Receipt number 9998-4582694

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

FILED
April 3 2018
U.S. COURT OF
FEDERAL CLAIMS

BLUE CROSS AND BLUE SHIELD OF NEBRASKA,

and

HAWAI'I MEDICAL SERVICE ASSOCIATION,

Plaintiffs, on behalf of themselves and all others similarly situated

v.

THE UNITED STATES OF AMERICA,

Defendant.

No. 18-491 C

CLASS ACTION COMPLAINT

Plaintiffs Blue Cross and Blue Shield of Nebraska ("BCBS-NE") and Hawai'i Medical Service Association ("HMSA") (collectively, "Plaintiffs"), on their own behalf and on behalf of all those similarly situated, bring this class action against Defendant the United States of America (the "United States" or "Defendant" or the "government"), and allege as follows:

INTRODUCTION

1. This case is about the government's failure to live up to its obligations under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010). The ACA was passed by Congress in 2010 and made sweeping changes in the U. S. health insurance market, many of which went into effect in 2014. Among other things, the ACA creates "Exchanges" on which individual and small group health insurance are sold. The law

eliminates insurers' ability to deny coverage for sick individuals or charge higher rates based on an individual's health condition. The ACA also requires health insurers to cover certain types of benefits. And, the ACA contains other reforms designed to increase significantly the number of individuals with health insurance.

2. These and other changes introduced by the ACA presented enormous risks for insurers, which were required to cover many new people and had to sell products and participate in markets with which they had no previous experience. To mitigate, but not eliminate, these risks, the ACA created three premium stabilization programs designed to "help protect insurers against risk selection and market uncertainty." *Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment* at 2, HealthCare.gov (July 11, 2011) (attached as Exhibit A). According to the government, these "programs will mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Affordable Insurance Exchanges ('Exchanges') are implemented, starting in 2014." 77 Fed. Reg. 17,219, 17,220 (Mar. 23, 2012).

3. The three premium stabilization programs are critically important to the ACA and to the viability of U.S. health insurance markets. Each program involves payments by the government to certain insurers and payments by other insurers to the government, typically in the hundreds of millions or billions of dollars in each direction. Without the protections offered by these programs, many insurers either would have elected not to participate on the Exchanges at all or would have been forced to increase premiums significantly to account for the added risks.

4. Despite the importance of the premium stabilization programs and the government's and insurers' express, mutual obligations under those programs, the government has failed to live up to its commitments. It has failed to make billions of dollars of payments that

it acknowledges are owed under two of these programs: the risk corridors program and the risk adjustment program.

5. As to the risk corridors program, the government's only excuse for non-payment is that the money owed *to* insurers exceeds the amount owed *by* insurers. But nothing about the program suggests those two amounts will match and the government has long recognized that this program was not designed to operate in a budget neutral manner. Moreover, the statute and regulations creating and implementing the risk corridors program are money-mandating and leave no discretion for the government to elect not to make payments. Plaintiffs bring their risk corridors claims on an individual basis, because there is already a class action regarding such claims pending in this Court. *See Health Republic Ins. Co. v. United States*, No. 1:16-cv-00259-MMS (Fed. Cl. filed Feb. 24, 2016).

6. The government's excuse for not making risk adjustment payments is different. Unlike the risk corridors program, the risk adjustment program was designed to be budget neutral. That is, it was mathematically designed such that the amounts owed by insurers would equal exactly the amounts owed to insurers. Indeed, the government computed amounts owed to and from the participating insurers and, in the aggregate, those amounts did match. But the government claims to have failed to collect all of the amounts owed by insurers and, on that basis, has refused to pay fully the amounts owed to insurers that the government itself had calculated. This failure to pay was illegal for four separate reasons and Plaintiffs bring these claims on a class basis.

7. First, as with the risk corridors program, the statute creating the risk adjustment program is money-mandating and requires the government to make payments to insurers

regardless of whether the government's collections from other insurers occur as planned. In other words, the statute mandates that the government bear the risk of non-collection.

8. The three remaining reasons the government's non-payment was illegal all relate in some way to the government's regulatory authority to net amounts it owes to an insurer against certain enumerated types of ACA obligations the insurer owes to the government. One of these further reasons establishing illegality is that, using this regulatory authority, the government collected some risk adjustment funds from insurers that owed such funds, but then failed to pay those funds to the insurers to which those funds were owed. The last two reasons involve insurers that owed risk adjustment funds to the government and that also were owed funds by the government. The government could have used its regulatory authority to net the mutual debts, thereby collecting the risk adjustment debts owed by the insurers. Instead, in some cases the government netted its obligations to the insurer against types of insurer debt for which the government has no authority to collect via netting. In other cases, the government simply paid the amounts owed to the insurer and failed to net those amounts against anything, despite the fact that the insurer owed the government risk adjustment amounts. In both cases, the government actually possessed funds that could have and should have been used to satisfy the government's risk adjustment obligations to Plaintiffs and other insurers.

9. The government has failed to pay Plaintiffs and other insurers substantial sums that are unquestionably owed under the risk corridors and risk adjustment programs. The government's failure to make these required payments is undermining the health insurance markets in the United States and has already contributed to numerous insurers either failing financially or electing not to participate in the Exchanges. Plaintiffs held up their part of the bargain under the ACA. The government should do the same.

JURISDICTION AND VENUE

10. Jurisdiction and venue are proper in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491(a), because this action is based on claims for monetary damages against the United States founded upon federal statutes and regulations, and an implied-in-fact contract to which the United States is a party.

PARTIES

11. BCBS-NE is a nonprofit mutual benefit corporation licensed by the Blue Cross and Blue Shield Association. BCBS-NE is incorporated under the laws of Nebraska, with its principal place of business in Nebraska. It is a member owned and operated company. BCBS-NE offers health insurance in Nebraska.

12. HMSA is a nonprofit mutual benefit society licensed by the Blue Cross and Blue Shield Association. HMSA is incorporated under the laws of Hawai'i, with its principal place of business in Hawai'i, and offers health insurance in Hawai'i.

13. Defendant is the United States of America. The U.S. Department of Health and Human Services ("HHS") and the U.S. Centers for Medicare & Medicaid Services ("CMS") are agencies of Defendant.

STATEMENT OF FACTS

The Affordable Care Act

14. In 2010, Congress enacted the Patient Protection and Affordable Care Act ("ACA") to improve access to quality, affordable health care.

15. One feature of the ACA is the creation of health exchanges ("Exchanges") where a health insurance issuer ("Issuer") could offer quality, affordable healthcare plans to consumers.

For each state, the ACA sought to create a separate Exchange for the individual market and a separate Exchange for the small group market. Plaintiffs are both Issuers.

16. In order to participate on an Exchange, an Issuer must offer a qualified health plan ("QHP"). QHPs are health plans that must meet various statutory and regulatory requirements. QHPs must, for example, provide specific health benefits as set forth under the ACA. Issuers such as Plaintiffs, designed, created, and maintained QHPs to comply with the applicable statutory and regulatory requirements. An Issuer can offer a QHP on an Exchange or through other channels.

17. Congress designed the ACA to improve access to health care by, among other things, implementing what the U.S. Supreme Court has described as three key measures. *See King v. Burwell*, 135 S. Ct. 2480, 2485–87 (2015).

18. First, the ACA generally mandates that Issuers accept every individual who applies for coverage regardless of their health condition and limits Issuers' ability to charge different rates to different individuals. Issuers cannot, for example, charge higher rates for Exchange plans based on an enrollee's health condition.

19. Second, the ACA requires individuals to maintain coverage and subjects them to a tax penalty for noncompliance, in order to reduce the danger that individuals would refrain from purchasing health insurance until they actually needed care.

20. Third, the ACA provides monetary mechanisms to subsidize to certain low-income individuals purchasing insurance plans on the Exchanges.

The Premium Stabilization Programs

21. As a result of the aforementioned and other substantial provisions in the ACA, no one (including Issuers) could accurately predict the volume or health characteristics of future enrollees in health plans sold either on or off the Exchanges.

22. To reduce the uncertainties created by the ACA and to induce Issuers to participate on the Exchanges notwithstanding the uncertainties involved, Congress established three risk-spreading mechanisms known as the premium stabilization or "three Rs" programs. These programs were designed to mitigate the financial risk to Issuers who enroll consumers with health conditions and to discourage Issuers from increasing premiums to protect themselves from the risk. In Defendant's words, these programs were meant to provide "protection for qualified health plan issuers in the Exchange." Ex. A at 2.

23. HHS and its sub-agency CMS are responsible for administering the ACA's premium stabilization programs.

24. One of the three Rs programs, not directly at issue in this case, is the reinsurance program created by Section 1341 of the ACA. The reinsurance program is a temporary, three-year program for the 2014, 2015, and 2016 calendar years. ACA § 1341(b)(1)(A); 42 U.S.C. § 18061(b)(1)(A); 45 C.F.R.§§ 153.210(a), 153.230(b) (2016). The program provides for partial reimbursement of certain claims costs—in excess of a specified attachment point and up to a specified reinsurance cap—incurred by health insurance issuers on behalf of particular enrollees. The goal of the program is to alleviate an Issuer's need to build into premiums the risk of accepting enrollees with significant health needs, and therefore "equitably stabiliz[e] premiums in the individual market. . . ." 78 Fed. Reg. 15,409, 15,452 (Mar. 11, 2013). The program is

funded by contributions from health insurers and self-funded group health plans. Although it is tangentially relevant, the reinsurance program is not the subject of this lawsuit.

