IN THE UNITED STATES COURT OF FEDERAL CLAIMS

NEW MEXICO HEALTH CONNECTIONS, a New Mexico Non-Profit Corporation,	)	
Plaintiff,	)	
v.	)	
THE UNITED STATES OF AMERICA,	)	No. 16-1199 Senior Judge Loren A. Smith
Defendant.	)	

FIRST AMENDED COMPLAINT

Plaintiff New Mexico Health Connections ("Plaintiff or "NMHC") is a New Mexico non-profit health insurance company that is owed tens of millions of dollars from Defendant the United States of America ("Defendant," "United States," or "Government") under the risk corridors program of the Patient Protection and Affordable Care Act ("ACA"). The amounts owed to NMHC are expressly provided for by statute and regulation, specifically determinable as an accounting matter, and are not in dispute. The Government has acknowledged its obligations to make full risk corridors payments to NMHC (and other insurers) and has recorded those amounts as payment obligations of the Government. Despite this express acknowledgment, the Government has failed to make risk corridors payments to NMHC and other insurers purportedly because of funding shortfalls.

In *Maine Community Health Options v. United States*, __ U.S. __, 140 S. Ct. 1308 (2020), the Supreme Court upheld four health insurance carriers' identical challenges to the Government's failure to pay them funds owed under the ACA's risk corridors program, holding that (1) Congress created an enforceable payment obligation in the ACA, (2) this payment obligation was not repealed by subsequent appropriations riders, and (3) health insurance carriers

like NMHC have an action for damages under the Tucker Act for unpaid monies due and owing under the risk corridors program. *Maine Community Health Options* is directly on point, controlling, and mandates entry of judgment in NMHC's favor. Accordingly, NMHC, through its undersigned counsel, petitions this Court for relief and alleges as follows:

INTRODUCTION

1. NMHC brings this action to recover damages for Defendant's failure to make mandatory risk corridors payments in violation of Section 1342 of the ACA, and its implementing federal regulations. *See* 42 U.S.C. § 18042(b) (2010); 45 C.F.R. § 153.510.

2. Based on the U.S. Supreme Court's recent decision in *Maine Community Health Options*, there can be no question that NMHC is entitled to the relief it seeks. This action falls squarely within the holding of *Maine Community Health Options.*

3. In 2010, the Government enacted the ACA, which marked a major reform in the United States health care market. The ACA extended guaranteed availability of health care coverage to all Americans regardless of medical history and prohibited health insurers from using factors such as health status, medical history, gender, and industry of employment to set premium rates.

4. The ACA not only required individuals to purchase coverage if they were not otherwise insured, but also created federal subsidies to offset the cost of coverage. The ACA's individual health insurance policy purchase mandate, coupled with the availability of federal subsidies and the ease of online shopping on the ACA's health insurance exchanges, dramatically increased the number of individuals—many previously uninsured—who now purchase health insurance.

5. To further facilitate affordability and access to competitive health insurance through the exchanges, Congress created the Consumer Operated and Oriented Plan

("CO-OP") program to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets . . . ." ACA, Pub. L. No. 111-148, § 1322 (codified at 42 U.S.C. § 18042 (2010)). CO-OPs are required to offer at least two-thirds of their plans as qualified health plans ("QHPs") certified by the Centers for Medicare and Medicare Services ("CMS") in the individual and small group markets. In other words, unlike their larger, entrenched competitors, CO-OPs are required to offer products on the exchanges established by the ACA, and are required to do "substantially all" of their business in the individual and small group markets. NMHC was created under the CO-OP program and is the CO-OP insurance carrier for New Mexico.

6. Because the ACA introduced thousands of previously uninsured or underinsured citizens into the health care marketplace, it created great uncertainty for health insurers, including NMHC, that had no previous experience with the uninsured persons seeking coverage and had no reliable data to meaningfully assess the risks and set the premiums for this new population of insureds. Congress included three premium-stabilization programs in the ACA to mitigate the effects of this lack of information, which could otherwise compel nervous carriers to charge extremely high premiums to obtain protection against such unknown risks: a 3-year temporary reinsurance program, a 3-year temporary risk corridors program, and a permanent risk adjustment program. The reinsurance and risk adjustment programs are not at issue in this First Amended Complaint.

7. The temporary risk corridors program aimed to support the marketplace by providing insurers with protection against uncertainty in claims costs during the first three years of the ACA's marketplaces, from 2014 through 2016. It did this by having the Government share risk in a health plan's losses and gains. Thus, issuers whose premiums exceeded claims

and other costs by more than a certain amount paid into the program, and insurers whose claims exceeded premiums by a certain amount were supposed to receive payments for their shortfall.

