed rule, HHS noted that although the proposed regulations did not contain any deadlines for QHPs to remit charges to HHS or for HHS to make risk corridors payments to QHPs, such deadlines were under consideration, with HHS stating that:

HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that ***the payment deadlines should be the same*** for HHS and QHP issuers.

76 FR 41929, 41943 (July 15, 2011) (emphasis added), Ex. 02.

81. Also in the July 15, 2011 proposed rule, HHS confirmed that the risk corridors program was designed to share risk between the Government and QHPs, stating that “[r]isk

corridors create a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers.” *Id.* at 41942.

82. On March 23, 2012, HHS implemented a final rule regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (77 FR 17219). Although HHS recognized that it did not propose deadlines for making risk corridors payments, *HHS re-stated that “QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.”* 77 FR 17219, 17238 (Mar. 23, 2012) (emphasis added), Ex. 01.

83. In the same March 23, 2012 final rule, HHS also reconfirmed that the Government was sharing the risk with QHPs under the risk corridors program. *See id.*

84. In a March 2012 written presentation to health insurers regarding the final rule, CMS explained that risk corridors is a “Federal program under the statute,” and that the risk corridors program “[p]rotects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and qualified health plans to help ensure stable health insurance premiums.” Presentation, CMS, “Reinsurance, Risk Corridors, and Risk Adjustment Final Rule,” at 11 (Mar. 2012), attached hereto at Exhibit 13.

85. In proposed rulemaking on December 7, 2012, HHS assured QHPs, like Independent Health’s, that “[t]he risk corridors program, which is a Federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.” 77 FR 73118, 73119 (Dec. 7, 2012), Ex. 03.

86. Also in the December 7, 2012 proposed rule, HHS reconfirmed the Government-QHP risk-sharing aspect of risk corridors, stating that “[t]he temporary risk corridors program

permits the Federal government and QHPs to share in the profits or losses resulting from inaccurate rate setting from 2014 to 2016.” *Id.* at 73121.

87. When HHS implemented a final rule on March 11, 2013, regarding HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15409), HHS confirmed that

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.

78 FR 15409, 15473 (Mar. 11, 2013) (emphasis added), Ex. 08.

88. The March 11, 2013 final rule also “specifie[d] the annual schedule for the risk corridors program.” *Id.* at 15520.

89. A March 2013 CMS written presentation regarding the final rule to health insurers – some of whom, including Independent Health, were preparing to apply to become certified as QHP issuers for the upcoming CY 2014 ACA Marketplace – contained the same affirmations of Government-to-QHP risk-sharing as in the March 2012 presentation discussed above. *See* Presentation, CMS, *HHS Notice of Benefit and Payment Parameters for 2014*, at 18 & 19 (Mar. 2013), attached hereto at Exhibit 14.

90. In August 2013, in reliance on the Government’s statutory, regulatory and contractual obligations and inducements described above, Plaintiff executed its QHP Agreement and, upon approval and certification by NYSDOH, became a QHP issuer in New York. *See* Ex. 09.

91. On January 1, 2014, Independent Health began offering plans on the CY 2014 New York ACA Exchange, pursuant to its commitments to the Government.

92. The Senate Finance Committee’s “Chairman’s Mark” of the “America’s Healthy Future Act of 2009,” a precursor bill to the ACA, included risk corridors language nearly identical to what became ACA Section 1342. *See* Sen. Comm. on Fin., Chairman’s Mark,

America's Healthy Future Act of 2009, at 9 (Sept. 16, 2009), attached hereto at Exhibit 15. The Chairman's Mark, including the risk corridors provision, was approved by the Committee. *See* S. 1796, 111th Cong. § 2214 (2009), attached hereto at Exhibit 16.

93. The CBO contemporaneously described the Chairman's Mark's risk-corridors proposal:

The risk corridors would be modeled on those specified in the 2003 Medicare Modernization Act and would be in effect for 3 years. In that period, if plans incur costs (net of their reinsurance payments) that differ from their premium bids by more than 3 percent, the federal government would bear an increasing share of any losses or be paid the same increasing share of any gains.

CBO, A Summary of the Specifications for Health Insurance Coverage Provided by the Staff of the Senate Finance Committee, at 5, attachment to Letter, CBO to Hon. Max Baucus (Sept. 16, 2009), attached hereto at Exhibit 17.

94. In a proposed rule of December 2, 2013, and a final rule of March 11, 2014, HHS reiterated that the risk corridors program creates "a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers," and that "[t]he risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains" 78 FR 72322, 72379 (Dec. 2, 2013), attached hereto at Exhibit 18; 79 FR 13743, 13829 (Mar. 11, 2014), attached hereto at Exhibit 19.

95. In the March 11, 2014 final rule, HHS confirmed that risk corridors payments would be made annually, stating that "we believe that the risk corridors program as a whole will be budget neutral or, will result in net revenue to the Federal government in FY 2015 for the 2014 benefit year." 79 FR 13743, 13829 (Mar. 11, 2014), Ex. 19.