The Risk Corridors Program

25. The second of the three Rs programs is called the "risk corridors" program and was created by Section 1342 of the ACA (42 U.S.C. § 18062). It too is a temporary program covering the years 2014, 2015, and 2016. And it is at issue here.

26. A health insurance Issuer that offers a QHP in the individual or small group market must participate in the risk corridors program for the 2014 through 2016 calendar years. ACA § 1342(a); 42 U.S.C. § 18062(a); 45 C.F.R. §§ 153.500 (definition of "QHP"), 153.510.

27. The risk corridors program applies to all QHPs sold on an Exchange as well as QHPs sold outside an Exchange if they are substantially the same as a QHP offered on an Exchange.

28. The essence of the risk corridors program is that HHS will pay money out to the Issuer of a QHP that has actual costs of providing coverage that end up being more than 3% higher than "the target amount" for that plan, while HHS will collect money from the Issuer of a QHP that has actual costs of providing coverage that end up being more than 3% lower than "the target amount" for the plan. *See* 42 U.S.C. § 18062(b).

29. The computation described in the previous paragraph is done after each plan year ends on December 31.

30. Because the computation is based, in large part, on the actual costs of providing coverage, for any given year of the program (or for the program as a whole), it is impossible to know ahead of time whether an Issuer will be entitled to a risk corridors payment from HHS or will be required to make a risk corridors payment to HHS, or the amount of either such payment.

31. Likewise, from the government's perspective, for any given year of the program (or for the program as a whole), it is impossible to know ahead of time whether the risk corridors payments it owes to Issuers will be less than, equal to, or more than the risk corridors amounts it is entitled to collect from Issuers.

32. The risk corridors program was meant to enable Issuers "to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." 78 Fed. Reg. at 15,413.

33. ACA § 1342(a) (42 U.S.C. § 18062(a)) provides:

> 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.

34. ACA § 1342(b) (42 U.S.C. § 18062(b)) is entitled "Payment Methodology" and describes the specific risk corridors payments that will be due to Issuers from HHS and to HHS from Issuers.

35. ACA § 1342(b)(1) (42 U.S.C. § 18062(b)(1)) relates to risk corridors payments to be made from HHS to Issuers. It provides:

> (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.

36. ACA § 1342(b)(2) (42 U.S.C. § 18062(b)(2)) relates to risk corridor payments to be made from Issuers to HHS. It states:

> (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.

37. The term "allowable costs" is defined as "an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan" minus "any risk adjustment and reinsurance payments received" by the Issuer. ACA § 1342(c)(1) (42 U.S.C. § 18062(c)(1)).

38. The term "target amount" is defined as "an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan." *Id.* § 1342(c)(2) (42 U.S.C. § 18062(c)(2)).

39. In March 2012, HHS issued its final rule establishing the risk corridors program and outlining the payment methodology. *See* 77 Fed. Reg. at 17,251 (codified at 45 C.F.R. § 153.510).

40. 45 C.F.R. § 153.510(b) details the payments HHS must make to Issuers and provides:

> 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.

41. 45 C.F.R. § 153.510(c) details the payments Issuers must make to HHS and provides:

> 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.

42. To the extent Issuers must make risk corridors payments to HHS, 45 C.F.R. § 153.510(d) requires Issuers to make those payments "within 30 days after notification of such charges."

43. As to the deadline on itself to remit risk corridors payments to Issuers, HHS recognized that Issuers entitled to risk corridors money would want "prompt payment," and that

the 30 day payment deadline "should be the same" for Issuers and HHS. *See* 77 Fed. Reg. at 17,238; *see also* 76 Fed. Reg. 41,929, 41,943 (July 15, 2011).

The Risk Adjustment Program

44. The last of the three Rs programs, also at issue in this case, is called the "risk adjustment" program and was created by § 1343 of the ACA (42 U.S.C. § 18063).

45. The goal of the risk adjustment program is to transfer funds from Issuers that, given the make-up of their enrollees, are taking on an actuarial risk that is lower than the average risk in that state to Issuers that are taking on an actuarial risk that is higher than the average risk in that state.

46. The purpose of the program is to (1) reduce incentives for Issuers to avoid higher-risk enrollees; (2) reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection or choices by higher-risk enrollees in the individual and small group markets; and (3) mitigate the potential for excessive premium growth or instability within the Exchange. *See* 78 Fed. Reg. at 15,415; 77 Fed. Reg. at 17,221, 17,230.

47. HHS has explained that without the risk adjustment program, "plans that enroll a higher proportion of high-risk enrollees would need to charge a higher average premium (across all of their enrollees) to be financially viable." CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting, Discussion Paper* at 5 (Mar. 24, 2016) (attached as Exhibit B).[1]

48. According to HHS:

> The risk adjustment program serves to level the playing field, both inside and outside of the Exchange. Risk adjustment ends the incentive for issuers to avoid the sick and market only to the healthy by transferring excess payments from

[1] Available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

> plans with lower risk enrollees to plans with higher risk enrollees. For this reason, plans will have to compete on the basis of price, quality and service. This allows consumers the ability to pick the plan that best meets his or her needs.

Ex. A at 1.

49. Unlike the risk corridors program, the risk adjustment program applies not just to QHPs, but to any health plan (except a "grandfathered health plan") sold on or off an Exchange.

50. Unlike the risk corridors program (which depends on actual costs), the risk adjustment program is based on the actuarial risks that are deemed to be taken on by an Issuer.

51. Unlike the risk corridors program, the risk adjustment program is permanent.

52. Unlike the risk corridors program (where HHS's pay-outs might be lower than, equal to, or higher than its receivables), the risk adjustment program is designed so that the amount of government liabilities will be exactly equal to the amount of Issuer liabilities. *See* Ex. B at 91.

53. As to risk adjustment payments made from Issuers, the ACA provides:

> Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year . . . .

42 U.S.C. § 18063(a)(1).

54. As to risk adjustment payments made to Issuers, the ACA provides:

> Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year . . . .

Id. § 18063(a)(2).

55. Subsection (b) referenced in the previous two paragraphs provides:

> The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 18041 of this title.

Id. § 18063(b) (internal citation omitted).

56. In turn, 42 U.S.C. § 18041 (§ 1321 of the ACA) requires the Secretary of HHS to "issue regulations setting standards for meeting the requirements under this title . . . with respect to . . . the establishment of the . . . risk adjustment program[] . . . ," among other things. *Id*. § 18041(a)(1)(C).

57. Section 18041 also sets forth an option for each State either to elect to establish and operate a risk adjustment program itself or to have HHS do so in the State. *Id*. § 18041(b), (c).

58. For the years at issue in this case, all States except for Massachusetts elected not to establish or operate their own risk adjustment program.

59. Instead, for the years at issue in this case, in all States except Massachusetts, HHS has established and has operated the risk adjustment program. Thus, for the years at issue in this case, HHS established and operated the risk adjustment program in both Nebraska and Hawai'i.

60. For the years at issue in this case, Nebraska and Hawai'i (and every other State except Massachusetts) have forgone "implementation of all State functions" under HHS's risk adjustment regulations and, instead, "HHS will carry out all of the provisions of [those regulations] on behalf of the State." 45 C.F.R. § 153.310(a)(3).

61. Thus, among other things, for the years at issue in this case, in Nebraska and Hawai'i (and in every other State except Massachusetts), an Issuer was required to submit to

HHS any risk adjustment amounts the Issuer owed under § 18063(a)(1), and was entitled to receive from HHS any risk adjustment amounts the Issuer was due under § 18063(a)(2).

62. For the benefit years[2] at issue in this case, in Nebraska and Hawai'i (and in every other State except Massachusetts), HHS did in fact collect risk adjustment payments from Issuers and did in fact issue risk adjustment payments to Issuers.

63. The sole statutory authority for HHS to collect and make risk adjustment payments is §§ 1321 and 1343 of the ACA (42 U.S.C. §§ 18041, 18063).

64. Under HHS's risk adjustment regulations, the risk adjustment methodology used in each State must be a federally certified methodology. *See* 45 C.F.R. § 153.320(a).

65. A risk adjustment methodology is certified if it either was "developed by HHS and published in advance of the benefit year in rulemaking" or "is submitted by a State . . . , reviewed and certified by HHS, and published" by HHS. *Id*. § 153.320(a)(1)–(2).

66. For the years at issue in this case, only one State—Massachusetts—submitted a risk adjustment methodology for HHS's review.

67. For all other States, the risk adjustment methodology developed by HHS was used to administer the risk adjustment program.

68. For each benefit year at issue in this case (2014 and 2015), HHS published its risk adjustment methodology in the Federal Register at 78 Fed. Reg. at 15,417–34 (for the 2014 benefit year) and 79 Fed. Reg. 13,743, 13,753–55 (Mar. 11, 2014) (for the 2015 benefit year).

