IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MAINE COMMUNITY HEALTH OPTIONS, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 17-1387 C Related Case: No. 17-2395 **COMPLAINT**

Plaintiff Maine Community Health Options ("Plaintiff" or "Health Options") brings this action seeking damages and other relief for the Defendant's (1) violation of the Risk Corridors Program ("RCP"), as codified in Section 1342 of the Patient Protection and Affordable Care Act ("Section 1342") and 45 C.F.R. § 153.510(b) ("Section 153.510"); and (2) breach of its risk corridors payment obligations under an implied-in-fact contract. This is the second action of this type brought by Health Options against the Government. In its first action, *Maine Cmty. Health Options v. United States*, 133 Fed. Cl. 1 (2017), *appeal docketed*, No. 17-2395 (Fed. Cir. Aug. 7, 2017), Health Options is seeking the RCP payments the Government owes it for benefit years 2014 and 2015. This action seeks the RCP payment the Government owes Plaintiff for 2016.

In support of this action, Plaintiff states and alleges as follows:

NATURE OF ACTION

1. In March 2010, the United States Government ("Defendant" or "Government") enacted the Patient Protection and Affordable Care Act[1] and the Health Care and Education Reconciliation Act[2] (collectively, the "Affordable Care Act," "Act," or "ACA").

2. The Act represented a major shift in healthcare regulation and coverage in the country. The ACA ushered in a host of market-wide reforms and requirements affecting the private health insurance industry. Among other things, the Act addressed the scope of covered services, availability of coverage, renewability of coverage, out-of-pocket costs for consumers, pricing, and other coverage determinants. The Act limits health insurance product variation and restricts pricing and underwriting practices. For example, by placing restrictions on the premium spread based on the age of the policy holder, the Act ensures that premiums are based on community rating (*i.e.*, the risk pool posed by the entire community) instead of an assessment of an individual's health status. The Act also provides for guaranteed issuance of coverage and renewability of coverage.

3. The ACA requires individuals to purchase coverage if they are not otherwise insured, and also created an elaborate scheme of federal subsidies to offset the cost of coverage. Another hallmark of the ACA was its establishment of health insurance exchanges, which are online marketplaces where individuals and small groups may purchase health insurance. The ACA's individual mandate coupled with the availability of federal subsidies dramatically increased the number of individuals—many previously uninsured—purchasing health insurance. Created by Title I, Subtitle D of the ACA, the health insurance exchanges "are designed to bring

[1] Pub. L. No. 111-148 (March 23, 2010), 124 Stat. 119.
[2] Pub. L. No. 111-152, (March 30, 2010), 124 Stat. 1029.

together buyers and sellers of insurance, with the goal of increasing access to coverage" offered in a competitive marketplace.

4. To further facilitate affordability and access to competitive health insurance through the exchanges (also referred to as "marketplaces"), Congress created the Consumer Operated and Oriented Plan ("CO-OP") program in ACA Section 1322. ACA Section 1322(a)(2) explicitly states that, "the purpose of the CO-OP program [is] to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets." A qualified health plan ("QHP") is a health plan that meets certain standards established by the Centers for Medicare & Medicaid Services ("CMS") in order to be sold to consumers through the exchanges. Congress intended for CO-OP insurers to increase competition among health insurers and to provide consumers with a nonprofit option for high-quality care with integrated service delivery. The ACA requires CO-OP insurers to derive substantially all of their business from the individual and small group markets—the markets served by the exchanges.

5. Additionally, the ACA requires health plans in the individual and small group markets to cover essential health benefits ("EHBs").[3] The EHBs are largely an expansion of what was covered pre-ACA. Benefits previously subject to copays or other cost-sharing mechanisms are now mandated to be provided at no cost to the insured, which has made it difficult to predict utilization of these services.

[3] EHBs include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

6. The health insurance exchanges presented a new and uncertain risk pool for health insurers. Health insurers considering whether to participate in the exchanges had to confront the uncertainties of pricing health plans for new populations. Insurers had neither sufficient data to accurately predict the needs of the newly insured individuals signing up for plans starting in 2014, nor a model to price with confidence these ACA plans to reflect the medical costs associated with this new and untested marketplace.

7. To minimize the risks these uncertainties pose, the ACA features three marketplace premium stabilization programs: a permanent risk adjustment program, a temporary reinsurance program (for each of 2014, 2015, and 2016), and a temporary "risk corridors" program (again, for each of the 2014, 2015, and 2016 benefit years, *i.e.*, the calendar year for which a health plan provides coverage for health benefits). The RCP, like the other two premium stabilization programs, was designed to limit the effects of adverse selection and to mitigate the uncertainty inherent in establishing rates for new, unquantifiable health insurance risks in the context of an untested regulatory framework.

8. The RCP is required by statute to be modeled after a similar program enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act signed into law in 2003.