The Government Breaches its Risk Corridors Payment Obligations

96. Also in the March 11, 2014 final rule, HHS announced for the first time, without prior notice in the December 2, 2013 proposed rule or anywhere else that “HHS intends to implement this [risk corridors] program in a budget neutral manner.” *Id.*

97. This statement was contrary to HHS’ prior statement – made exactly one year earlier in the Federal Register, March 11, 2013 – which stated: “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.” 78 FR 15409, 15473 (Mar. 11, 2013), Ex. 08.

98. The Government’s announcement that the United States would not honor its risk corridors obligations in the manner it had promised came after Plaintiff (which had executed the QHP Agreement in August 2013) already had begun to participate in the New York ACA Exchange in reliance upon the Government’s risk corridors payment obligations.

99. The American Academy of Actuaries stated in April 2014 that the proposed “new budget neutrality policy … would change the basic nature of the risk corridor program retroactively” and “changes the nature of the risk corridor program from one that shares risk between issuers and CMS to one that shares risk between competing issuers.” Am. Acad. of Actuaries, Comment to HHS on Proposed Rule, Exchange and Insurance Market Standards for 2015 and Beyond at 3 (Apr. 21, 2014), attached hereto at Exhibit 20.

100. HHS’ “budget neutral” statement of March 11, 2014, was also contrary to Congress’ intent for the Government to share risk with insurers, and Congress’ direction to model the ACA risk corridors program on the Medicare Part D program, which is not required to

be budget neutral. *See* 42 C.F.R. § 423.336, attached hereto at Exhibit 21; U.S. Gov't Accountability Office Report, *Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk*, GAO-15-447 (2015), attached hereto at Exhibit 22 ("For the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions."); Am. Acad. of Actuaries, Comment to HHS on Proposed Rule, Exchange and Insurance Market Standards for 2015 and Beyond at 2 (Apr. 21, 2014), Ex. 20, ("The Part D risk corridor program is not budget neutral and has resulted in net payments to the Centers for Medicare and Medicaid Services (CMS). Similarly, the design of the ACA risk corridor program does not guarantee budget neutrality.").

101. HHS' statement was also contrary to the CBO's February 2014 published projections that the risk corridors program would net the Government \$8 billion in positive revenue. *See* CBO, *The Budget and Economic Outlook: 2014 to 2024* at 110 n. 6 (Feb. 2014), attached hereto at Exhibit 23.

102. The December 2, 2013 proposed rule demonstrates the agencies' lack of reasoned decision-making regarding budget neutrality because the proposed rule did not contain any proposal by HHS or CMS to implement the risk corridors program in a budget neutral manner. *See generally* 78 FR 72322, 72379 (Dec. 2, 2013), Ex. 18. Therefore, the budget neutrality position adopted in the March 11, 2014 final rule was not the product of notice-and-comment rulemaking.

103. A month later, on April 11, 2014, HHS and CMS issued a bulletin entitled "Risk Corridors and Budget Neutrality," stating that:

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.

Bulletin, CMS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014) (emphasis added), attached hereto at Exhibit 24.

104. The April 11, 2014 Bulletin was the first instance in which HHS and CMS publicly suggested that risk corridors charges collected from QHPs might be less than the Government's full mandatory risk corridors payment obligations owed to QHPs.

105. Only one month earlier, on March 11, 2014, HHS and CMS had publicly announced that "we believe that the risk corridors program as a whole will be budget neutral or, [sic] will result in net revenue to the Federal government in FY 2015 for the 2014 benefit year." 79 FR 13743, 13829 (Mar. 11, 2014), Ex. 19.

106. Indeed, in the April 11, 2014 Bulletin, HHS and CMS assured QHPs that "[w]e anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments." Bulletin, CMS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014), Ex. 24.

107. HHS' and CMS' change in position to call for "budget neutrality" in the risk corridors program caused the CBO to update its projections for risk corridors payments and charges in April 2014. *See* CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014* (Apr. 2014), attached hereto at Exhibit 25. CBO stated that it "believes that the Administration has sufficient flexibility to ensure that

payments to insurers will approximately equal payments from insurers to the federal government, and thus that the program will have no net budgetary effect over the three years of its operation. (Previously, CBO had estimated that the risk corridor program would yield net budgetary savings of \$8 billion.)” *Id.* at 18.

108. In a final rule of May 27, 2014, HHS summarized its statements from the April 11, 2014 bulletin, providing that “we intend to administer risk corridors in a budget neutral way over the three-year life of the program” and that “if risk corridors collections in the first or second year are insufficient to make risk corridors payments as prescribed by the regulations, 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 remaining funds will then be used to fund current year payments.” 79 FR 30239, 30260 (May 27, 2014), attached hereto at Exhibit 26.

109. In the May 27, 2014 final rule, HHS also repeated that “we anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments,” and reassured QHPs that “a shortfall for the 2015 program year” would be an “unlikely event” – but should such an unlikely event occur, “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.” *Id.*

110. In HHS’ response letter to the U.S. Government Accountability Office (“GAO”) dated May 20, 2014, HHS again admitted that “Section 1342(b)(1) … establishes … the formula to determine … the amounts the Secretary must pay to the QHPs if the risk corridors threshold is

met.” Letter from William B. Schultz, General Counsel, HHS, to Julia C. Matta, Assistant General Counsel, GAO (May 20, 2014), attached hereto at Exhibit 27.