69. Except for minor differences not relevant to this case, HHS's risk adjustment methodology was the same for the 2014 and 2015 benefit years.

[2] "Benefit year" and "plan year" are used interchangeably throughout this complaint.

70. Under HHS's risk adjustment methodology for the 2014 and 2015 benefit years, the payments owed to Issuers would equal the payments owed from Issuers.

71. In that sense, the "risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers." 78 Fed. Reg. at 15,441.

72. "A State, or HHS on behalf of the State, must implement risk adjustment for the 2014 benefit year and every benefit year thereafter. For each benefit year, a State, or HHS on behalf of the State, must notify issuers of risk adjustment payments due or charges owed annually by June 30 of the year following the benefit year." 45 C.F.R. § 153.310(e).

73. There is no provision in the ACA or in the risk adjustment regulations that excuses the obligation of HHS or a State (as the case may be) to issue risk adjustment payments in the amount determined under the applicable federally certified methodology.

74. Thus, a failure by HHS or a State (as the case may be) to collect risk adjustment amounts owed by insurers does not permit HHS or the State to withhold risk adjustment payments owed to insurers.

The Government's Offset Rights

75. Given the three separate three Rs premium stabilization programs, an Issuer, for a single year, may have both liabilities to, and credits from, HHS.

76. For example, in a given year between 2014 and 2016, HHS might be entitled to *collect* payments from an Issuer under the risk adjustment program, but HHS may *owe* the same Issuer payments under the risk corridors program.

77. HHS contemplated the scenario where HHS and issuers have mutual debts arising from the ACA's premium stabilization programs. Specifically, in 2014, as part of its authority to

administer the three Rs programs, HHS issued 45 C.F.R. § 156.1215, which is known as the "Netting Regulation."

78. 45 C.F.R. § 156.1215(b) provides:

> HHS may net payments owed to issuers . . . against amounts due to the Federal or State governments from the issuers . . . for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, payment of any fees for State-based Exchanges utilizing the Federal platform, and risk adjustment, reinsurance, and risk corridors payments and charges.

79. In July 2016, HHS explained that its policy is to net all payments and charges specified under § 156.1215—including payments and charges under the risk-spreading programs—in order to "expeditiously support payments under the premium stabilization programs, including risk adjustment." *See* CMS, *Netting of Payments and Charges under 45 CFR 156.1215* (July 15, 2016) (attached as Exhibit C).[3] HHS explained that netting payments and charges allows it to make "timely and complete payments to issuers under the premium stabilization program." *Id*.

The Government's Implementation of the Risk Corridors Program and Breach of its Risk Corridors Program Obligations

80. In March 2013, HHS issued its Notice of Benefit and Payment Parameters for 2014. 78 Fed. Reg. 15,409. HHS explained that "[t]he risk corridors program is not statutorily required to be budget neutral." 78 Fed. Reg. at 15,473. HHS also stated that "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." *Id*.

81. Thus, in March 2013, HHS represented to Issuers (and the general public) that HHS would make risk corridors payments to Issuers as required by ACA § 1342 regardless of

[3] Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Netting-Guidance-7-15-16finalv2.pdf.

whether those amounts exceeded the amounts HHS collected from Issuers under the risk corridors program.

82. In October 2013, Issuers, including Plaintiffs, began selling their QHPs on the Exchanges for the 2014 benefit year (under the ACA, a benefit year is a calendar year).

83. Well in advance of that time, Issuers, including BCBS-NE and HMSA, had to decide on the QHPs they would offer and the rates they would charge.

84. In setting their rates for the 2014 plan year, BCBS-NE and HMSA each relied reasonably on HHS's statements that HHS would make full risk corridors payments to Issuers regardless of whether those amounts exceeded the amounts HHS collected from Issuers under the risk corridors program.

85. Consistent with HHS's March 2013 statements, the Congressional Budget Office ("CBO") in February 2014 stated that the risk corridors program was not meant to be a budget neutral program. *See* CBO, *The Budget and Economic Outlook: 2014 to 2024* at 59 (Feb. 2014) (attached as Exhibit D).[4]

86. The CBO explained: "[R]isk corridors collections (which will be recorded as revenues) will not necessarily equal risk corridors payments, so that program can have net effects on the budget deficit." *Id*.

87. Despite HHS's and CBO's prior statements, in March 2014 HHS for the first time took the contrary position that the risk corridors program would be implemented in a budget-neutral manner (i.e., that HHS's payments out would not exceed its payments received).

88. In March 2014, HHS stated that it "intend[s] to implement [the risk corridors program] in a budget neutral manner." 79 Fed. Reg. at 13,787.

[4] Available at: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf.

89. In April 2014, HHS reiterated this change of position, stating that it "intends to implement the risk corridors program in a budget neutral manner." CMS, *Risk Corridors and Budget Neutrality* at 1 (Apr. 11, 2014) (attached as Exhibit E).[5]

90. At that time, HHS stated that it "anticipate[s] that risk corridors collections will be sufficient to pay for all risk corridors payments." *Id*. at 2.

91. But, HHS explained, if risk corridors collections were insufficient to meet its risk corridors obligations, HHS would pro-rate the amount due to Issuers in proportion to the shortfall. *See id*. HHS stated that, for example, if risk corridors collections fell short by ten percent, HHS would reduce risk corridors payments by ten percent. *See id*.

92. HHS also stated that its risk corridors collections for 2015 would be used to satisfy any balance of risk corridors payments due to Issuers for 2014. *See id*.

93. In May 2014, HHS again stated that it would administer the risk corridors program in a budget neutral manner. *See* 79 Fed. Reg. 30,240, 30,260 (May 27, 2014). HHS also stated that if 2015 presented HHS with another shortfall, HHS "recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." *Id*. "In that event," HHS continued, "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." *Id*.

94. In February 2015, HHS again acknowledged its mandate to make complete risk corridors payments to Issuers, recognizing that "the Affordable Care Act requires the Secretary to make full payments to issuers." *See* 80 Fed. Reg. 10,749, 10,779 (Feb. 27, 2015).

95. In a July 2015 letter addressed to state insurance commissioners, HHS stated that it "remain[ed] committed to the risk corridor program," and again recognized that "the

[5] Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

Affordable Care Act requires the Secretary to make full payments to issuers." Letter from Kevin J. Counihan, Chief Exec. Officer of Health Ins. Marketplace, to CMS Comm'r at 2 (July 21, 2015) (attached as Exhibit F).[6]

96. On October 1, 2015, HHS announced that HHS owed Issuers approximately $2.87 billion in risk corridors payments for the 2014 benefit year, while Issuers owed $362 million to HHS in risk corridors payments. *See* CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015) (attached as Exhibit G).[7]

97. HHS explained that it would not make full risk corridors payments to Issuers for 2014 because the risk corridors amounts HHS owed to Issuers exceeded the amounts Issuers owed to HHS. *Id*.

98. HHS decided to pro-rate its 2014 risk corridors payments to Issuers by paying each Issuer that was owed risk corridors obligations 12.6% of the amounts they were owed. *Id*.

99. In November 2015, HHS determined which Issuers were entitled to risk corridors payments for 2014, which Issuers owed risk corridors amounts to the government for 2014, and the amounts of such credits and liabilities. *See* CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015) (attached as Exhibit H).[8]

100. For 2014, HHS determined that HMSA was neither entitled to nor owed any risk corridors amount. *Id*.

---

[6] Available at: https://www.cms.gov/CCIIO/Resources/Letters/Downloads/DOI-Commissioner-Letter-7-20-15.pdf.

[7] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[8] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

101. For 2014, HHS determined that BCBS-NE was entitled to $14,143,024.12 in risk corridors payments for the individual market and that BCBS-NE owed $267,402.83 in risk corridors payments for the small group market. *Id.* at Table 28.

102. On November 19, 2015, HHS stated that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation of the United States Government for which full payment is required." CMS, *Risk Corridors Payment for the 2014 Benefit Year* (Nov. 19, 2015) (attached as Exhibit I).[9]

103. HHS announced that, of the $14,143,024.12 in 2014 risk corridors payments that BCBS-NE was owed for the individual market, HHS would pay only $1,784,547.91. *See* Ex. H at Table 28.

104. Most of that amount ($1,531,855.86) was paid to BCBS-NE on or about December 24, 2015, at approximately the same time HHS made risk corridors payments to other Issuers that were entitled to payments under ACA § 1342.

105. Additional payments were made to BCBS-NE in the months that followed.

106. Issuers that owed risk corridors payments to HHS for 2014 were required by HHS to remit those payments on or about December 19, 2015 (i.e., within thirty days of HHS's November 19, 2015 notification of the amounts due).

107. BCBS-NE, for example, remitted the $267,402.83 it owed to HHS in risk corridors payments for its 2014 small group market business on or about November 20, 2015.

108. Meanwhile, in November 2014, Issuers, including BCBS-NE and HMSA, began selling their QHPs on the Exchanges for the 2015 year.