9. Specifically, Section 1342 of the ACA contains two related mandatory terms for all issuers of QHPs on an exchange: (1) any health insurer selling a QHP on the exchange (a "QHP issuer") would receive compensation from the Government if its losses exceeded a certain defined amount due to high utilization and high medical costs; and (2) the QHP issuers would pay the Government a percentage of any gains they made in excess of similarly defined amounts. The Act's framework thus compares "allowable costs" (essentially claims costs and adjustments

for quality improvement activities, reinsurance, and risk adjustment charges or payments) with a "target amount" (the QHP's premium less its allocable administrative costs). If the ratio of a QHP issuer's allowable costs to the target amount is greater than 1, then it experiences losses; but if the ratio is less than 1, then it experiences gains.

10. The RCP specifically guarantees that if an insurer's allowable costs "for any plan year" exceeded the target amount, the U.S. Department of Health & Human Services ("HHS"), CMS's parent agency, "shall pay to the plan" a portion of such excess allowable costs pursuant to the payment-calculation formula set forth in the ACA. And, conversely, plans that incurred allowable costs below the target amount in the benefit year shall pay a portion of the differential to the Government.

11. Under the text of Section 1342, the Government established an obligation to "pay" certain participating QHP issuers in accordance with the statutory payment formula at a later date. This obligation was undefinitized (an unmatured commitment), in that payment was not due until QHP issuers submitted their calculation of revenue and cost data to CMS so that the obligation could be definitized to a precise amount. Section 1342 contained no other material steps or preconditions encumbering or permitting avoidance of CMS's statutory obligation to "pay" in accordance with the formula.

12. Despite these express and binding obligations, the RCP—like the ACA as a whole—was targeted by congressional opponents who, lacking the votes to amend the law itself, sought to impede, through appropriations, CMS's ability to administer the program as mandated by the ACA. In particular, in the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. No. 113-235) ("2015 Spending Rider"), the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Rider"), and the Consolidated Appropriations Act, 2017

(Pub. L. No. 115-31) ("2017 Spending Rider," collectively, the "Spending Riders"), Congress prohibited CMS and HHS from using certain accounts to fund the Government's risk corridors payment obligations. Specifically, Congress prohibited CMS from using the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, as well as funds transferred from other accounts funded by the Spending Riders to the CMS Program Management account, for the applicable fiscal years.

13. The practical effect of the Spending Riders was that CMS chose not to pay QHP issuers their full risk corridor receivable amounts due for 2014, 2015, and 2016. During 2014, QHP issuers incurred almost $2.9 billion in losses that were compensable under the risk corridor provisions of the ACA. The QHP issuers on the whole incurred even greater compensable losses in 2015 and 2016 which CMS has not paid because of the Spending Riders.

14. Nevertheless, Congress did not otherwise restrict availability of federal funds, and did not amend Section 1342 to limit, much less eliminate, the Government's risk corridors payment obligations to insurers under the ACA.

15. Plaintiff in this action is a non-profit corporation organized under the laws of Maine, with its principal place of business in Lewiston, Maine. Plaintiff is a QHP issuer under the ACA.

16. In 2016, Plaintiff provided health insurance to its members on the federally facilitated marketplace in Maine and the state-partnership marketplace in New Hampshire.

17. Plaintiff is owed $35,998,655 for its participation in the Maine and New Hampshire marketplaces for benefit year 2016.

18. CMS has indicated in sub-regulatory guidance that it will not make full payment under the RCP until a later—but as-of-yet undetermined—date, if at all.

19. By this lawsuit, Plaintiff seeks full payment of the risk corridors payments to which it is entitled from the Government under the ACA for benefit year 2016. The law is clear, and the Government must abide by its statutory obligations. Plaintiff respectfully asks the Court to compel the Government to do so.

JURISDICTION

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

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

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

PARTIES

23. Plaintiff, Health Options, is a non-profit corporation organized under the laws of Maine, with its principal place of business in Lewiston, Maine.

24. Health Options is a member-led QHP issuer on the exchanges in the states of Maine and New Hampshire. It is organized as a non-profit under the CO-OP model and offers comprehensive health insurance benefits to individuals, families, and businesses in both Maine

and New Hampshire. Its stated mission is to partner with members, employers, and providers to create affordable, high-quality benefits that promote health and wellbeing. It is the state of Maine's only non-profit CO-OP insurer and the only non-profit issuer on the marketplace that is domiciled in Maine.

25. Health Options began providing affordable, high-quality health plans in Maine in 2014 and in New Hampshire in 2015. Since commencing business, Health Options' enrollment grew to over 80,000 members at the beginning of 2016, and has been the largest writer of individual health insurance in the state of Maine since the inception of Marketplace operations. In its first year of operations, Health Options attracted over 80 percent of the exchange enrollment in Maine. But for Health Options existence, there would have been only one carrier on Maine's individual marketplace in 2014. In 2016, Health Options insured two-thirds of the state's individual marketplace. As a result of rate adjustments for 2017, Health Options has a market share of 44% of the individual market, which continues to be the largest single portion of the individual market.