111. On June 18, 2014, HHS sent to U.S. Senator Sessions and U.S. Representative Upton identical letters stating that, “As established in statute, … [QHP] plans with allowable costs at least three percent higher than the plan’s target amount will receive payments from HHS to offset a percentage of those losses.” Letter from Sylvia M. Burwell, Secretary, HHS, to U.S. Senator Jeff Sessions (June 18, 2014), attached hereto at Exhibit 28.

112. In the summer of 2014, in reliance on the Government’s statutory, regulatory and contractual obligations and inducements and assurances described above, Plaintiff participated in New York’s QHP recertification process, and its plans were certified or recertified in September 2014 for the CY 2015 benefit year. *See Ex. 10.*

113. In proposed rulemaking on November 26, 2014, HHS repeated to QHPs that “a shortfall in the 2016 benefit year” is an “unlikely event.” 79 FR 70673, 70676 (Nov. 26, 2014), attached hereto at Exhibit 29. HHS also repeated that “we anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments,” and that “***HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.***” *Id.* at 70700 (emphasis added). So confident was HHS about the collections potential for the risk corridors program, that in its November 26, 2014 proposed rulemaking, HHS discussed its “propos[al] that if, for the 2016 benefit year, cumulative risk corridors collections exceed cumulative risk corridors payment requests, we would [adjust certain parameters] to pay out all collections to QHP issuers.” *Id.* No detailed plan was expressed for a scenario in which collections were insufficient to satisfy all payment requests.

114. On December 16, 2014 – after Independent Health had committed to the CY 2015 New York ACA Exchange and after the Government’s obligation for CY 2014 risk corridors payments had matured – Congress enacted the Cromnibus appropriations bill for fiscal year 2015, the “Consolidated and Further Continuing Appropriations Act, 2015” (the “2015 Appropriations Act”). Pub. L. 113-235.

115. In the 2015 Appropriations Act, Congress limited the source of appropriations for risk corridors payment obligations from three large funding sources by including the following text at Section 227 of the 2015 Appropriations Act:

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 corridors).

128 Stat. 2491, attached hereto at Exhibit 30.

116. Section 1342(b)(1) of Public Law 111-148 – referenced immediately above – is the ACA’s prescribed methodology for the Government’s mandatory risk corridors payments to QHPs.

117. Congress did not repeal, amend, suspend or otherwise abrogate the United States’ statutory obligation created by Section 1342 to make full and timely risk corridors payments to QHPs, including Plaintiff’s.

118. On January 1, 2015, Independent Health began offering plans on the CY 2015 New York ACA Exchange, pursuant to its commitments with the Government.

119. On February 27, 2015, HHS’ implementation of a final rule regarding HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10749), finalized the proposed policy that HHS planned to implement if cumulative risk corridors collections exceed cumulative

payment obligations by CY 2016, and further confirmed that “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 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.”

80 FR 10749, 10779 (Feb. 27, 2015), attached hereto at Exhibit 31.

120. CMS’ letter to state insurance commissioners on July 21, 2015, stated in boldface text that “**CMS remains committed to the risk corridor program.**” Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 21, 2015), attached hereto at Exhibit 32.

121. On or about July 31, 2015, Plaintiff submitted its CY 2014 risk corridors data to CMS per 45 C.F.R. § 153.530(d).

122. In August 2015, in reliance on the Government’s statutory, regulatory and contractual obligations and inducements described above, Plaintiff participated in New York’s QHP recertification process, and its plans were certified or recertified in September 2015 for the CY 2016 benefit year. *See* Ex. 10.

123. On October 1, 2015, after collecting risk corridors data from QHPs for CY 2014, and after receiving Independent Health’s and other QHPs’ commitments to the CY 2016 ACA Exchanges, HHS and CMS announced a severe shortfall in the CY 2014 risk corridors program and that they intended to prorate the risk corridors payments owed to QHPs, including Plaintiff’s, for CY 2014. HHS and CMS stated that:

Based on current data from QHP issuers’ risk corridors submissions, issuers will pay \$362 million in risk corridors charges, and have submitted for \$2.87 billion in risk corridors payments for 2014. At this time,

assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.

Bulletin, CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), attached hereto at Exhibit 33.

124. HHS and CMS further announced on October 1, 2015, that they would be collecting full risk corridors charges from QHPs in November 2015, and would begin making the prorated risk corridors payments to QHPs starting in December 2015. *See id.*

125. Independent Health made its CY 2014 risk corridors charge remittances in December 2015, pursuant to Plaintiff's obligations.

126. On or about October 2015 or November 2015, QHP issuers received a letter from CMS stating, "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[.]" Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS (Oct./Nov. 2015) (emphasis added). The letter further stated 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." *Id.*

127. CMS also stated in an email transmitting Mr. Counihan's letter to QHP issuers that the "letter from CMS reiterat[es] that risk corridors payments *are an obligation of the U.S. Government.*" Email from Counihan, CMS (Oct./Nov. 2015) (emphasis added).