---

[9] Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf.

109. Well in advance of that time, Issuers, including BCBS-NE and HMSA, had to decide on the QHPs they would offer and the rates they would charge.

110. In setting their rates for the 2015 plan year, BCBS-NE and HMSA each relied reasonably on HHS's statements that HHS would make full risk corridors payments to Issuers regardless of whether those amounts exceeded the amounts HHS collected from Issuers under the risk corridors program.

111. In September 2016, HHS stated that it did not expect to remit any risk corridors payments to issuers for 2015. *See* CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016) (attached as Exhibit J).[10] HHS explained that all of its risk corridors collections for 2015 would be used toward the balance of HHS's risk corridors debts to Issuers for 2014. *Id*.

112. At that time, HHS also stated that "HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required." *Id*. at 1.

113. In November 2016, HHS determined which Issuers were entitled to risk corridors payments for 2015, which Issuers owed risk corridors amounts to the government for 2015, and the amounts of such credits and liabilities. *See* CMS, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year* (Nov. 18, 2016) (attached as Exhibit K).[11]

114. For 2015, HHS determined that HMSA was entitled to $17,759,344.35 in risk corridors payments for the individual market, and that HMSA neither owed nor was owed any risk corridors amounts for the small group market. *Id*. at 4.

---

[10] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF.

[11] Available at: https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/2015-rc-issuer-level-report-11-18-16-final-v2.pdf.

115. For 2015, HHS determined that BCBS-NE was entitled to $24,733,023.87 in risk corridors payments for the individual market, and that BCBS-NE neither owed nor was owed any risk corridors amounts for the small group market. *Id*. at 8.

116. At that time, HHS again stated that it would not make any risk corridors payments owed to Issuers for 2015 and, instead, would use all 2015 risk corridors proceeds to satisfy parts of the remaining balance of risk corridors payments owed to Issuers for 2014. *Id*.

117. For example, HHS stated that, using 2015 risk corridors proceeds, it would pay BCBS-NE an additional $469,807.48 toward the 2014 risk corridors amount HHS still owed to BCBS-NE. *Id.*

118. Issuers that owed risk corridors payments to HHS for 2015 were required by HHS to remit those payments on or about December 18, 2016 (i.e., within thirty days of HHS's November 18, 2016, notification of the amounts due).

119. In its report released on November 15, 2017, HHS indicated which Issuers were entitled to risk corridors payments for 2016, which Issuers owed risk corridors amounts to the government for 2016, and the amounts of such credits and liabilities. *See* CMS, *Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year* (Nov. 15, 2017) (attached as Exhibit L).[12] The November 15, 2017, report is an updated version of the report HHS first released on November 13, 2017.

120. For 2016, HHS determined that HMSA was entitled to $14,609,115.03 in risk corridors payments for the individual market, and $1,514,974.14 in risk corridors payments for the small group market, for a total of $16,124,089.17. *Id*. at 6.

[12] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

121. For 2016, HHS determined that BCBS-NE was entitled to $25,923,663.23 in risk corridors payments for the individual market, and $520,261.48 in risk corridors payments for the small group market, for a total of $26,443,924.71. *Id*. at 12.

122. In the November 15, 2017, risk corridors report, HHS stated that because payments HHS made using 2014 and 2015 risk corridors proceeds were insufficient to pay the remaining risk corridors amounts owed to Issuers for the 2014 plan year, HHS would use 2016 risk corridors proceeds toward risk corridors payments owed to Issuers for 2014. *Id*.

123. For example, HHS stated that, using 2016 risk corridors proceeds, it would pay BCBS-NE an additional $123,027.09 toward the risk corridors amount HHS still owed to BCBS-NE for 2014. *Id*. HHS further stated that it would begin paying that additional amount in January 2018. *Id*.

124. In January 2018, HHS paid BCBS-NE $104,516.20 toward the 2014 risk corridors amount HHS still owed to BCBS-NE—$18,510.89 short of the amount HHS stated it would pay BCBS-NE in the November 15, 2017 risk corridors report.

125. To date, HHS has paid BCBS-NE a total of $2,349,189.84 in 2014 risk corridors payments for the individual market. That amount is $11,793,834.28 less than the amount owed to BCBS-NE in 2014 risk corridors payments in the individual market.

126. Issuers that owed risk corridors payments to HHS for 2016 were required by HHS to remit those payments no later than December 15, 2017 (i.e., within thirty days of HHS's November 15, 2017, updated notification of the amounts due).

127. In sum, HHS currently owes to HMSA $17,759,344.35 in risk corridors payments for 2015 and $16,124,089.17 in risk corridors payments for 2016, for a total of $33,883,433.52.

128. In sum, HHS currently owes to BCBS-NE $11,793,834.28 in risk corridors payments for 2014, $24,733,023.87 in risk corridors payments for 2015, and $26,443,924.71 in risk corridors payments for 2016, for a total of $62,970,782.86.

The Government's Breach of its Risk Adjustment Program Obligations

A. The Government's Breaches as to HMSA for the 2014 Benefit Year

129. For the 2014 benefit year, for both the individual and small group markets HMSA attracted enrollee populations that had actuarial risks that were higher than the average risks in the state.

130. As a result, HMSA was entitled to risk adjustment payments for the 2014 benefit year for both the individual and small group markets.

131. For the 2014 benefit year, HHS determined that HMSA was entitled to $16,170,796.86 in risk adjustment payments, $10,430,372.28 of which was associated with the individual market and $5,740,424.58 of which was associated with the small group market. *See* CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* at 19 (June 30, 2015) (attached as Exhibit M); CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* at 19 (Sept. 17, 2015) (attached as Exhibit N).[13]

132. Family Health Hawaii, MBS ("FHH") is one of the Issuers in Hawai'i that owed a risk adjustment payment to HHS in connection with the 2014 benefit year in the small group market. *Id*.

[13] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-2014.pdf; *see also* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

133. FHH owed that risk adjustment payment because it attracted an enrollee population in the small group market for the 2014 benefit year that had an actuarial risk that was lower than the average risk in the state.

134. Specifically, FHH owed $541,621.36 in risk adjustment payments in connection with the small group market for the 2014 benefit year. Ex. N at 19.

135. On information and belief, HHS did not collect any of the $541,621.36 that FHH owed in risk adjustment charges in connection with the small group market for the 2014 benefit year.

136. Of the $5,740,424.58 in risk adjustment payments owed to HMSA in connection with the small group market for the 2014 benefit year, HHS paid only $5,198,935.15.

137. HHS has failed to pay HMSA the remaining $541,489.43 owed to HMSA in connection with the small group market for the 2014 benefit year.

138. On information and belief, HHS has failed to pay that amount because HHS has not collected the $541,621.36 that FHH owes in risk adjustment charges in connection with the small group market for the 2014 benefit year.

139. Another Issuer in Hawai'i (UnitedHealthcare Insurance Company) was also entitled to receive a risk adjustment payment in connection with the small group market for the 2014 benefit year. Ex. L at 19; Ex. M at 19.

140. On information and belief, HHS has failed to pay UnitedHealthcare Insurance Company its full risk adjustment amounts for the 2014 benefit year because HHS has not collected the $541,621.36 that FHH owes in risk adjustment charges in connection with the small group market for that year.

141. Neither HHS nor any other government agency has suffered any negative financial consequence due to HHS's failure to collect the $541,621.36 that FHH owes in risk adjustment charges in connection with the small group market for the 2014 benefit year.

B. The Government's Breaches as to HMSA for the 2015 Benefit Year

142. For the 2015 benefit year, for both the individual and small group markets, HMSA again attracted enrollee populations that had actuarial risks that were higher than the average risks in the state.

143. As a result, HMSA was entitled to risk adjustment payments for the 2015 benefit year for both the individual and small group markets.

144. For the 2015 benefit year, HHS determined that HMSA was entitled to $22,789,588.79 in risk adjustment payments, $15,467,100.50 of which was associated with the individual market and $7,322,488.29 of which was associated with the small group market. *See* CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* at 24 (June 30, 2016) (attached as Exhibit O); CMS, *Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* at 12 (Dec. 6, 2016) (attached as Exhibit P).[14]

145. FHH is one of the Issuers in Hawai'i that owed a risk adjustment payment in connection with the 2015 benefit year in the small group market. Ex. O at 24; Ex. P at 12.

146. FHH owed that risk adjustment payment because it attracted an enrollee population for the 2015 benefit year in the small group market that had an actuarial risk that was lower than the average risk in the state.

[14] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf; *see also* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

147. FHH owed $462,123.43 in risk adjustment payments in connection with the small group market for the 2015 benefit year. Ex. O at 24; Ex. P at 12.

148. On information and belief, HHS did not collect any of the $462,123.43 that FHH owed in risk adjustment charges in connection with the small group market for the 2015 benefit year.

149. Of the $7,322,488.29 in risk adjustment payments owed to HMSA in connection with the small group market for the 2015 benefit year, HHS paid only $6,898,728.29.

150. HHS has failed to pay HMSA the remaining $423,760.00 owed to HMSA in connection with the small group market for the 2015 benefit year.