26. Health Options has conducted and participated in 1,508 outreach and educational sessions throughout Maine and New Hampshire on the availability of coverage through the ACA, the mechanics of the marketplaces, and the benefit plans offered by Health Options. Health Options has focused its outreach broadly across its entire service area, first in Maine and then in New Hampshire.

27. Consistent with the ACA's intended mission for CO-OPs, Health Options has targeted particular groups and industries that have typically lacked insurance coverage or have been underinsured: farmers, fishermen, artists, sole proprietors and small businesses, refugees, immigrants and asylum seekers, and migrant workers. To this end, Health Options has teamed

with the Lobstermen's Association and run articles in its trade newsletter; participated in farming conventions and related trade shows; participated within the Greater Portland Refugee and Immigrant Health Collaborative; worked with the Maine Migrant Health Program to improve accessibility of information; and created instructional brochures in multiple languages (French, Spanish, Portuguese, Haitian Creole, Somali, Arabic, and Nepali). In short, Health Options has aggressively pursued the ACA's goal of connecting the people in its service area to insurance coverage opportunities with the understanding that a broader base of insured is better for the individuals within the pool and the overall functioning of the marketplace.

28. Through its extensive outreach and enrollment efforts, Health Options enrolled 89 percent of the New Hampshire Ryan White (HIV/AIDS program) patient population with marketplace coverage into its plans. Similarly, in Maine, Health Options covers 80 percent of the Ryan White participants with marketplace coverage.

29. Health Options entered the marketplace with a benefits design that greatly reduces member cost-sharing for the "active management" of particularly prevalent chronic conditions: asthma, chronic obstructive pulmonary disease and emphysema, coronary artery disease, diabetes, and hypertension. The purpose of Health Options' approach is to encourage more active patient engagement in treatment plans, which thereby results in better health outcomes at lower total costs of care.

30. In its bid to increase accessibility of coverage and open doors to treatment and care to people formerly without access to coverage or sufficient coverage, Health Options initiated operations in both Maine and New Hampshire without the use of a tobacco rating band that differentiates premiums based on tobacco use. Instead, Health Options provided incentives to tobacco cessation, recognizing that tobacco cessation often requires a multi-year commitment

and multiple attempts before achieving lasting results that can finally drive down the cost of care.

31. Similarly, Health Options placed an emphasis on behavioral health integration through both its benefit design and the focus of its care management work. Health Options provides plan designs wherein the first three outpatient behavioral health visits are provided at no cost to the Member so as to reduce the threshold barrier to obtaining timely access to cost-effective therapy. Health Options also provides enhanced care coordination for members discharged from an inpatient behavioral health setting (*i.e.*, mental health/substance use disorder) to facilitate 7-day follow-up with a behavioral health provider. Health Options incorporated registered nurses and licensed social workers with behavioral health backgrounds onto care management teams, and partnered with Amistad, a local behavior health peer support program. Health Options' care managers consistently initiate outreach calls to members within 72 hours of discharge, and mobilize community care teams and/or peer support for some of its most vulnerable members. Peers meet members at locations such as shelters and soup kitchens to encourage treatment adherence and provider follow-up, and to offer transportation to local appointments. As a result of these efforts, Health Options has seen a demonstrable increase in post-discharge visits, thereby facilitating continuity of care, improving self-care skills, and reducing the risk of relapse and readmission.

32. Health Options also piloted an extensive care coordination model within Maine's two largest tertiary hospitals to reduce duplication, maximize the positive impact of available resources, and ensure consistency of communication with the insured. The early results indicate lowered total costs of care and improved health outcomes, and Health Options is working to identify ways to apply this approach to smaller community hospitals as well.

33. The Defendant is the Government, acting through CMS (or CMS's parent agency HHS). Unless otherwise noted, references in this Complaint to CMS include HHS where applicable.

FACTUAL ALLEGATIONS

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

34. The Affordable Care Act established three insurance premium stabilization programs to address uncertainties in the marketplace, commonly referred to as the "Three Rs": (1) a three-year risk corridors program; (2) a three-year reinsurance program; and (3) a permanent risk adjustment program. Both the reinsurance and risk corridors programs were in effect in 2014, 2015, and 2016.

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

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

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

Pub. L. No. 111-148, § 1342 (emphases added). Section 1342 also includes a provision dealing with "payments in," requiring QHP issuers to pay amounts to HHS if the plans' actual costs are less than its targeted costs. *Id.* § 1342(b)(2). For both the "payments out" and "payments in" provisions, the terms "allowable costs" and "target amount" are defined by the statute. *Id.* § 1342(c).