128. HHS' and CMS' direct statements to Independent Health have unequivocally confirmed the agencies' position and interpretation that full annual risk corridors payments were owed to QHPs and were a binding obligation of the United States.

129. On November 19, 2015, CMS issued a public announcement further confirming that "HHS recognizes that the Affordable Care Act requires the Secretary to make *full payments*

to issuers,” and adding that “HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation [sic] of the United States Government for which full payment is required.” Bulletin, CMS, “Risk Corridors Payments for the 2014 Benefit Year” (Nov. 19, 2015) (emphasis added), attached hereto at Exhibit 34.

130. By stating that the remaining 87.4% of issuers’ risk corridors payments for CY 2014 would be recorded “as fiscal year 2015 obligation[s] of the United States Government for which full payment is required,” HHS and CMS admitted that full payment for CY 2014 was due and owing in 2015 – not at some future indeterminate date.

131. On December 18, 2015, after the Government’s obligation for CY 2015 risk corridors payments had matured, Congress enacted the Omnibus appropriations bill for fiscal year 2016, the “Consolidated Appropriations Act, 2016” (the “2016 Appropriations Act”). Pub. L. 114-113.

132. In the 2016 Appropriations Act, Congress again limited the source of appropriations for the risk corridors payment obligations from three large funding sources by including the following text at Section 225 of the 2016 Appropriations Act:

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 corridors).

129 Stat. 2624, attached hereto at Exhibit 35.

133. Again, Section 1342(b)(1) of Public Law 111-148 is the ACA’s prescribed methodology for the Government’s mandatory risk corridors payments to QHPs.

134. Congress did not repeal, amend, suspend or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridors payments to QHPs, including Plaintiff's.

135. On January 1, 2016, Plaintiff began offering plans on the CY 2016 New York ACA Exchange, pursuant to its commitments to the Government.

136. On or about July 31, 2016, Plaintiff submitted its CY 2015 risk corridors data to CMS per 45 C.F.R. § 153.530(d).

137. On September 9, 2016 – after several lawsuits had been filed by other QHPs in the U.S. Court of Federal Claims that, like this lawsuit, seeking monetary relief from the United States for breaches of the Government's risk corridors payment obligations – CMS publicly confirmed that “HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers,” and that “HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required.” Bulletin, CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016), attached hereto at Exhibit 36. CMS confirmed its full risk corridors obligation to QHPs, despite revealing that “based on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments,” and that “[c]ollections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments.” *Id.*

138. In its November 18, 2016 announcement of the severe risk corridors shortfall for CY 2015, CMS confirmed that “if risk corridors collections for a particular year are insufficient to make full risk corridors *payments for that year*, risk corridors *payments for the year* will be

reduced pro rata to the extent of any shortfall,” and also that “HHS is collecting 2015 risk corridor charges in November 2016, and will begin remitting risk corridors payments to issuers in December 2016, as collections are received.” Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year* (Nov. 18, 2016) (“CY 2015 Risk Corridors Report”) (emphasis added), attached hereto at Exhibit 37. In the announcement, CMS confirmed “that all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments,” and that no timely CY 2015 risk corridors payments would be made to QHPs like Independent Health. *Id.*

139. The December 2016 payment schedule was consistent with CMS’ written presentation to insurers on June 7, 2016, which represented to Independent Health and other QHPs that “CMS will begin making [CY 2015] RC [risk corridor] payments to issuers” in “December 2016,” supporting HHS’ and CMS’ continued intention and representation to make annual risk corridors payments by the end of the year. CMS, *Completing the Risk Corridors Plan-Level Data Form for the 2015 Benefit Year* at 7 (June 7, 2016), attached hereto at Exhibit 38.

140. On May 5, 2017, after the Government’s obligation for CY 2016 risk corridors payments had matured, Congress enacted the Omnibus appropriations bill for fiscal year 2017, the “Consolidated Appropriations Act, 2017” (the “2017 Appropriations Act”), which once again limited the source of appropriations for the risk corridors payment obligations from three large funding sources by including the following text at Section 223 of the 2017 Appropriations Act:

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 corridors).

Pub. L. 115-31, § 223, 131 Stat. 135 (May 5, 2017), attached hereto at Exhibit 39.

141. On May 9, 2017, CMS issued a bulletin to insurers regarding reporting of CY 2016 risk corridors, confirming the agency's understanding – even in light of the Government's contrary litigation position that the statute creates no payment obligation – that “[u]nder Section 1342 of the [ACA], issuers of qualified health plans (QHPs) must participate in the risk corridors program and pay charges *or receive payments from HHS based on the ratio of the issuer's allowable costs to the target amount*,” and not limited by collections or the availability of appropriations. Bulletin, CMS, *Announcement of Medical Loss Ratio and Risk Corridors Annual Reporting Procedures for the 2016 MLR Reporting Year*, at 1 (May 9, 2017) (emphasis added), attached hereto at Exhibit 40.