151. On information and belief, HHS failed to pay the remaining $423,760.00 to HMSA because HHS has not collected the $462,123.43 that FHH owes in risk adjustment charges in connection with the small group market for the 2015 benefit year.

152. Another Issuer in Hawai'i (Hawaii Medical Assurance Association) was also entitled to receive a risk adjustment payment in connection with the small group market for the 2015 benefit year. Ex. O at 24; Ex. P at 12.

153. On information and belief, HHS has failed to pay Hawaii Medical Assurance Association its full risk adjustment amounts for the 2015 benefit year, in part, because HHS has not collected the $462,123.43 that FHH owes in risk adjustment charges in connection with the small group market for that year.

154. Neither HHS nor any other government agency has suffered any negative financial consequence due to HHS's failure to collect the $462,123.43 that FHH owes in risk adjustment charges in connection with the small group market for the 2015 benefit year.

C. The Government's Breaches as to BCBS-NE for the 2015 Benefit Year

1. Amounts Owed to BCBS-NE and the Government's Incomplete Payments to BCBS-NE

155. For the 2015 benefit year, for both the non-catastrophic individual[15] and the small group markets, BCBS-NE attracted enrollee populations that had actuarial risks that were higher than the average risks in the state.

156. As a result, BCBS-NE was entitled to risk adjustment payments for the 2015 benefit year for both the non-catastrophic individual and the small group markets.

157. Also for the 2015 benefit year, for the catastrophic individual market, BCBS-NE attracted an enrollee population that had an actuarial risk that was lower than the average risk in the state.

158. As a result, BCBS-NE owed risk adjustment payments to HHS for the catastrophic individual market.

159. For the 2015 benefit year, HHS determined that BCBS-NE was entitled to a net total of $17,518,307.39 in risk adjustment payments: $13,604,468.81 that HHS owed BCBS-NE for the non-catastrophic individual market, minus $63,419.18 that BCBS-NE owed to HHS for the catastrophic individual market, plus $3,977,257.76 that HHS owed BCBS-NE for the small group market. The net total owed by HHS to BCBS-NE in risk adjustment payments for the 2015 plan year in the individual market was $13,541,094.63 (i.e., $13,604,468.81 owed to BCBS-NE for the non-catastrophic individual market minus $63,419.18 that BCBS-NE owed for catastrophic individual market). *See* Ex. O at 37; Ex. P at 25.[16]

---

[15] For purposes of the risk adjustment program, HHS further divides the individual market into two sub-markets: (1) catastrophic individual coverage, and (2) traditional or non-catastrophic individual coverage.

[16] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf; *see also*

160. HHS collected $63,419.18—the full amount BCBS-NE owed in risk adjustment payments in connection with the Nebraska catastrophic individual market—on August 20, 2016, but did not make any risk adjustment payments to BCBS-NE at that time. Thus, as of August 20, 2016, HHS owed BCBS-NE the full $13,604,468.81 in risk adjustment payments in individual market for the 2015 plan year (all of which was associated with the non-catastrophic individual market).

161. Of the $13,604,468.81 in risk adjustment payments owed to BCBS-NE in connection with the Nebraska individual market for the 2015 benefit year, HHS paid only $12,111,331.96.

162. HHS has failed to pay BCBS-NE the remaining $1,493,136.85 owed to BCBS-NE in connection with the Nebraska individual market for the 2015 benefit year.

163. Of the $3,977,257.76 in risk adjustment payments owed to BCBS-NE in connection with the small group market for the 2015 benefit year, HHS paid only $2,138,340.46.

164. HHS has failed to pay BCBS-NE the remaining $1,838,917.30 owed to BCBS-NE in connection with the Nebraska small group market for the 2015 benefit year.

165. Thus, for the individual and small group markets in Nebraska, HHS failed to pay BCBS-NE a total of $3,332,054.15 in risk adjustment amounts for the 2015 benefit year.

2. The Government Failed to Make Complete Risk Adjustment Payments to BCBS-NE (and Other Issuers in Nebraska) Because the Government Claims Not to Have Collected Complete Risk Adjustment Debts Owed to the Government by CoOportunity Health

166. CoOportunity Health ("CoOportunity") is a now-insolvent Issuer. It formerly offered insurance in Nebraska and Iowa.

---

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

167. CoOportunity was created under the ACA's Consumer Operated and Oriented Plan ("CO-OP") program. Congress established the CO-OP program to facilitate the creation of non-profit health insurance companies—"CO-OPs"—that would participate on the Exchanges. CoOportunity was one of about two dozen CO-OPs created under the program. Congress charged HHS with implementing and administering the CO-OP program.

168. CoOportunity began offering QHPs on the Exchanges for the 2014 plan year. However, CoOportunity's liabilities soon exceeded its assets, and an Iowa court declared CoOportunity insolvent and placed it into liquidation effective February 28, 2015.

169. CoOportunity is one of the Issuers in Nebraska that owed risk adjustment payments in connection with the 2015 benefit year. *See* Ex. O at 37; Ex. P at 25.[17] For that year, CoOportunity owed $10,205,123.79 for the Nebraska individual market and another $7,075,784.88 for the Nebraska small group market, for a total of $17,280,908.67. Ex. N at 37; Ex. O at 25. Of the $10,205,123.79 that CoOportunity owed for the Nebraska individual market for the 2015 benefit year, $4,144.03 was for individual catastrophic coverage, and the remaining $10,200,979.76 was for traditional individual coverage.

170. CoOportunity also owed risk adjustment payments in connection with the 2015 benefit year in Iowa. Ex. O at 37; Ex. P at 25. For that year, CoOportunity owed $1,753,954.62 for the Iowa individual market and another $3,537,357.91 for the Iowa small group market, for a total of $5,291,312.53. Ex. P at 25; Ex. O at 13.

171. Thus, including amounts in both the Nebraska and Iowa markets, CoOportunity owed a total of $22,572,221.20 in risk adjustment payments for the 2015 benefit year.

---

[17] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf; *see also* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

172. CoOportunity owed these risk adjustment payments because it attracted enrollee populations for the 2015 benefit year that had actuarial risks that were lower than the average risks in the state.

173. On information and belief, of the $10,205,123.79 in risk adjustment payments that CoOportunity owed for the Nebraska individual market for the 2015 benefit year, HHS claims to have collected only $9,412,196.77.

174. On information and belief, HHS claims that CoOportunity still owes $792,927.02 in risk adjustment payments for the Nebraska individual market for the 2015 benefit year.

175. On information and belief, HHS claims not to have collected any of the $7,075,784.88 in risk adjustment payments that CoOportunity owed for the Nebraska small group market for the 2015 benefit year.

176. On information and belief, HHS claims that CoOportunity still owes $7,075,784.88 in risk adjustment payments for the Nebraska small group market for the 2015 benefit year.

177. Aside from BCBS-NE, five other Issuers in Nebraska were entitled to receive a risk adjustment payment in connection with the individual market for the 2015 benefit year. Ex. O at 36–37; Ex. P at 24–25.

178. On information and belief, HHS has failed to pay each of these other Issuers their full risk adjustment amounts for the 2015 benefit year in the Nebraska individual market.

179. HHS's purported reason for not making full 2015 benefit year individual market risk adjustment payments to BCBS-NE (and the five other Issuers in Nebraska) is that HHS claims to have not collected all of the $10,205,123.79 that CoOportunity owes in risk adjustment charges in connection with the Nebraska individual market for that year.

180. Aside from BCBS-NE, two other Issuers in Nebraska were entitled to receive a risk adjustment payment in connection with the small group market for the 2015 benefit year. Ex. O at 36–37; Ex. P at 24–25. On information and belief, HHS has failed to pay each of these other Issuers their full risk adjustment amounts for the 2015 benefit year in the Nebraska small group market.

181. HHS's purported reason for not making full 2015 benefit year small group market risk adjustment payments to BCBS-NE (and the two other Issuers in Nebraska) is that HHS claims to have not collected all of the $7,075,784.88 that CoOportunity owes in risk adjustment charges in connection with the Nebraska small group market for that year.

182. Neither HHS nor any other government agency has suffered any negative financial consequence due to HHS's alleged failure to collect the full risk adjustment amounts from CoOportunity in the Nebraska markets for the 2015 benefit year.

3. The Government's Failure to Make Risk Adjustment Payments on Risk Adjustment Amounts It Actually or Constructively Collected from CoOportunity via Offset or Could Have Collected via Offset

183. As described above, HHS claims to have not collected risk adjustment amounts owed by CoOportunity for the 2015 benefit year in the Nebraska markets, and that is the purported reason why HHS has not made full risk adjustment payments to BCBS-NE and other Issuers in Nebraska for the 2015 benefit year.

184. However, HHS (1) failed to pay to Issuers all of the risk adjustment funds that HHS actually collected from CoOportunity via offset; (2) collected additional amounts from CoOportunity via offset but, in violation of the Netting Regulation, improperly credited those amounts against other debts instead of against CoOportunity's risk adjustment debts; and (3) paid amounts to CoOportunity under the ACA instead of offsetting those amounts against CoOportunity's risk adjustment debts. Each of these issues is discussed below.