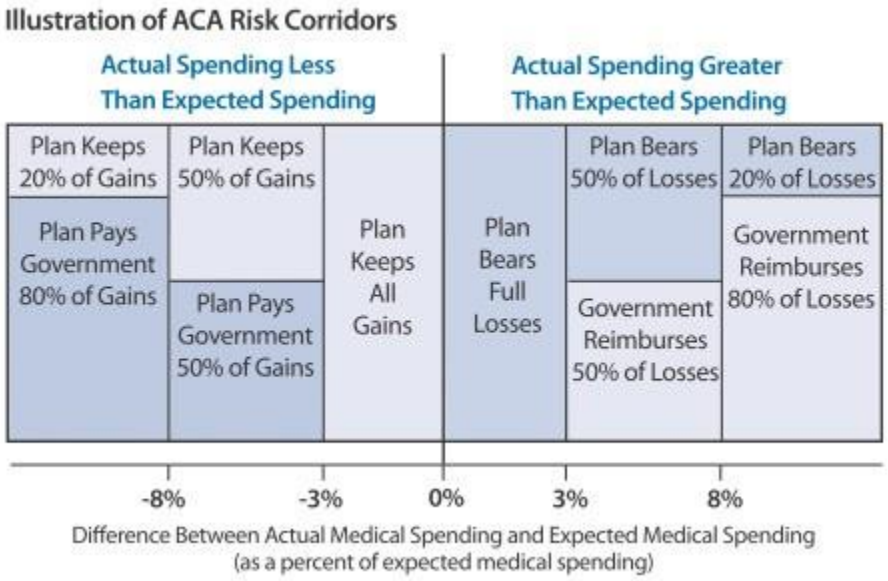
36. HHS implemented the RCP in the Code of Federal Regulations at 45 C.F.R. § 153.510. In relevant part, Section 153.510 states:

> (b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
>
> > (1) When a QHP's allowable costs ***for any benefit year*** are more than 103 percent but not more than 108 percent of the target amount, ***HHS will pay the QHP issuer*** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
> >
> > (2) When a QHP's allowable costs ***for any benefit year*** are more than 108 percent of the target amount, ***HHS will pay to the QHP issuer*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(Emphases added.)

37. This regulation and other regulations adopted by HHS further mandate certain data reporting requirements and deadlines applicable to the QHP issuers. 45 C.F.R. §§ 153.510, 153.530. Following verification by HHS of the QHP issuers' data submissions, HHS is required to pay the insurers based on the plan's excess expenses (one amount for expenses greater than 103 percent and another amount for expenses greater than 108 percent of each QHP issuer's target amount).

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



39. The purpose of the RCP—in conjunction with the other of the Three Rs—was to induce health insurer participation in the health insurance exchanges by mitigating their risk of loss. Congress recognized that this could only work effectively if the payment obligations were honored on an annual benefit or plan year basis. The program would hardly be able to serve its purpose of mitigation if, after incurring potentially millions of dollars in unbudgeted expenditures over a plan year, QHP issuers could not timely collect the reimbursements owed to them by the Government pursuant to the statutory formula as soon as the plan's accounting for the preceding year (which established the amounts owed) was finalized.

40. Section 1342 does not establish a fund into which QHP issuers must make payments due or from which payments must be made under the RCP, *i.e.*, the statute does not create a single account to service both payments in and payments out. Nor does the statute provide that the RCP must be budget neutral. In other words, payments out are ***not*** subject to

payments in, and vice versa. The statute is clear that the Government will share in the losses for plans with higher-than-anticipated costs so that if, hypothetically, all plans have higher-than-anticipated costs, the Government would need to make payments even though there would be no insurer payments coming in. The program could not have been subject to budget neutrality for the reason stated in the preceding paragraph. Had the program been cabined by budget neutrality concerns, the ACA would have failed to attract sufficient insurers into the marketplace because the venture would have been too risky. HHS's timely payment to plans under the RCP is essential to realizing Congress's intent to stabilize premiums.

41. Section 1342 is expressly modeled for just that reason on the Medicare Part D program, which is also not required to be budget neutral. *See* 42 C.F.R. § 423.336.

B. QHP Issuers Participated in Exchanges and Set Prices in Reliance on the Risk Corridors Program.

42. As noted above, the ACA's health insurance exchanges became operational for the 2014 benefit year. For QHP issuers to participate on the marketplaces for the 2014 benefit year, they had to submit their premiums to the appropriate state or federal regulatory authority during calendar year 2013 and their commitments to such participation was fixed and irrevocable in or around October 1, 2013. QHP issuers entered onto the exchanges with the express understanding—based on the plain text of Section 1342—that if their allowable costs "for any ***plan year***" exceeded the target amount, the Secretary "***shall pay to the plan***" the amounts set forth in the ACA. The implementing regulations at 45 C.F.R. § 153.510 expressly reiterated this ACA requirement, stating that when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the amounts set forth in the ACA. The Government gave no indication at that time that it would subsequently refuse to pay its risk corridors obligations, or hold payments due for a particular plan year until a later and indefinite

date.

43. Health insurers had relied on the statutorily mandated RCP and the other premium stabilization programs in setting their premiums for each year of the RCP. It was not until October 2015 that the Government first indicated that it would pay only 12.6 percent of its obligations under the RCP for the 2014 benefit year.[4] Similarly, in the fall of 2016, CMS stated it would not make payments for the 2015 benefit year.[5]

44. The premium stabilization programs of the ACA enticed insurers and would-be insurers like Plaintiff to enter the marketplaces. The existence of the RCP's safeguards also helped to prevent unnecessarily high premium rates to offset the many uncertainties of the newly developing individual and small group markets that made it difficult to create budgets and forecasts.