142. On or about July 31, 2017, Plaintiff submitted its CY 2016 risk corridors data to CMS per 45 C.F.R. § 153.530(d).

143. On November 13, 2017, HHS and CMS announced the CY 2016 collection and payment amounts for the final year of the risk corridors program. See Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year* (Nov. 18, 2016), Ex. 37. The data HHS and CMS provided in the November 13, 2017 announcement indicated that the Government owes QHPs \$3,978,220,798.38 in CY 2016 risk corridors payments and QHPs owe the Government \$27,090,317.25 in CY 2016 risk corridors collections.

144. In total, for all three years of the risk corridors program, the Government owes QHPs CY 2014, CY 2015 and CY 2016 risk corridors payments of approximately \$12.3 billion. In total, QHPs owed the Government CY 2014, CY 2015 and CY 2016 risk corridors collections of approximately \$484.5 million.

145. The Government failed to provide Plaintiff with any statutory authority for its unilateral decision to make no risk corridors payments for CY 2015 by the end of CY 2016, and to make no risk corridors payments for CY 2016 by the end of CY 2017, while Independent Health was obligated to fully remit its annual risk corridors collection charges to the Government on time.

146. Congress, through Section 1342 of the ACA, did not either expressly or implicitly grant the Secretary of HHS any discretion to pay QHPs that qualified for risk corridors payments any amount less than the full risk corridors payment amount prescribed in Section 1342(b)(1) and (2).

147. Congress also did not limit in any way the Secretary of HHS' obligation to make full risk corridors payments owed to QHPs, due to appropriations, restriction on the use of funds, or otherwise in Section 1342 or anywhere else in the ACA.

148. The United States Court of Appeals for the Federal Circuit held that "Section 1342 is unambiguously mandatory. It provides that '[t]he Secretary *shall* establish and administer' a risk corridors program pursuant to which '[t]he Secretary *shall* provide' under the program that 'the Secretary *shall* pay' an amount according to a statutory formula. 42 U.S.C. § 18062 (emphases added). Nothing in section 1342 indicates that the payment methodology is somehow limited by payments in. It simply sets forth a formula for calculating payment amounts based on a percentage of a 'target amount' of allowable costs." *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1321 (Fed. Cir. 2018), *petition for rehearing en banc denied, per curiam*, 908 F.3d 738 (Fed. Cir. 2018, *cert. granted*, 2019 US Lexis 4338 (June 24, 2019)).

149. The Federal Circuit in *Moda Health* held that the risk corridors payment "obligation is created by the statute itself, not by the agency....We conclude that the plain

language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program.” *Id.* at 1322.

150. The Federal Circuit in *Moda Health* concluded that “[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties.” *Id.* at 1321 (citations omitted).

151. Accordingly, the Federal Circuit in *Moda Health* held that it was of “no moment that, as the government notes, HHS could not have made payments out to insurers in an amount totaling more than the amount of payments in without running afoul of the Anti-Deficiency Act.”. *Id.* at 1322 (observing that “the Supreme Court has rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government.” (citations omitted)).

152. Congress has not amended Section 1342 since enactment of the ACA.

153. Congress has not repealed Section 1342, and all prior attempts to repeal Section 1342 have failed. *Id.* at 1332 (Newman, J., dissenting); *see also* S. 1726, Obamacare Taxpayer Bailout Prevention Act, *available at* <https://www.congress.gov/bill/113th-congress/senate-bill/1726>.

154. Any potential future repeal of Section 1342 could not apply retroactively to negate the United States' obligation to make full risk corridors payments to QHPs, including Independent Health's, for CY 2015, and CY 2016.

155. The Federal Circuit in *Moda Health* determined that Congress, in passing the appropriations riders limiting the source of funds from which HHS could make risk corridors

payments must have intended, implicitly, to temporarily suspend or cap, Congress' underlying statutory payment obligation. 892 F.3d at 1327-29. The Supreme Court granted *certiorari* in *Moda Health* on June 24, 2019 to review whether that holding is inconsistent with controlling precedent.

Independent Health's Risk Corridors Payment and Charge Amounts for CY 2014

156. In a report released on November 19, 2015, HHS and CMS publicly announced QHPs' risk corridors charges and payments for CY 2014, and emphasized that "**Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated.**" Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015) ("CY 2014 Risk Corridors Report"), attached hereto at Exhibit 41.

157. The amount of Independent Health's gains in the ACA New York Individual and Small Group Markets for CY 2014 resulted in Independent Health being required to remit risk corridors charges to the Secretary of HHS in the amount of \$2,870,470.22 and \$530,639.45 respectively, for a total charge of \$3,401,109.67. See CY 2014 Risk Corridors Report at Table 33 – New York, Ex. 41.

158. Independent Health was required to pay the Government 100% of its CY 2014 risk corridors charges (\$3,401,109.67) – not some unilaterally determined fraction thereof – and to do so promptly.

159. Pursuant to CMS' instruction, Independent Health's risk corridors charges were netted against amounts owed by CMS to Independent Health under other ACA programs, for a total amount payable by Independent Health of \$339,286.06. Independent Health made its full and timely remittance of CY 2014 risk corridors charges to the Government on December 14,

2015. *See* November 2015 Payment Processing Report for Independent Health, (Nov. 2015) and Pay.gov Receipt, attached hereto at Exhibit 42.