8. The United States has admitted its statutory and regulatory obligations to pay the full amount of risk corridors payments owed to health insurance carriers, but has failed to make the required payments, to the tune of over $12 billion in the aggregate, over the program's three-year period from 2014-2016.

9. Instead, the Government arbitrarily has paid Plaintiff and other issuers only a pro-rata share—between 12 and 13%—of the total amount due for 2014 and nothing at all for amounts due for 2015 and 2016, asserting that full payment is limited by available appropriations, even though no such limits appear anywhere in the ACA or its implementing regulations.

10. This action seeks damages from the Government of $46,116,878.00, the amount of unpaid risk corridors payments still owed to NMHC under the ACA's formula for 2014, 2015 and 2016.

JURISDICTION AND VENUE

11. This Court has jurisdiction over this action and venue is proper in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1) (2011), because Plaintiff brings claims for damages over $10,000 against the United States, and these claims are founded upon the Government's violations of a money-mandating Act of Congress and a money-mandating regulation of an executive department. In *Maine Community Health Options*, *supra*, the Supreme Court specifically held that the Tucker Act authorizes actions seeking damages against the Government for unpaid risk corridors receivables.

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

PARTIES

13. NMHC is a not-for-profit New Mexico company with headquarters located in Albuquerque. It is organized as a non-profit under the ACA's CO-OP program and has offered comprehensive health insurance benefits to individuals, families and businesses in New Mexico. It is the State of New Mexico's only non-profit CO-OP insurer. NMHC began providing affordable, high-quality health plans in New Mexico in 2014.

14. From NMHC's inception, both its Board of Directors and senior management have focused on offering health insurance plans to individuals and families through the New Mexico health insurance exchange.

15. NMHC has always been committed to providing access to quality healthcare to individuals and families regardless of income.

16. Defendant is the United States of America. HHS and CMS are agencies of the Defendant United States of America. These Government agencies are responsible for overseeing the administration of the ACA.

FACTUAL ALLEGATIONS

Congress Enacts the Patient Protection and Affordable Care Act

17. In 2010, Congress enacted the ACA, Pub. L. No. 111-148 (codified at 42 U.S.C. § 18001, *et seq.* (2010)).

18. The ACA aimed to increase the number of Americans covered by health insurance and decrease the cost of health care in the United States.

19. The ACA provides that "each health insurance issuer that offers health insurance coverage in the individual . . . market in a State must accept every . . . individual in the State that applies for such coverage." ACA, Pub. L. No. 111-148, § 2702(a) (codified at 42 U.S.C. § 300gg-1(a) (2010)).

20. The ACA also bars insurers from charging higher premiums on the basis of a person's health. ACA, Pub. L. No. 111-148, § 2701 (codified at 42 U.S.C.§ 300gg (2010)).

21. Beginning on January 1, 2014, individuals and small businesses were permitted to purchase private health insurance through competitive statewide marketplaces called "American Health Benefit Exchanges." ACA Section 1311 establishes the framework for these exchanges. *See* ACA, Pub. L. No. 111-148, § 1311 (codified at 42 U.S.C. § 18031 (2010)).

22. NMHC participated in the exchange in New Mexico in 2014, 2015 and 2016.

NMHC Establishes Itself as a QHP

23. As noted, one major aspect of the ACA's health care overhaul was the establishment of health insurance exchanges, which offered consumers organized platforms to shop for coverage with specified benefit levels. These exchanges were established to meet the ACA's goal of providing "competitive environments in which consumers can choose from a number of affordable and high quality health plans." STEVEN SHEINGOLD ET AL., DEP'T OF HEALTH AND HUMAN SERVICES, ASSISTANT SEC'Y FOR PLANNING AND EVALUATION ISSUE BRIEF: COMPETITION AND CHOICE IN THE HEALTH INSURANCE MARKETPLACES, 2014-2015: IMPACT ON PREMIUMS 1 (July 27, 2015), https://aspe.hhs.gov/sites/default/files/pdf/108466/rpt_MarketplaceCompetition.pdf.

24. To offer plans on the exchanges, an issuer must certify that the plans are QHPs, that is, that they meet certain federally-mandated criteria. The ACA offers tax credits and

cost-sharing subsidies to help lower-income individuals purchase QHPs through the exchanges. *See* ACA, Pub. L. No. 111-148, §§ 1401-02 (codified at 26 U.S.C. § 36B (2010), 42 U.S.C. § 18071 (2010)).