45. From 2014 through 2016, Health Options' rates for individual coverage in Maine were relatively flat, 0.1 percent and 0.5 percent, respectively, demonstrating Health Options' commitment to affordable premiums based on available data and the anticipated risk pool. At the time Health Options set its rates, QHP issuers had incomplete data to predict what their actual experience in the exchanges would be. Instead of raising premiums higher to give Health Options some additional "cushion" in the face of this uncertainty, Health Options established its 2014 rates based on a best estimate of the cost of care. Plaintiff relied on published experience

[4] CMS, "Risk Corridors Payment Proration Rate for 2014" (Oct. 1, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf; CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[5] CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016), *available at* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/2015-rc-issuer-level-report-11-18-16-final-v2.pdf.

from other issuers in Maine, the Maine All Payer Claims Database, and consultant actuarial databases. Actual experience in 2014 emerged very close to what was anticipated in the pricing. However, assumptions for the 2015 and 2016 benefit year did not fully reflect the continued increase in utilization of services by the newly insured in 2014 and 2015 whose healthcare needs were higher than expected in both 2015 and 2016. Such fluctuations reflect precisely the type of uncertainty inherent in building rates for new, unquantified health insurance risks in the context of a reformed regulatory framework, which the RCP was created to *mitigate* by guaranteeing that the Government would make payment to plans in the event of higher-than-expected allowable costs.

C. <u>The Risk Corridors Program Was Contravened After Enactment.</u>

46. Since its enactment, Congress has not altered the Government's obligations under the ACA's RCP. Despite this, the Government has taken several steps to frustrate the purpose it was intended to serve: timely and complete payment to QHP issuers in order to retain them in the marketplaces and allow them to learn from and adapt to this uncharted new market.

47. The first such step was in March 2014, when HHS unexpectedly took the position in sub-regulatory guidance that the RCP would be self-funding or "budget-neutral." Each spring, HHS publishes an annual rulemaking in which it articulates the payment policies and requirements for participation in the ACA marketplaces, the so-called annual Payment Rule. Specifically, in the preamble to the 2015 Payment Rule, issued in March 2014, and related guidance issued in April 2014, HHS indicated that it would attempt to administer the RCP in a budget-neutral manner and would offset liabilities with future collections.

48. The preamble to the 2015 Payment Rule stated:

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

the extent necessary to achieve this goal.

HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014).

49. Then, in April 2014, CMS issued a statement entitled "Risk Corridors and Budget Neutrality," asserting:

> if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments.

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

50. That 2014 guidance radically departed from what the ACA intended and requires and what the implementing regulation reflected: the RCP is supposed to operate without regard to budget neutrality. Indeed, in its 2014 Payment Rule, issued March 11, 2013, HHS conceded as much, stating that "[t]he risk corridors program is not statutorily required to be budget neutral." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013). Further, Congress stated expressly in Section 1342 that the RCP was to be modeled after the Medicare Part D risk mitigation program, which is not budget neutral. *See* U.S. Gov't Accountability Office, GAO Report GAO-15-447 (April 2015) at 14 (available at http://www.gao.gov/assets/680/670161.pdf) ("For the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions.").

51. In short, the Government announced by agency fiat in the spring of 2014 that it

would aspire to administer the RCP in a budget neutral manner notwithstanding the lack of any statutory basis for doing so. It reiterated that position for years 2015 and 2016, pointing to the April 11, 2014 "FAQ" on Risk Corridors and Budget Neutrality and leaving a decision on how the Government would make QHP issuers whole under the RCP to some indeterminate later day.

52. The Government's budget neutrality approach is not supported by law. Neither Section 1342 nor Section 153.510 provides that the risk corridors payments will come from the pot of payments made to the Government by other insurers (*i.e.*, payments in). Nor does either provision contemplate permitting the Government to postpone payments that are owed until the following year's collections are accounted for (or, as it seems might be the case should HHS have its way, some indeterminate date in the future, if at all).

53. On November 19, 2015, Defendant stated that "HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter ***as a fiscal year 2015 obligation of the United States Government for which full payment is required***." CMS, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015). The statement is extraordinary in that the agency *concedes* that it owes QHP issuers payment under the RCP, yet *refuses* to pay the amounts due, and offers instead to pay "12.6 percent" of what is owed with a vague promise to pay more at some indeterminate point in the future.

D. Congress Curtailed the Availability of Certain Funds for the Risk Corridors Program But Did Not Amend Section 1342.

54. In December 2014, Congress passed the first of three appropriation riders prohibiting HHS's use of Medicare and certain other trust funds to make risk corridors payments. This "2015 Spending Rider" did not, however, eliminate the use of all funds in the CMS Program Management account, such as fees received by HHS for the federally-facilitated exchanges. And, more importantly, Congress *did not amend Section 1342 to require budget*

neutrality or to alter the underlying risk corridors obligations of the Government. Given that the 2015 Spending Rider was enacted on December 16, 2014, nearly a year after QHP issuers began offering insurance on the newly formed exchanges, and approximately 18 months after they had submitted rates for regulatory approval, QHP issuers, including Plaintiff, continued to abide by their obligations to the Government and their insured, even while receiving little immediate guidance as to what would happen with the risk corridors payments.