Independent Health's Risk Corridors Payment and Charge Amounts for CY 2015

160. In a report released on November 18, 2016, HHS and CMS publicly announced QHPs' risk corridors charges and payments for CY 2015, stating that "all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments," and that "HHS intends to collect the full 2015 risk corridors charge amounts indicated in the tables" printed in the report. CY 2015 Risk Corridors Report, Ex. 37.

161. Independent Health's losses in the ACA New York Small Group Market for CY 2015 resulted in the Government being required to pay Independent Health a risk corridors payment of \$868,523.25. *See id.* at 9. The Government, however, did not make any payments to Plaintiff for the CY 2015 risk corridors amounts owed.

162. The Government lacks the authority, under statute, regulation or contract, to unilaterally withhold full and timely CY 2015 risk corridors payments from QHPs such as Independent Health's.

Independent Health's Risk Corridors Payment and Charge Amounts for CY 2016

163. In a report released on November 13, 2017, HHS and CMS publicly announced the amount of risk corridors payments the Government owes to QHPs, and the amount of risk corridors charges the Government will collect from QHPs, for the CY 2016 plan year. CMS announced that "HHS will use 2016 benefit year risk corridors collection to make additional payments toward 2014 benefit year balances," indicating that the Government will not make any payments to QHPs, including Independent Health's, toward the Government's CY 2015 or CY 2016 risk corridors amounts still owed. Bulletin, CMS, *Risk Corridors Payment and Charge*

Amounts for the 2016 Benefit Year at 1 (Nov. 13, 2017) (“CY 2016 Risk Corridors Report”), attached hereto at Exhibit 43.

164. Additionally, CMS announced that “HHS intends to collect the full 2016 risk corridors charge amounts indicated in the tables” printed in the report, and that HHS “is collecting 2016 risk corridor charges in November 2017.” *Id.* at 1-2.

165. Contrary to recent guidance by CMS, which had represented to Independent Health and other QHPs that “Remittance of Risk Corridors Payments Begins” on “12/2017,” *see CMS, Key Dates for Calendar Year 2017* at 3 (Apr. 13, 2017), attached hereto at Exhibit 44, HHS and CMS announced on November 13, 2017 that “HHS … will begin remitting risk corridors payments to issuers in January 2018, as collections are received.” CY 2016 Risk Corridors Report at 2, Ex. 43.

166. Independent Health’s losses in the ACA New York Individual and Small Group Markets for CY 2016 resulted in the Government being required to pay Independent Health risk corridors payments of \$ 2,527,441.24 and \$12,491,216.10, for a total amount owed of \$15,018,657.34 for CY 2016. *See id.* at 13. The Government, however, has not made any CY 2016 risk corridors payments to Plaintiff.

167. The Government lacks the authority, under statute, regulation or contract, to unilaterally withhold full and timely CY 2016 risk corridors payments from QHPs such as Independent Health’s.

168. In total, the Government owes Plaintiff \$15,887,180.59 in unpaid risk corridors payments for CY 2015 and CY 2016 combined, and has not paid any of this amount to Plaintiff. Independent Health is entitled to receive, and demands, full and immediate payment from the United States.

COUNT I

Violation of Federal Statute and Regulation

169. Plaintiff re-alleges and incorporates by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

170. Section 1342(b)(1) of the ACA mandates compensation, expressly stating that the Secretary of HHS “shall pay” risk corridors payments to eligible QHPs based on their annual ACA exchange losses, in accordance with the payment formula set forth in the statute. *See* 42 U.S.C. § 18062(b), Ex. 04; 45 C.F.R. § 153.510, Ex. 07.

171. HHS’ and CMS’ implementing regulation at 45 C.F.R. § 153.510(b) also mandates compensation, expressly stating that “when” QHPs’ allowable costs exceed the 3 percent risk corridors threshold, HHS “will pay” risk corridors payments to QHPs in accordance with the payment formula set forth in the regulation, which formula is mathematically identical to the formula in Section 1342(b)(1) of the ACA.

172. Congress, through Section 1342 of the ACA, did not either expressly or implicitly grant the Secretary of HHS any discretion to pay QHPs that qualified for risk corridors payments any amount less than the full risk corridors payment amount prescribed by the statutory formula in Section 1342(b)(1) and (2), or to pay the risk corridors amounts due pursuant to the statutory formula over the course of, or after the end of, the three-year risk corridors program.

173. HHS’ and CMS’ regulation at 45 C.F.R. § 153.510(d) requires a QHP to remit risk corridors charges it owes to HHS within 30 days after notification of such charges. In CY 2014, CY 2015, and CY 2016, Independent Health timely and fully complied with this requirement.

174. Plaintiff voluntarily applied to become, was certified as, committed itself to be, and in fact was, a QHP issuer on the New York ACA Exchange in CY 2014, CY 2015 and CY 2016, *see Ex. 10*, and was qualified for and entitled to receive mandated risk corridors payments from the Government for CY 2015 and CY 2016.