25. In order to promote competition within the exchanges and to provide consumers with greater choice among QHPs, the ACA created the CO-OP program, which provided funding to new non-profit health insurers committed to the development of innovative health insurance models that would invigorate competition, drive costs down, and increase the quality of health care delivered to consumers in the individual and small group markets. *See* ACA, Pub. L. No. 111-148, § 1322(a)(1)-(2) (codified at 42 U.S.C. § 18042(a)(1)-(2) (2010)); HHS ET AL., *Loan Funding Opportunity Number: OO-COO-11-001* 7, 10 (Dec. 9, 2011).

26. NMHC was initiated by a group of community advocates in 2011 to apply for CO-OP funding under Section 1322 of the ACA.

27. NMHC was awarded this funding, and on February 19, 2012, NMHC signed a loan agreement ("Loan Agreement") with HHS to fund its initial formation and operation in New Mexico. *See* Loan Agreement, CMS & NMHC (Feb. 19, 2012). The stated purpose of the Loan Agreement (which was drafted by the Government) was to permit NMHC "to offer health plans primarily in the individual and small group markets" on the exchanges. *Id.* at 8.

28. The Loan Agreement required NMHC to develop a viable and sustainable CO-OP, offering plans certified by CMS as QHPs to participate on the exchanges. *See* HHS ET AL., *Loan Funding Opportunity Number: OO-COO-11-001* 8, 22.

29. To be deemed certified, NMHC was required to comply with all standards set forth in Section 1311(c) of the ACA, all state specific standards, and any CO-OP regulatory

standards. NMHC was also required to offer at least two-thirds of its plans as QHPs in the individual and small group markets.

30. The Loan Agreement was executed by representatives of the Government who had actual authority to bind the United States, and was entered into with mutual assent and consideration by both parties.

31. NMHC also signed QHP Agreements with CMS for 2014, 2015 and 2016.

32. NMHC executed its initial QHP Agreement in September 2013 ("2014 QHP Agreement"). *See* QHP Agreement, CMS & NMHC (Sept. 23, 2013). The 2014 QHP Agreement was executed by representatives of the Government who had actual authority to bind the United States, and was entered into with mutual assent and consideration by both parties.

33. Before NMHC executed the 2014 QHP Agreement, NMHC executed an attestation certifying its compliance with the obligations it was undertaking by agreeing to become a QHP on the ACA exchange in New Mexico. Plaintiff submitted its executed attestation to CMS on April 25, 2013.

34. By executing and submitting this attestation to CMS, NMHC agreed to the many obligations and responsibilities imposed upon all QHPs that accept the Government's offer to participate in the ACA exchanges. Those obligations and responsibilities that Plaintiff undertook include, *inter alia,* licensing, reporting requirements, employment restrictions, marketing parameters, HHS oversight of the QHP's compliance plan, maintenance of an internal grievance process, benefit design standards, cost-sharing limits, rate requirements, enrollment parameters, premium payment process requirements, participating in financial management programs established under the ACA (including the risk corridors program), adhering to data

standards, and establishing dedicated and secure server environments and data security procedures.

35. NMHC affirmatively attested that it would agree to comply with certain "Financial Management" obligations, including, among others:

> (1) New Mexico Health Connections attests that it will . . . be bound by Federal statutes and requirements that govern Federal funds. Federal funds include . . . Federal payments related to the risk adjustment, reinsurance, and risk corridor programs.
>
> (2) New Mexico Health Connections attests that it will adhere to the risk corridor standards and requirements set by HHS as applicable for:
>
> **(a)** risk corridor data standards and annual HHS notice of benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 C.F.R. 153.510); [and]
>
> **(b)** remit charges to HHS under the circumstances described in 45 C.F.R. 153.510. . . .
>
> (3) New Mexico Health Connections attests that it will:
>
> **(a)** adhere to the risk adjustment standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR Subparts G and H); [and]
>
> **(b)** remit charges to HHS under the circumstances described in 45 C.F.R. 153.610. . . .

Martin E. Hickey, *Qualified Health Plan Program Attestations* (Apr. 25, 2013), at 5.

36. NMHC's QHP agreements with CMS for the 2015 and 2016 benefit years contained substantially similar terms.

37. The financial risk sharing that Congress mandated through the risk corridors program was a significant factor in NMHC's decision to agree to execute the Loan Agreement, become a QHP, and undertake the many responsibilities and obligations required for NMHC to participate in the ACA exchange.