185. As to the first issue, HHS has not paid out to BCBS-NE and other Issuers in Nebraska risk adjustment amounts that it has actually collected from CoOportunity via offset.

186. For example, the aforementioned $9,412,196.77 that HHS collected from CoOportunity in risk adjustment payments for the Nebraska individual market for the 2015 benefit year was obtained by HHS on or about August 11, 2016, when HHS offset that amount against separate amounts that HHS owed to CoOportunity. *See* Decl. of Special Deputy Liquidator Dan Watkins at Ex. A, *Gerhart v. U.S. Dep't of Health & Human Servs.*, No. 4:16-cv-00151-RGE-CFB (S.D. Iowa Oct. 28, 2016), ECF No. 71 (attached as Exhibit Q); Decl. of Jeffrey Grant in Supp. of the United States' Mot. to Dismiss ¶ 6, *Gerhart v. U.S. Dep't of Health & Human Servs.*, No. 4:16-cv-00151-RGE-CFB (S.D. Iowa Sept. 8, 2016), ECF No. 64 (attached as Exhibit R). HHS obtained that amount pursuant to the Netting Regulation.

187. After HHS collected that $9,412,196.77 from CoOportunity, CoOportunity owed only $792,927.02 in risk adjustment payments for the Nebraska individual market for the 2015 benefit year ($4,144.03 for individual catastrophic coverage and $788,782.99 for traditional individual coverage). *See* Ex. Q at Exs. G, H (Letters from Pamela Koenigh, Director of Division of Financial Transfers & Operations, to CoOportunity Health (August 12, 2016)).

188. Despite the fact that HHS had collected all but $792,927.02 in risk adjustment payments for the Nebraska individual market for the 2015 benefit year, HHS continued to withhold more than that amount from Issuers in the state that are owed those risk adjustment monies. As stated above, BCBS-NE alone is owed $1,493,136.85 in risk adjustment payments for the Nebraska individual market for the 2015 benefit year. As also stated above, five other Issuers are owed risk adjustment payments for the Nebraska individual market for the 2015 benefit year too.

189. Further, in July 2017, CoOportunity's liquidator alleged that HHS had offset a total of $22.5 million that HHS owed to CoOportunity to satisfy risk adjustment charges that CoOportunity owed to HHS. *See* Compl. ¶ 222, *Ommen v. United States*, No. 17-957C (Fed. Cl. July 17, 2017), ECF No. 1.

190. If CoOportunity's allegation in the previous paragraph is true, then HHS has collected all (or nearly all) of the amount CoOportunity owed in risk adjustment charges in both the Nebraska and Iowa markets for the 2015 benefit year (which, as stated above, totaled $22,572,221.20).

191. If HHS has in fact collected these risk adjustment charges for the 2015 benefit year from CoOportunity via offset, then HHS is improperly withholding collected risk adjustment funds owed to BCBS-NE (and other Issuers in Nebraska and Iowa).

192. As to the second issue, HHS has collected substantial additional amounts from CoOportunity but has failed to credit them towards CoOportunity's risk adjustment debts.

193. For example, in March 2016—before HHS used the Netting Regulation to collect the aforementioned $9,412,196.77 from CoOportunity—HHS collected $14,700,000 from CoOportunity by offsetting that amount against other funds HHS owed to CoOportunity in connection with the three Rs programs.

194. However, HHS failed to credit that $14,700,000 against CoOportunity's 2015 risk adjustment debts or against any other amounts due from CoOportunity "for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, payment of any fees for State-based Exchanges utilizing the Federal platform, and risk adjustment, reinsurance, and risk corridors payments and charges," as permitted by the Netting Regulation. *See* 45 C.F.R. § 156.1215(b).

195. Instead, HHS credited the $14,700,000 against a so-called "Start-up Loan" that HHS had provided to CoOportunity under the CO-OP program. *See* The United States' Br. in Supp. of Its Mot. to Dismiss at 12–13, *Gerhart v. U.S. Dep't of Health & Human Servs.*, No. 4:16-cv-00151-RGE-CFB (S.D. Iowa Sept. 8, 2016), ECF No. 64 (attached as Exhibit S).

196. Start-up Loans are not among the types of debts that HHS can collect via offset pursuant to the Netting Regulation.

197. HHS should have credited the $14,700,000 against CoOportunity's risk adjustment debts as permitted by the Netting Regulation. That amount is sufficient to cover all of CoOportunity's outstanding risk adjustment debts in both Nebraska and Iowa.

198. Accordingly, HHS should have made full risk adjustment payments to BCBS-NE and other Issues in Nebraska.

199. As to the third issue, HHS continued to make various ACA payments to CoOportunity despite the fact that CoOportunity had outstanding risk adjustment debts that should have been netted against those payments.

200. For example, on October 14, 2016, HHS paid $274,447 to CoOportunity in connection with the risk corridors program. *See* Ex. Q ¶ 6.g.

201. Similarly, on September 16, 2016, HHS made a $197.40 risk adjustment payment to CoOportunity in connection with catastrophic coverage in the Iowa individual market for the 2015 benefit year. *See id.* ¶ 6.f. & Ex. J attached thereto.

202. HHS made the payments described in the previous two paragraphs despite knowing that CoOportunity owed risk adjustment amounts for the 2015 benefit year in connection with the Nebraska individual market (both traditional and catastrophic), the Nebraska small group market, the Iowa individual market (traditional), and the Iowa small group market.

203. HHS should not have paid these amounts to CoOportunity and instead should have netted them against CoOportunity's risk adjustment debts, pursuant to the Netting Regulation.

CLASS ACTION ALLEGATIONS

204. With respect to the risk adjustment program, Plaintiffs bring this action as a class action under Rule 23 of the Rules of the Court of Federal Claims.

205. The proposed "Class" is defined as:

> All Issuers in every state except Massachusetts that were entitled to receive risk adjustment payments for the 2014 plan year and/or the 2015 plan year, but that did not receive full payment for one or both of those years.

206. There are potentially hundreds of members of the Class ("Class Members") throughout the country, making the joinder of all Class Members impractical.

207. Similar to Plaintiffs' circumstances, many Issuers across the country are entitled to risk adjustment payments for the 2014 plan year and/or the 2015 plan year, but have yet to receive full payment because of HHS's purported collection problems with other Issuers that owed risk adjustment amounts.

208. In particular, many of the Issuers entitled to risk adjustment payments operate in states where CO-OPs owe substantial risk adjustment charges. *See, e.g.*, Exs. O, P.[18]

209. As just one example, and as mentioned above, CoOportunity also owed risk adjustment payments in connection with the 2015 benefit year in Iowa.

210. For the 2015 benefit year, CO-OPs operating in the following twenty-three states owed risk adjustment charges for their individual or small group market participation, or both:

---

[18] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf; *see also* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

Arizona (Meritus Health Partners), Colorado (Colorado Health Insurance Cooperative), Connecticut (HealthyCT), Idaho (Montana Health Cooperative), Illinois (Land of Lincoln Mutual Health Insurance Company), Iowa (CoOportunity). Kentucky (Kentucky Health Cooperative), Louisiana (Louisiana Health Cooperative), Maine (Community Health Options), Maryland (Evergreen Health Cooperative), Michigan (Consumers Mutual Insurance of Michigan), Nebraska (CoOportunity), Nevada (Nevada Health Cooperative), New Hampshire (Community Health Options; Minuteman Health), New Jersey (Health Republic Insurance of New Jersey), New Mexico (New Mexico Health Connections), New York (Health Republic Insurance of New York), Ohio (Coordinated Health Mutual), Oregon (Health Republic Insurance of Oregon; Community Care of Oregon), South Carolina (Consumers' Choice Health Insurance Company), Tennessee (Community Health Alliance Mutual Insurance Company), Utah (Arches Mutual Insurance Company), and Wisconsin (Common Ground Healthcare Cooperative). Ex. O at 16–54; Ex. P at 4–42.

211. In many cases, the CO-OPs' risk adjustment charges represent a large share of risk adjustment payments owed to other Issuers operating in the same states:

a. Evergreen Health ("Evergreen")—a CO-OP established under the ACA—is one of the Issuers in Maryland that owed risk adjustment payments in connection with the 2015 benefit year. Ex. O at 31; Ex. P at 19. For that year, Evergreen owed $3,443,885.20 in risk adjustment charges in connection with the Maryland individual market and another $20,766,948.84 for the Maryland small group market, for a total of $24,210,834.04. Ex. O at 31; Ex. P at 19. Evergreen's small group charges alone represent the majority of risk adjustment payments owed to

other Issuers in connection with the Maryland small group market for that year. *See* Ex. O at 31; Ex. P at 19.

b. Land of Lincoln Mutual Health Insurance Company ("Land of Lincoln"), also a CO-OP, is one of the Issuers in Illinois that also owed risk adjustment payments in connection with the 2015 benefit year. Ex. O at 27; Ex. P at 15. For that year, Land of Lincoln owed $22,604,098.38 in risk adjustment charges in connection with the Illinois individual market and another $9,219,351.96 for the Illinois small group market, for a total of $31,823,450.34. Ex. O at 27; Ex. P at 15. Similar to Evergreen, Land of Lincoln's individual market charges alone represent the majority of risk adjustment payments owed to other Issuers in connection with the Illinois individual market for that year. *See* Ex. O at 27; Ex. P at 15.

c. Health Republic Insurance of New York ("Health Republic"), another CO-OP, is one of the Issuers in New York that owed risk adjustment payments in connection with the 2015 benefit year. Ex. O at 40; Ex. P at 28. For that year, Health Republic owed $37,496,765.22 in risk adjustment charges in connection with the New York individual market and another $153,842,015.39 for the New York small group market, for a total of $191,338,780.61. Ex. O at 40; Ex. P at 28. Health Republic's individual and small group market charges represent a substantial share of the risk adjustment payments owed to other Issuers in connection with the New York individual and small group markets for that year. *See* Ex. O at 40; Ex. P at 28.