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

56. On September 9, 2016, CMS issued a memorandum reiterating the agency's understanding that the Government owed "full" payment to insurers. CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF ("Sept. 2016 Memo"). That memorandum was followed by testimony of CMS Acting Administrator Andy Slavitt before the House Energy and Commerce Committee on September 14, 2016. Among other things, Mr. Slavitt stated without equivocation in response to a question posed by a committee member that, notwithstanding the lack of an appropriation to fund the payments due insurers under Section 1342, it was "an obligation of the federal government" to

remit full payment to insurers.[6]

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

E. Plaintiff Has Suffered Substantial Harm as a Result of the Government's Refusal to Pay Amounts Owed.

58. Health Options was one of twenty-four CO-OPs created across the country, pursuant to the ACA, to inject competition into the insurance market through non-profit, consumer-focused health plans. The ACA requires CO-OPs to derive substantially all of their business from the individual and small group markets and to offer QHPs. The ACA authorized HHS to award $6 billion in loans and grants to CO-OPs to help establish them. When it enacted the American Taxpayer Relief Act of 2012 (Pub. L. No. 112-240, H.R. 8, 126 Stat. 2313) (Jan. 2, 2013), Congress slashed about two-thirds of this funding and prevented CMS from making new loan awards or entering into new loan agreements with CO-OPs. This action left many CO-OPs in challenging financial conditions.

59. An issuer of QHPs is required by federal regulations to set its ACA-related health insurance rates well before the year they become effective. This creates a challenge for a nonprofit CO-OP, like Health Options, which seeks to insure individuals who were previously uninsured and whose use of medical services once covered is difficult to predict.

60. In 2014, Health Options exceeded its membership expectations by 250 percent,

[6] CMS, Statement of Andy Slavitt Acting Administrator CMS on The ACA before the United States House Committee on Energy, *available at* http://docs.house.gov/meetings/IF/IF02/20160914/l05306/HHRG-1 l 4-IF02-Wstate-SlavittA-20160914.pdf.

while attaining 83 percent of the total individual marketplace by the end of the first Open Enrollment period. In 2015, Health Options doubled its membership. And in 2016, Health Options experienced a further 12 percent increase in its membership. Its policyholders, many of whom had been uninsured before, accessed health care at a higher-than-anticipated rate, causing an unanticipated spike in costs.

61. Health Options imposed a small (0.1 percent) rate increase on premiums between 2014 and 2015 and an average rate increase of 0.5% between 2015 and 2016, based on the best information available to it at the time, and gained so many new enrollees that the total value of premiums collected increased nearly 90 percent in 2015 compared to 2014 and increased by 14 percent in 2016 as compared to 2015. However, its benefits payments in 2015 for health care services to its members grew by 131 percent. Health Options realized a $74 million shortfall, including a $43 million premium deficiency reserve for plan year 2016. In 2016, benefits payments in 2016 grew by an additional 13 percent, causing an additional $14 million shortfall.

62. In response, Health Options initiated $11 million in administrative cuts, which included voluntary pay cuts by company officers and suspended 401K contributions for all employees. Health Options switched pharmacy benefits managers, changed reinsurers, brokered provider rate concessions, and eliminated 90% of the marketing budget, among the variety of immediate actions taken to preserve capital.

63. Notwithstanding these cuts, Health Options' financial shortfall in 2016 is entirely attributable to higher-than-expected allowable costs specifically addressed by the risk corridors program, *i.e.*, losses incurred as a result of Health Options' participation in the Maine and New Hampshire marketplaces.

64. In September 2016, Health Options announced that it would withdraw from the

New Hampshire market in 2017. Individual New Hampshire customers had to find a new insurer when open enrollment began in November 2016. This extraordinarily difficult decision was forced principally by financial difficulties resulting from the Government's decision to withhold RCP payments owed to Health Options for benefit year 2015.

65. Section 1342 of the ACA requires the Government to reimburse Plaintiff a percentage of its higher-than-expected allowable costs incurred as a result of its participation on the marketplaces, just as it requires Plaintiff or any other QHP issuer to pay CMS a percentage of lower-than-expected allowable costs. In either case, the amount owed—either in or out—is calculated using the statutory formula.

66. The RCP is one of the principal marketplace premium stabilization programs created by the ACA. It was designed to *limit* the effects of adverse selection and to *mitigate* the uncertainty inherent in building rates for new, unquantified health insurance risks in the context of a reformed regulatory framework. Under Section 1342, payments out are not contingent on payments in.