The ACA's Premium-Stabilization Programs

38. To help protect health insurers against the risks inherent in covering a new and previously uninsured population about whom little was known, the ACA established three premium-stabilization programs, 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. Of these programs, only risk corridors is directly relevant to this action.

39. The goal of the temporary risk corridors program was to give insurers payment stability as insurance market reforms began.

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

41. Since the ACA's rollout, NMHC has worked with the Government to make the ACA exchange successful in New Mexico. Participating as a QHP on the New Mexico exchange, NMHC has developed a broad spectrum of health insurance products at competitive rates, providing quality, low-cost options to its thousands of members and sparking greater competition among other issuers.

42. NMHC has stayed true to its mission and to the goals of the ACA, expanding health care coverage by providing quality options at affordable rates. But doing so was not easy in a new market where the risk profile of its enrolled population was unknown. When it first offered insurance policies on the ACA exchange, NMHC had none of the information typically used by insurers to set premiums—namely, historical data on the health

care utilization patterns of the consumers who would be buying its policies. NMHC could have protected itself from these unknown risks by setting premiums high—attempting to ensure that it would take in more money than it would pay out in claims. But, doing that would be anathema to the mission of NMHC and the ACA. Rather, NMHC relied on the protections built into the market stabilization programs, including the risk corridors program, to keep its premiums at affordable levels. The premium rates NMHC set for its QHPs were lower than they would have been in the absence of the Government's promise of risk corridors payments.

43. The lower premiums obviously benefitted tens of thousands of NMHC members. But they also benefitted the Government and federal taxpayers. The Government was obligated to provide premium tax credits under the ACA, to help individuals pay premiums for QHPs. Higher premiums would have equated to higher Government payments. By keeping premiums low, the tax credits provided by the Government to NMHC members were much lower than they otherwise would have been.

44. NMHC demonstrated its willingness to be a meaningful partner in the ACA's goals and programs, and did so in good faith, with the understanding that the United States would honor its statutory and regulatory commitments regarding the premium-stabilization programs, including the temporary risk corridors program.

The ACA's Risk Corridors Program

45. As noted above, this action is concerned with the risk corridors program.

46. Section 1342 of the ACA expressly requires the Secretary of HHS to establish a temporary risk corridors program that provides for the sharing in gains or losses between the Government and certain participating health plans in the individual and small group markets. *See* ACA, Pub. L. No. 111-148, § 1342 (codified at 42 U.S.C. § 18062 (2010)).

47. The risk corridors program applied only to participating plans that agreed to accept the responsibilities and obligations of QHPs. All insurers that elected to enter into agreements to become QHPs were required by Section 1342(a) of the ACA to participate in the risk corridors program. As a CO-OP, NMHC was required by its Loan Agreement to become a QHP and thus to participate in the risk corridors program.

48. By enacting Section 1342 of the ACA, Congress recognized that, due to uncertainty about the population entering the exchanges during the first few years, health insurers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted.

49. Congress intended the ACA's temporary risk corridors provision to serve as an important safety valve for consumers and insurers as millions of Americans would transition to new coverage in a brand new marketplace, protecting against the uncertainty that health insurers, like NMHC, would face when estimating enrollments and costs resulting from the market reforms by creating a mechanism for sharing risk between the Government and issuers of QHPs in each of the first three years of the new regulatory scheme and exchange marketplaces.

50. Under the risk corridors program, the Government shares risk with QHP health insurers by collecting charges from a health insurer if the insurer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and by making payments to the insurer if the insurer's QHP premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments.

51. Congress, through Sections 1342(b)(1) and (2) of the ACA, expressly established the payment methodology and formula for the risk corridors program:

> (b) **Payment methodology**
>
> **(1) Payments out**
>
> The Secretary ***shall*** provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 percent of the target amount, the Secretary ***shall pay*** to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs ***for any plan year*** are more than 108 percent of the target amount, the Secretary ***shall*** pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> **(2) Payments in**
>
> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

ACA, Pub. L. No. 111-148, § 1342(b) (codified at 42 U.S.C. § 18062(b) (2010)) (emphasis added).

52. HHS implemented the risk corridors program 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.

45 C.F.R. § 153.510(b) (emphasis added).

53. To determine whether a QHP pays into, or receives payments from, the risk corridors program, HHS compares allowable costs (essentially, claims costs subject to adjustments for health care quality, health IT, risk adjustment payments and charges and reinsurance payments) and the target amount (*i.e.*, the difference between a QHP's earned premiums and allowable administrative costs).