212. Despite the large sums of risk adjustment charges owed by CO-OPs, the vast majority of CO-OPs are now insolvent and have been placed into liquidation. CoOportunity,

Evergreen, Land of Lincoln, and Health Republic, to name a few, have all been placed into liquidation or receivership.

213. On information and belief, the failed CO-OPs and other failed Issuers have not remitted full risk adjustment payments to HHS because of their financial condition. As a result, HHS has not made full risk adjustment payments to Plaintiffs or to the other Class Members.

214. There are questions of law and fact common to the Class, including but not limited to:

a. Whether ACA § 1343 (in conjunction with § 1321) is a money-mandating statute;

b. Whether Defendant's failure to collect risk adjustment amounts owed it by Issuers excuses the Defendant from making full risk adjustment payments to Issuers owed such payments;

c. Whether Defendant has failed to pay out risk adjustment amounts that it has collected from Issuers via the Netting Regulation; and

d. Whether Defendant has improperly used, or has failed to use, the Netting Regulation such that Defendant possesses or possessed risk adjustment funds that should have been but were not paid to Issuers owed such funds.

215. Plaintiffs' risk adjustment claims are typical of the Class Members' risk adjustment claims. Similarly, Defendant's defenses to Plaintiffs' risk adjustment claims are typical of Defendant's defenses to the Class Members' risk adjustment claims.

216. Plaintiffs will fairly and adequately protect the interests of the Class. Plaintiffs have retained competent counsel with experience litigating class actions, including class actions brought under the ACA.

217. Defendant has acted or refused to act on grounds generally applicable to the Class. Among other things, Defendant has failed to pay each Class Member risk adjustment amounts owed on the grounds that Defendant is excused from doing so because it failed to collect risk adjustment amounts from other Issuers.

218. Questions of law or fact common to the Class Members predominate over any questions affecting only individual members of the Class and a class action is superior to other available methods for fairly and efficiently adjudicating the controversy regarding risk adjustment payments. Reasons for this include: that whether each Class Member is entitled to unpaid risk adjustment amounts turns largely on the same underlying legal questions; that a class action is the most efficient way to resolve those legal questions for all the Class Members; that separate actions risk inconsistent results for the Class Members; that some of the amounts at issue are relatively small such that for many Class Members it is not worth pursuing risk adjustment claims on their own; that there are no pending lawsuits regarding risk adjustment claims of the sort in this action, to Plaintiffs' knowledge; the Class is readily definable and can easily be determined from Defendant's records; and that a class action will not be difficult to manage in this case.

CAUSES OF ACTION

Count One

Breach of Statutory and Regulatory Mandate to Pay Risk Corridors Amounts
(On Behalf of BCBS-NE and HMSA Individually)

219. Plaintiffs incorporate by reference the allegations contained in paragraphs 1-218, above.

220. ACA § 1342 provides that the Secretary of HHS must create a risk corridors program pursuant to which the Secretary "shall pay" participating Issuers the amount specified in

the statute if and when the costs of their QHPs exceed statutorily-defined thresholds for each benefit year from 2014 to 2016.

221. 45 C.F.R. § 153.510(b) provides that HHS "will pay" participating Issuers the specified amount if the costs of their QHPs exceed the same thresholds specified in Section 1342 for each benefit year from 2014 to 2016.

222. BCBS-NE and HMSA each complied with all statutory and regulatory requirements necessary for obtaining payment under the risk corridors program for both the 2014 and 2015 plan years.

223. For the 2014, 2015, and 2016 plan years, BCBS-NE and HMSA each created, certified, offered, and maintained QHPs, and furnished all necessary data to HHS required under the risk corridors program. *See, e.g.*, 45 C.F.R. § 153.530.

224. For the 2014, 2015, and 2016 benefit years in connection with the individual market, BCBS-NE's allowable costs exceeded the target amount, triggering HHS's statutory and regulatory mandate to make payments to BCBS-NE under the risk corridors program.

225. In addition, for the 2016 benefit year in connection with the small group market, BCBS-NE's allowable costs exceeded the target amount, triggering HHS's statutory and regulatory mandate to make payments to BCBS-NE under the risk corridors program.

226. For the 2014 benefit year in connection with the individual market, HHS has determined that BCBE-NE is entitled to a $14,143,024.12 risk corridors payment.

227. That $14,143,024.12 risk corridors payment was due and payable by HHS to BCBS-NE no later than the end of 2015, which is more than 30 days after HHS finalized its risk corridors determinations for the 2014 benefit year.

228. To date, HHS has paid only $2,349,189.84 of the aforementioned $14,143,024.12 risk corridors payment to BCBS-NE, leaving an unpaid balance of $11,793,834.28.

229. For the 2015 benefit year in connection with the individual market, HHS has determined that BCBS-NE is entitled to a $24,733,023.87 risk corridors payment.

230. That $24,733,023.87 risk corridors payment was due and payable by HHS to BCBS-NE no later than the end of 2016, which is more than 30 days after HHS finalized its risk corridors determinations for the 2015 benefit year.

231. HHS has not paid any of the aforementioned $24,733,023.87 risk corridors payment to BCBS-NE.

232. For the 2016 benefit year in connection with the individual market, HHS has determined that BCBS-NE is entitled to a $25,923,663.23 risk corridors payment.

233. For the 2016 benefit year in connection with the small group market, HHS has determined that BCBS-NE is entitled to a $520,261.48 risk corridor payment.

234. Thus, HHS has determined that BCBS-NE is entitled to a total of $26,443,924.71 in risk corridors payments for the 2016 benefit year.

235. That $26,443,924.71 risk corridors payment was due and payable by HHS to BCBS-NE no later than December 15, 2017, which is 30 days after HHS finalized its updated risk corridors determinations for the 2016 benefit year.

236. HHS has not paid any of the aforementioned $26,443,924.71 risk corridors payment to BCBS-NE.

237. HHS has failed to fulfill its statutory and regulatory obligation to make full risk corridors payments to BCBS-NE for the 2014, 2015, and 2016 benefit years.

238. HHS's failures to remit complete and timely 2014, 2015, and 2016 risk corridors payments to BCBS-NE are violations of HHS's mandate under ACA § 1342.

239. HHS's failures to remit complete and timely 2014,2015, and 2016 risk corridors payments to BCBS-NE are violations of HHS's mandate under HHS's own regulation (45 C.F.R. § 153.510(b)) to pay such funds.

240. For both the 2015 and 2016 benefit years in connection with the individual market, HMSA's allowable costs exceeded the target amount, triggering HHS's statutory and regulatory mandate to make payments to HMSA under the risk corridors program.

241. In addition, for the 2016 benefit year in connection with the small group market, HMSA's allowable costs exceeded the target amount, triggering HHS's statutory and regulatory mandate to make payments to HMSA under the risk corridors program.

242. For the 2015 benefit year in connection with the individual market, HHS has determined that HMSA is entitled to a $17,759,344.35 risk corridors payment.

243. That $17,759,344.35 risk corridors payment was due and payable by HHS to HMSA no later than the end of 2016, which is more than 30 days after HHS finalized its risk corridors determinations for the 2015 benefit year.

244. HHS has not paid any of the aforementioned $17,759,344.35 risk corridors payment to HMSA.

245. For the 2016 benefit year in connection with the individual market, HHS has determined that HMSA is entitled to a $14,609,115.03 risk corridors payment.

246. For the 2016 benefit year in connection with the small group market, HHS has determined that HMSA is entitled to a $1,514,974.14 risk corridors payment.

247. Thus, HHS has determined that HMSA is entitled to a total of $16,124,089.17 in risk corridors payments for the 2016 benefit year.

248. That $16,124,089.17 risk corridors payment was due and payable by HHS to HMSA no later than December 15, 2017, which is 30 days after HHS finalized its updated risk corridors determinations for the 2016 benefit year.

249. HHS has not paid any of the aforementioned $16,124,089.17 risk corridors payment to HMSA.

250. HHS has failed to fulfill its statutory and regulatory obligation to make full risk corridors payments to HMSA for both the 2015 and 2016 benefit years.

251. HHS's failure to remit complete and timely 2015 and 2016 risk corridors payments to HMSA is a violation of HHS's mandate under ACA § 1342.