67. On November 19, 2015, CMS released a document titled "Risk Corridors Payment and Charge Amounts for Benefit Year 2014," setting forth the amount of money CMS concedes that it owes to insurers (and is owed by insurers) for benefit year 2014 as a result of the risk corridors program. The calculations are separated into individual market and small group market. For benefit year 2014, Health Options was *owed* $241,717.00 under the RCP as a result of higher-than-expected allowable costs in the individual and small group markets. In total, including initial and subsequent payments, Health Options has received $38,363.44 of the amount CMS concedes that it owes to Health Options for benefit year 2014.

68. On September 9, 2016, HHS published guidance stating that all benefit year 2015

collections would be used to pay outstanding liabilities for the 2014 benefit year. Sept. 2016 Memo. That is, there would be no payments made for the 2015 benefit year.

69. On November 18, 2016, CMS released a document titled "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year," setting forth the amount of money CMS concedes that it owes to insurers (and is owed by insurers) for benefit year 2015 as a result of the risk corridors program. The calculations are separated into individual market and small group market. For benefit year 2015, Health Options was *owed* $22,739,206 under the RCP as a result of higher-than-expected allowable costs in the individual and small group markets. To date, CMS has paid no portion of the full amount CMS concedes that it owes to Health Options for benefit year 2015.

70. The amounts the Government owes Health Options for benefit years 2014 and 2015 were at issue in Case No. 16-967C, and is currently on appeal.

F. 2016 Risk Corridors Payments Owed to Plaintiff.

71. Plaintiff's participation as a QHP issuer in the Maine and New Hampshire marketplaces was fixed and irrevocable in October 2015, when Plaintiff fully executed QHP Issuer Agreements with CMS for the 2016 benefit year commencing January 1, 2016.

72. Consistent with CMS regulations and its policy, Plaintiff began selling QHPs to consumers in Maine and New Hampshire on or around November 1, 2015, with coverage effective January 1, 2016.

73. Plaintiff complied with its statutory requirements and submitted to HHS all data required by the ACA demonstrating that it experienced higher-than-expected allowable costs under the RCP for benefit year 2016, entitling Plaintiff to payment by HHS in the amount of $35,998,655.

74. On information and belief, and based upon the agency's treatment of 2014 and

2015 risk corridors payments due, HHS has no intention of making payment for the 2016 benefit year as required by the ACA. The 2017 Spending Rider prevents CMS and HHS from making risk corridors payments from certain funding sources. HHS has not modified its position that it will continue to treat the RCP as "budget neutral" (although there is no basis in the ACA for doing so).

75. For a non-profit CO-OP like Health Options, the Government's refusal to pay money due under the RCP gives rise to significant financial difficulties. While more than eighty percent of the CO-OPs created under the ACA have failed, Health Options has fought to continue in operation to fulfill its mission of increasing the accessibility of healthcare coverage to individuals who traditionally lacked sufficient coverage. Withholding risk corridors payments defeats the very purpose of the RCP—mitigation of the risk that CO-OPs were otherwise assuming by entering the expanded health insurance marketplace in answer to the ACA's challenge to assure the availability of affordable health insurance coverage for all Americans.

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

* * * * *

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

especially crucial for new entrants who relied on the promise of Congress that cost overruns would be partially mitigated through reimbursement. Notwithstanding subsequent agency pronouncements, *made only after QHP issuers such as Plaintiff entered the market*, CMS's implementing regulation (Section 153.510) reflected the mandatory nature of the payments without regard to budget neutrality.

78. Plaintiff relied upon the RCP when it entered and participated in the ACA exchanges, and when it designed and priced its 2016 plans. At the end of benefit year 2016, Plaintiff was *owed* money based on its participation in both the individual and small group markets.

79. Health Options sustained $88 million in losses for benefit years 2015 and 2016 combined, of which $35,998,655 is owed and presently due to Plaintiff for benefit year 2016,[7] under the express terms of Section 1342 of the ACA. By this lawsuit, Plaintiff seeks the immediate payment in full of risk corridors receivables for the 2016 benefit year so that it can continue to offer affordable health insurance as contemplated by the ACA.

CLAIM FOR RELIEF

COUNT I

(Violation of Statutory and Regulatory Mandate to Make Payments)

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

81. As part of its obligations under Section 1342 of the ACA and its obligations under 45 C.F.R. § 153.510(b), the Government is required to pay any QHP issuer certain amounts

[7] Plaintiff's 2016 risk corridors payment has been calculated pursuant to the formula prescribed in the ACA, using the same methodology Plaintiff applied to its 2014 and 2015 data, both of which have been validated by CMS. Plaintiff has therefore properly calculated its losses, documented them, and submitted them to CMS in accordance with the law.

exceeding the target costs they incurred in 2016.