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

55. As detailed below, in 2014, 2015 and 2016, NMHC experienced allowable-cost losses in excess of its target costs, making NMHC eligible to receive mandatory risk corridors payments required under Section 1342.

56. Congress did not impose any financial limits or restraints on the Government's mandatory risk corridors payments to QHPs in either Section 1342 or any other section of the ACA.

57. The United States has failed or refused to make full and timely risk corridors payments to NMHC as required under Section 1342 of the ACA and 45 C.F.R. § 153.510.

58. HHS and CMS, which are charged with administering the risk corridors program, lack authority to pay anything less than 100% of the risk corridors payments due to Plaintiff and are legally obligated to make full payment.

HHS and CMS's Recognition of Risk Corridors Payment Obligations

59. Since Congress's enactment of the ACA in 2010, HHS and CMS have repeatedly and publicly acknowledged and confirmed their statutory and regulatory obligations to make full and timely—*i.e.*, annual—risk corridors payments to qualifying QHPs.

60. These public statements by HHS and CMS were made by representatives of the Government who had actual authority to bind the United States.

61. HHS and CMS intended for QHPs to rely on these public statements to assume and continue their QHP status, and participate on the ACA exchanges.

62. On July 11, 2011, HHS issued a fact sheet on HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment," stating that under the risk corridors program, "qualified health plan issuers with costs greater than three percent of cost projections ***will receive payments*** from HHS to offset a percentage of those losses." *Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, HEALTHCARE.GOV (July 11, 2011), http://web.archive.org/web/20110720093202/http:/www.healthcare.gov/news/factsheets/exchanges07112011e.html (emphasis added).

63. On March 23, 2012, HHS implemented a final rule regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. *See* Standards Related to

Reinsurance, Risk Corridors, and Risk Adjustment, 77 Fed. Reg. 17,219 (Mar. 23, 2012). Although HHS did not expressly propose deadlines for making risk corridors payments, HHS stated that "QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers." *Id.* at 17,238. The payment deadline for QHP issuers to pay HHS under the risk corridors program is within 30 days after notification of such charges. 45 C.F.R. § 153.510(d).

64. On March 11, 2013, HHS publicly affirmed that the risk corridors program is ***not*** statutorily required to be budget neutral, *i.e.*, payments into the program do not have to equal payments out of the program. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409 (Mar. 11, 2013). HHS confirmed that: "Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." *Id.* at 15,473.

65. The statute is in fact 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 full payments to each plan, even though there would be no insurer payments coming in. The risk corridors program could not have been subject to budget neutrality and still be operated in accordance with Congressional intent. Had the program been cabined by budget neutrality concerns, the ACA would have failed to attract sufficient entrants into the marketplace because the investment would have been too risky, as payments owed could easily swamp payments made into the program (as actually happened). HHS's timely payment to plans under the risk corridors program is essential to realizing the ACA's intent that the program stabilize premiums. Indeed, Section 1342 is modeled for just that

reason on the Medicare Part D program, which also is not required to be budget neutral. *See* 42 C.F.R. § 423.336.

66. In deciding to become and continue as a QHP, by entering into the Loan Agreement and 2014 QHP Agreement, NMHC relied upon HHS's commitments to make full risk corridors payments annually, as required in Section 1342 of the ACA, regardless of whether risk corridors payments to QHPs are actually greater than risk corridors charges collected from QHPs for a particular calendar year.

The Government Reneges on Its Statutory Obligation to Make Full and Timely Risk Corridors Program Payments

67. Since its enactment, Congress has not altered the Government's obligations under the ACA's risk corridors program. 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 permit them to survive, learn from and adapt to this uncharted new market.

68. The first such step was in March 2014, when HHS stated in the Federal Register that "HHS intends to implement this [risk corridors] program in a budget neutral manner." HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,743, 13,829 (Mar. 11, 2014).

69. That 2014 guidance radically departed from what the ACA intended and requires and what the implementing regulation reflected: that the risk corridors program had been enacted without regard to annual budget neutrality. Indeed, one year earlier, HHS clearly stated "[t]he risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342

of the Affordable Care Act." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,473.

70. 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 1 (Apr. 11, 2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

71. On December 16, 2014, Congress enacted the "Consolidated and Further Continuing Appropriations Act, 2015" ("2015 Appropriations Act"). *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (2014).