252. HHS's failure to remit complete and timely 2015 and 2016 risk corridors payments to HMSA is a violation of HHS's mandate under HHS's own regulation (45 C.F.R. § 153.510(b)) to pay such funds.

Count Two

Breach of Implied-In-Fact Contract to Pay Risk Corridors Amounts
(On Behalf of BCBS-NE and HMSA Individually)

253. Plaintiffs incorporate by reference the allegations contained in paragraphs 1-252, above.

254. BCBS-NE and the United States entered into a valid and enforceable implied-in-fact contract related to the risk corridors program.

255. HMSA and the United States entered into a valid and enforceable implied-in-fact contract related to the risk corridors program.

256. In establishing the risk corridors program, ACA § 1342 authorized HHS, on behalf of the United States, to enter into contracts with participating Issuers.

257. ACA § 1342 and its implementing regulations represent the United States' intent to enter into separate contracts with both BCBS-NE and HMSA. The United States unambiguously offered to make payments to BCBS-NE and HMSA when their allowable costs exceeded statutorily-defined thresholds, provided that BCBS-NE and HMSA (i) offered QHPs on an Exchange, (ii) complied with statutory and regulatory requirements under the risk corridors program, and (iii) agreed to make timely and complete risk corridors payments to the United States in the event that BCBS-NE's and HMSA's allowable costs fell below statutorily-defined thresholds so as to trigger liability for such payments.

258. BCBS-NE and HMSA each unambiguously accepted the United States' offer and rendered performance as prescribed by the ACA's statutory and regulatory requirements.

259. Specifically, BCBS-NE and HMSA each (i) designed, certified, offered, and maintained QHPs on an Exchange, (ii) complied with all statutory and regulatory requirements under the risk corridors program, including furnishing necessary data to HHS, and (iii) were prepared to remit risk corridors payments to the United States in the event its allowable costs fell below statutorily-defined thresholds so as to trigger liability for such payments.

260. The United States agreed to enter into the implied-in-fact contract by and through the words and actions of HHS, which has the authority to bind the United States.

261. Since BCBS-NE and HMSA each rendered full performance under its respective contract, the United States is required to make good on its promise by remitting a complete risk corridors payment to BCBS-NE and HMSA for 2014 and 2015.

262. Pursuant to the contract between the United States and BCBS-NE, the United States currently owes $11,793,834.28 to BCBS-NE in risk corridors payments for the 2014 benefit year.

263. Pursuant to the contract between the United States and BCBS-NE, the United States currently owes $24,733,023.87 to BCBS-NE in risk corridors payments for the 2015 benefit year.

264. Pursuant to the contract between the United States and BCBS-NE, the United States currently owes $26,443,924.71 to BCBS-NE in risk corridors payments for the 2016 benefit year.

265. Pursuant to the contract between the United States and HMSA, the United States currently owes $17,759,344.35 to HMSA in risk corridors payments for the 2015 benefit year.

266. Pursuant to the contract between the United States and HMSA, the United States currently owes $16,124,089.17 to HMSA in risk corridors payments for the 2016 benefit year.

267. As described above, HHS, on behalf of the United States, has recognized its obligation to make complete risk corridors payments to participating Issuers such as BCBS-NE and HMSA.

268. Because the United States has not made complete, timely risk corridors payments to BCBS-NE for the 2014, 2015, or 2016 benefit years, the United States has breached its contract with BCBS-NE.

269. In light of the United States' breach, BCBS-NE is entitled to damages equal to the amounts it is owed under the risk corridors program for the 2014, 2015, and 2016 benefit years.

270. Because the United States has not made complete, timely risk corridors payments to HMSA for the 2015 or 2016 benefit years, the United States has breached its contract with HMSA.

271. In light of the United States' breach, HMSA is entitled to damages equal to the amounts it is owed under the risk corridors program for the 2015 and 2016 benefit years.

Count Three

Breach of Statutory and Regulatory Mandate to Pay Risk Adjustment Amounts (On Behalf of the Class and BCBS-NE and HMSA Individually)

272. Plaintiffs incorporate by reference the allegations contained in paragraphs 1-271, above.

273. Section 1343 of the ACA provides that "each State shall provide a payment to health plans and health insurance issuers" whenever the Issuers' actuarial risk is higher than the average in the state.

274. Because neither Nebraska nor Hawai'i nor any other state except Massachusetts elected to create and operate a risk adjustment program, § 1321 of the ACA (42 U.S.C. § 18041) obligates HHS to "take such actions as are necessary to implement" the risk adjustment program in those states, including but not limited to assuming the State's obligation to provide risk adjustment payments as set forth in § 1343 of the ACA and the regulations thereunder.

275. For benefit year 2014 in connection with the small group market, HMSA was owed $5,740,424.58 in risk adjustment payments but HHS paid only $5,198,935.15 of that amount.

276. The remaining $541,489.43 is currently due and payable by HHS to HMSA.

277. For benefit year 2015 in connection with the small group market, HMSA was owed $7,322,488.29 in risk adjustment payments but HHS paid only $6,898,728.29 of that amount.

278. The remaining $423,760.00 is currently due and payable by HHS to HMSA.

279. In total for the 2014 and 2015 benefit years, HHS currently owes HMSA $965,249.43 in risk adjustment payments in connection with the small group market.

280. For benefit year 2015 in connection with the non-catastrophic individual market, BCBS-NE was owed $13,604,468.81 in risk adjustment payments but HHS paid only $12,111,331.96 of that amount.

281. The remaining $1,493,136.85 is currently due and payable by HHS to BCBS-NE.

282. For benefit year 2015 in connection with the small group market, BCBS-NE was owed $3,977,257.76 in risk adjustment payments but HHS paid only $2,138,340.46 of that amount.

283. The remaining $1,838,917.30 is currently due and payable by HHS to BCBS-NE.

284. In total for the individual and small group markets for the 2015 benefit year, HHS currently owes BCBS-NE $3,332,054.15 in risk adjustment payments.

285. Similarly, HHS has failed to make full risk adjustment payments to the other Class Members for the 2014 and/or 2015 benefit years.

286. HMSA, BCBS-NE, and the other Class Members have complied with all statutory and regulatory requirements necessary for obtaining payment under the risk adjustment program for the 2014 and 2015 benefit years.

287. HHS has failed to fulfill its statutory and regulatory obligation to make full risk adjustment payments to BCBS-NE, HMSA, and the other Class Members for 2014 and 2015.

288. HHS's failures to remit complete and timely risk adjustment payments to BCBS-NE, HMSA, and the other Class Members are violations of HHS's mandate under ACA §§ 1321 and 1343 to pay such funds.

PRAYER FOR RELIEF

WHEREFORE, BCBS-NE, HMSA, and the Class respectfully ask that the Court:

A. Enter judgment in BCBS-NE's favor and against the United States in the principle amount of $62,970,782.86, representing unpaid risk corridors payments for 2014, 2015, and 2016 to which BCBS-NE is entitled;

B. Enter judgment in HMSA's favor and against the United States in the principle amount of $33,883,433.52, representing unpaid risk corridors payments for 2015 and 2016 to which HMSA is entitled;

C. Enter judgment in BCBS-NE's favor and against the United States in the principle amount of $3,332,054.15, representing unpaid risk adjustment payments for 2015 to which BCBS-NE is entitled;

D. Enter judgment in HMSA's favor and against the United States in the principle amount of $965,249.43, representing unpaid risk adjustment payments for 2014 and 2015 to which HMSA is entitled;

E. Enter judgment in BCBS-NE's favor and against the United States for interest on the amounts in Paragraphs A and C above;

F. Enter judgment in HMSA's favor and against the United States for interest on the amounts in Paragraphs B and D above;

G. Certify this lawsuit as a class action with respect to Count Three, designate Plaintiffs as class representatives, and appoint Plaintiffs' counsel as counsel for the Class;

H. Enter judgment in favor of the Class and against the United States for unpaid risk adjustment payments for the 2014 and 2015 plan years;

I. Enter judgment in favor of the Class and against the United States for interest on the amounts in Paragraph H above;

J. Enter judgment in BCBS-NE's favor and against the United States for BCSB-NE's costs and attorneys' fees and expenses;

K. Enter judgment in HMSA's favor and against the United States for HMSA's costs and attorneys' fees and expenses; and

L. Award such other relief to BCBS-NE, HMSA, and the Class as justice requires.

April 3, 2018
Date

/s/ Adam P. Feinberg

ADAM P. FEINBERG
MILLER & CHEVALIER CHARTERED
900 Sixteenth Street, N.W.
Washington, D.C. 20006-2901
Telephone: (202) 626-5800
Fax: (202) 626-5801
Email: afeinberg@milchev.com
Counsel of Record

Of Counsel:
ANTHONY F. SHELLEY
DWIGHT B. N. POPE
MILLER & CHEVALIER CHARTERED
900 Sixteenth Street, N.W.
Washington, D.C. 20006-2901
Telephone: (202) 626-5800
Fax: (202) 626-5801
Email: ashelley@milchev.com
dpope@milchev.com