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

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

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

COUNT II

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

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

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

87. Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's repeated admissions regarding their obligation to make risk corridor payments were made or ratified by representatives of the Government, including, but not limited to, Kevin Counihan, Director of Consumer Information and Insurance Oversight ("CCIIO") and CEO of the Health Insurance Marketplaces; Andrew Slavitt, Administrator of

CMS; or other CMS officials, all of whom had actual authority to bind the Government. Section 1342, written and verbal agreements between Plaintiff and CMS, CMS's implementing regulations, and the repeated admissions by agency officials with authority to bind the Government constitute a clear and unambiguous offer by the Government to make full and timely risk corridor payments to health insurers, including Plaintiff, that agreed to participate as QHP issuers in the ACA marketplaces. This offer evidences a clear intent by the Government to contract with Plaintiff.

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

89. The Government's agreement to make full and timely risk corridor payments was a significant factor material to Plaintiff's decision to participate in the Maine and New Hampshire marketplaces.

90. The parties' mutual intent to contract is further confirmed by the parties' conduct, performance and statements following Plaintiff's acceptance of the Government's offer, and the Government's repeated assurances that full and timely risk corridor payments would be made and would not be subject to budget limitations. *See, e.g.*, 78 Fed. Reg. 15,409, 15,473 (Mar. 11, 2013).

91. The implied-in-fact contract was also supported by mutual consideration: The RCP's protection from uncertain risks and new market instability was a real benefit that

significantly influenced Plaintiff's decisions to agree to become a QHP issuer and participate in the Maine and New Hampshire marketplaces. Plaintiff, in turn, provided a real benefit to the Government by agreeing to become a QHP issuer and participating in the Maine and New Hampshire marketplaces, as adequate insurer participation was crucial to the Government achieving the overarching goal of the ACA exchange programs—to guarantee the availability of affordable, high-quality health insurance coverage for all Americans by protecting consumers from increases in premiums due to health insurer uncertainty.

92. The Government induced Plaintiff to participate in the Maine and New Hampshire marketplaces for benefit year 2016 by including the RCP in Section 1342 of the ACA and its implementing regulations, by which the Government committed to help protect health insurers financially against risk selection and market uncertainty.

93. The Government repeatedly acknowledged its commitments to share risk with QHP issuers and its obligations to make full and timely risk corridors payments to qualifying QHP issuers through its conduct and statements to the public and to Plaintiff and other similarly situated QHP issuers, made or ratified by representatives of the Government who had express or implied actual authority to bind the Government. *See, e.g.*, 77 Fed. Reg. 17,219, 17,238 (Mar. 23, 2012).

94. The Government also induced Plaintiff to participate in the marketplaces during and after HHS and CMS's announcement in 2014 of their intention to implement the RCP in a budget neutral manner, by repeatedly giving assurances to QHP issuers, including Plaintiff, that risk corridors collections will be sufficient to cover all of the Government's risk corridors payments, and that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("We anticipate that risk

corridors collections ***will be sufficient*** to pay for all risk corridors payments.") (emphasis added); Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2015) ("***In the unlikely event of a shortfall*** for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, ***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations.") (emphases added).

95. The Government continued to induce Plaintiff to commit to participating in the Maine and New Hampshire marketplaces for benefit year 2016 by providing assurance that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, Sept. 2016 Memo ("As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations.").

96. HHS and CMS acknowledged and published the full risk corridors payment amount of $241,717 that the Government concedes it owes Health Options for benefit year 2014. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015).[8]

97. HHS and CMS also acknowledged and published the full risk corridors payment amount of $22,739,206 that the Government concedes it owes Health Options for benefit year 2015. *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016).

98. Under the same calculation validated by CMS for benefit years 2014 and 2015,

[8] For benefit year 2014, Health Options "owed" the Government $2,045,819.48 for lower-than-expected allowable costs in the individual market as a result of the RCP, which Health Options timely paid.

CMS owes Plaintiff $35,998,655 for benefit year 2016.

99. Because Plaintiff accepted the Government's unilateral offer by beginning performance in or around October 2015, Congress's *subsequent* failure to appropriate sufficient funds for risk corridor payments in May 2017 did not extinguish the Government's extant contractual obligation to make full and timely risk corridor payments to Plaintiff. This contractual obligation survives and is enforceable regardless of whether the Court believes that the Spending Riders modified or repealed Section 1342 of the ACA. Once the contract became binding, the Government was—and remains—liable to make full payment to Plaintiff, using the Judgment Fund if necessary. Plaintiff is entitled to full payment from the Judgment Fund of the $35,998,655 in benefit year 2016 risk corridors payments.

100. The Government's failure to make full and timely risk corridor payment to Plaintiff is a material breach of the implied-in-fact contract, and Plaintiff has been damaged by this failure. Plaintiff therefore brings a claim for damages of $35,998,655 against the Government founded upon the Government's violation of an implied-in-fact contract.

PRAYER FOR RELIEF

Plaintiff requests the following relief:

A. That the Court award Plaintiff monetary relief in the amount of $35,998,655 for benefit year 2016 to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b);

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

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

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

Dated: September 29, 2017

Respectfully submitted,

/s/ Stephen McBrady

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CERTIFICATE OF SERVICE

I certify that on September 29, 2017, a copy of the forgoing "Complaint" was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

/s/ Stephen McBrady
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