175. Plaintiff is entitled under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b) to recover full and timely mandated risk corridors payments from the Government for CY 2014, CY 2015 and CY 2016.

176. In the CY 2015 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling \$868,523.25, that the Government concedes it owes Independent Health for CY 2015. *See Ex. 37.*

177. In the CY 2016 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling \$15,018,657.34, that the Government concedes it owes Independent Health for CY 2016. *See Ex. 43.*

178. The Government was obligated to make full risk corridors payments promptly to Plaintiff for CY 2015 by the end of CY 2016, and for CY 2016 by the end of CY 2017.

179. The United States has failed to make full and timely risk corridors payments to Independent Health for CY 2015 and CY 2016, despite the Government repeatedly confirming in writing that Section 1342 mandates that the Government make full risk corridors payments.

180. Instead, the Government has not paid any of the total amounts due for CY 2015 or CY 2016, asserting that full payment to Independent Health is limited by available appropriations, even though no such limits appear anywhere in the ACA, the money-mandating Section 1342, or the money-mandating implementing regulations.

181. Congress did not repeal, amend, suspend or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridors payments to QHPs, including Plaintiff's, that suffered annual losses on the ACA Exchanges in excess of their statutory targets.

182. The Government's failure to make full and timely risk corridors payments to Independent Health for CY 2015 and CY 2016 constitutes a violation and breach of the Government's mandatory payment obligations under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b).

183. As a result of the United States' violation of Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b), Independent Health has been damaged in the amount of at least \$15,887,180.59 in unpaid risk corridors payments for CY 2015 and CY 2016 combined.

COUNT II

Breach of Implied-In-Fact Contract

184. Plaintiff re-alleges and incorporates by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

185. The Government knowingly and voluntarily entered into valid implied-in-fact contracts with Plaintiff regarding the Government's obligation to make full and timely risk corridors payments to Plaintiff for CY 2014 and/or CY 2015 and/or CY 2016 in exchange for Plaintiff's respective voluntary agreements to become a QHP issuer and participate in the New York ACA Exchange in CY 2014, CY 2015 and CY 2016, including Plaintiff's obligation to remit full and timely risk corridors collection charges to the Government if Plaintiff was required to do so.

186. The existence of an implied-in-fact contract can be inferred from both the promissory "shall pay" and "will pay" language in, respectively, Section 1342 and its

implementing regulations, as well as from the parties' conduct and the totality of the circumstances surrounding the enactment and implementation of the ACA and the risk corridors program, by which Congress, HHS, and CMS committed the Government to share with QHPs the financial risk against adverse selection and market uncertainty.

187. Section 1342 of the ACA and HHS' implementing regulations (45 C.F.R. § 153.510), confirmed and ratified by HHS' and CMS' repeated assurances admitting the Government's obligation to make full risk corridors payments, constituted a clear and unambiguous offer by the Government to make full and timely risk corridors payments to health insurers, including Plaintiff, that agreed to participate as QHP issuers in the CY 2014 and/or CY 2015 and/or CY 2016 ACA Exchanges and whose plans were approved as certified QHPs at the Government's discretion. This offer evidences a clear intent by the Government to contract with Plaintiff.

188. Congress provided in Section 1342 a program that offered specified incentives in return for Plaintiff's voluntary performance in the form of an actual undertaking and gave HHS no discretion to make less than the specific amount of risk corridors payments prescribed by the statutory formula from the Government to eligible QHPs, like Independent Health's, that agreed to participate in the ACA Exchanges.

189. Plaintiff accepted the Government's offer by developing health insurance plans that complied with the ACA's new requirements, agreeing to become a QHP issuer, and by performing as a QHP issuer on the new ACA Exchanges, which posed uncertain risks that the Government agreed to share with Plaintiff by limiting the extent of Plaintiff's annual losses or profits based on a prescribed formula and targets. Plaintiff understood that the mutual "shall pay" risk corridors payment obligations imposed upon it and upon the Government were binding.

190. By agreeing to offer QHPs, Plaintiff agreed to provide services by offering health insurance on particular Exchanges established under the ACA, and to accept the new obligations, responsibilities and conditions the Government imposed on QHPs – subject to the implied covenant of good faith and fair dealing – under the ACA and, *inter alia*, 45 C.F.R. §§ 153.10 *et seq.* and 155.10 *et seq.*

191. Plaintiff was not obligated to participate as a QHP issuer, to incur Exchange-related costs and losses, and/or to provide healthcare benefits to numerous enrollees who had not previously been insured at premiums that were lower than they would have been without the Government's promised risk-sharing.

192. The Government's agreement to make full and timely risk corridors payments was a significant factor material to Plaintiff's agreement to become a QHP issuer and participate in the CY 2014, CY 2015 and CY 2016 ACA Exchanges.

193. The Government also induced QHPs, like Independent Health's, to commit to the CY 2015 and CY 2016 ACA Exchanges during and after HHS' and CMS' announcement in 2014 of their intention to implement the risk corridors program in a budget neutral manner by repeatedly giving assurances to QHPs that "full" risk corridors payments were owed and that risk corridors collections would be sufficient to cover all of the Government's risk corridors payments for a calendar year. *See, e.g.*, Bulletin, CMS, *Risk Corridors and Budget Neutrality*, at 1 (Apr. 11, 2014), Ex. 24 ("We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments.").

194. Plaintiff, in turn, provided a real benefit to the Government by agreeing to become a QHP issuer and, despite the uncertain financial risk, to offer affordable health insurance on and to participate in the New York ACA Exchange in CY 2014, CY 2015 and CY

2016. Without sufficient health insurers voluntarily agreeing to participate in the new ACA Exchanges, the ACA could not have been implemented as intended.

195. The Government received valuable consideration from insurers, like Independent Health, that agreed to participate on the ACA Exchanges, which were central to the ACA's infrastructure and furthered the ACA's stated goals of expanding healthcare coverage to millions of new and previously uninsured Americans. The Government benefitted from Plaintiff's participation as a QHP issuer with lower premiums because the lower premiums translated into reduced tax subsidies and attendant savings for the federal fisc.

196. Plaintiff satisfied and complied with its obligations and/or conditions which existed under the implied-in-fact contracts with the Government, including, but not limited to, remitting full and timely risk corridors charges owed to the Government for CY 2014.

197. The parties' mutual intent to contract is further confirmed by the parties' conduct, performance and statements, including, but not limited to, Plaintiff's execution of the QHP Agreement and the Government's repeated assurances that full and timely risk corridors payments would be made and would not be subject to budget limitations. *See, e.g.*, 78 FR 15409, 15473 (Mar. 11, 2013), Ex. 08.

198. Independent Health had a legitimate expectation based on the language of § 1342 and HHS' assurances from 2011-2014, that Congress would be bound to honor its "shall pay" obligation to make the prescribed risk corridors payments if Independent Health suffered the statutorily defined annual losses.

199. Congress obligated itself to make risk corridors payments to participating insurers, like Independent Health, because it knew that without its promised federal risk sharing, insurers would not participate at all or would price the increased risk of new populations of

insureds into their annual premiums. In exchange for participating and providing QHPs with lower than normal premiums, insurers legitimately expected to be receive the risk corridors payments they were owed.

200. Section 1342 states that the HHS Secretary “shall establish” the ACA risk corridors program and “shall pay” risk corridors payments, and the Secretary is responsible for administering and implementing the ACA and risk corridors program. 42 U.S.C. § 18062(a) & (b). The Secretary of HHS was explicitly authorized to make the Government’s risk corridors payments in specific amounts under Section 1342 of the ACA. The Secretary was therefore authorized by law under the ACA to make the Government’s risk corridors payments.

201. Each of the implied-in-fact contracts were authorized and/or ratified by representatives of the Government who had express or implied actual authority to bind the United States (including, but not limited to, the Secretary of HHS and/or Kevin J. Counihan), were clearly founded upon a meeting of the minds between the parties and entered into with mutual assent, and were supported by consideration.

202. In the CY 2015 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling \$868,523.25, that the Government concedes it owes Independent Health for CY 2015. *See Ex. 37.*

203. In the CY 2016 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling \$15,018,657.34, that the Government concedes it owes Independent Health for CY 2016. *See Ex. 43.*

204. The Government was obligated to make full risk corridors payments promptly to Plaintiff for CY 2015 by the end of CY 2016, and for CY 2016 by the end of CY 2017.

205. Congress did not vitiate the United States' contractual obligation to make full and timely risk corridors payments to Plaintiff.

206. Independent Health honored its obligation to remit full risk corridors collections charges promptly to the Government for CY 2014 by the end of CY 2015.

207. The Government was obligated to make full risk corridors payments promptly to for CY 2015 by the end of CY 2016, and for CY 2016 by the end of CY 2017.

208. The Government's failure to make full and timely CY 2015 and CY 2016 risk corridors payments to Plaintiff is a material breach of the implied-in-fact contracts.

209. As a result of the United States' material breach of its implied-in-fact contracts that it entered into with Plaintiff regarding ACA risk corridors payments for CY 2015 and/or CY 2016, Plaintiff has been damaged in the amount of at least \$15,887,180.59 in unpaid risk corridors payments for CY 2015 and CY 2016 combined.

PRAYER FOR RELIEF

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

(1) For Count I, awarding damages sustained by Plaintiff, in the amount of at least \$15,887,180.59, subject to proof at trial, as a result of the Defendant's violation of Section 1342(b)(1) of the ACA and of 45 C.F.R. § 153.510(b) regarding the CY 2015 and CY 2016 risk corridors payments;

(2) For Count II, awarding damages sustained by Plaintiff, in the amount of at least \$15,887,180.59, subject to proof at trial, regarding the CY 2015 and CY 2016 risk corridors payments;

(3) Awarding all available interest, including, but not limited to, post-judgment

interest, to Plaintiff;

- (4) Awarding all available attorneys' fees and costs to Plaintiff; and
- (5) Awarding such other and further relief to Plaintiff as the Court deems just and equitable.

Dated: February 18, 2020

Respectfully Submitted,

s/ Lawrence S. Sher
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