72. In the 2015 Appropriations Act, Congress specifically targeted the Government's existing, mandatory risk corridors payment obligations owed to QHPs, including Plaintiff, under Section 1342 of the ACA, limiting appropriations for those payment obligations from three large funding sources by including the following text at Section 227 of the 2015 Appropriations Act:

> *None of the funds* made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, *may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).*

Consolidated and Further Continuing Appropriations Act, 2015 § 227 (emphasis added).

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

74. Congress's failure to appropriate sufficient funds for risk corridors payments, without modifying or repealing Section 1342 of the ACA, did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridors payments to QHPs, including Plaintiff.

75. On October 1, 2015, after collecting risk corridors data from QHPs for 2014, HHS and CMS announced that they intended to prorate the risk corridors payments owed to QHPs, including Plaintiff, for 2014, stating that:

> Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. **At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.**

CMS, RISK CORRIDORS PAYMENT PRORATION RATE FOR 2014 (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

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

77. HHS and CMS failed to cite any statutory authority for their unilateral decision to make only partial, prorated risk corridors payments.

78. Recognizing that the United States was acting in contravention of its statutory and regulatory payment obligations, on November 19, 2015, HHS and CMS issued a bulletin acknowledging the Government's obligation to make full risk corridors payments.

> 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 [*sic*] of the United States Government for which full payment is required.

CMS, RISK CORRIDORS PAYMENTS FOR THE 2014 BENEFIT YEAR (Nov. 19, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf.

79. The Government's written acknowledgement of its risk corridors payment obligation, however, is no substitute for full and timely payment of the amounts owed.

80. On December 18, 2015, Congress enacted the "Consolidated Appropriations Act, 2016" ("2016 Appropriations Act"). *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 (2015).

81. In the 2016 Appropriations Act, Congress again specifically targeted the Government's existing, mandatory risk corridors payment obligations owed to QHPs, including Plaintiff, under Section 1342 of the ACA, limiting appropriations for those payment obligations from three large funding sources by including the following text at Section 225 of the 2016 Appropriations Act:

> *None of the funds* made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, *may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).*

Consolidated Appropriations Act, 2016, § 225 (emphasis added).

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

83. Congress enacted similar appropriations riders in subsequent years.

84. Congress's failure to appropriate sufficient funds for risk corridors payments, without modifying or repealing Section 1342 of the ACA, did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridors payments to QHPs, including Plaintiff.

NMHC's Risk Corridors Payment Amounts

85. In a report released on November 19, 2015 ("2014 Risk Corridors Report"), HHS and CMS publicly announced QHPs' risk corridors charges and payments for 2014, and emphasized that **"[r]isk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated."** CMS, RISK CORRIDORS PAYMENT AND CHARGE AMOUNTS FOR BENEFIT YEAR 2014 1 (Nov. 19, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf. In other words, issuers who had to pay into the risk corridors program had to pay 100% of their obligation while those who were owed money could expect only a prorated share to be paid by the Government.

86. NMHC's losses in the ACA New Mexico Individual Market for plan year 2014 resulted in the Government being required to pay NMHC a risk corridors payment of $4,211,650.62. *Id.* at 18-19.

87. The Government announced, however, that it would pay NMHC a prorated amount of only $531,420.45 for NMHC's 2014 losses. *See id.*

88. NMHC did not have gains in 2014 that resulted in NMHC being required to remit risk corridors charges to the Secretary of HHS. *See generally id.*

89. Had NMHC been required to remit a risk corridors charge to the Secretary of HHS, then NMHC would have been required to remit 100% of the amount of the charge to HHS before the close of calendar year 2015, as it had affirmatively attested it would do. *See id.*; *see also* Martin E. Hickey, *Qualified Health Plan Program Attestations* (Apr. 25, 2013), at 5.

90. The Government made some prorated risk corridors payments to Plaintiff totaling $516,379.00, as of the date of the filing of this Complaint. This amount represents only approximately 12.26% of 2014 risk corridors payments that the Government owes to Plaintiff—even less than the 12.6% pro rata amount that the Government stated it would pay NMHC for 2014 risk corridors payments.

91. The Government lacks the authority, under statute, regulation or contract, to withhold full and timely 2014 risk corridors payments from QHPs such as NMHC. Accordingly, it owes NMHC $3,695,272.00 for 2014 risk corridors payments.

92. In 2015, NMHC's losses entitled it to $18,987,011.00 in risk corridors payments. To date, the Government has not paid any of these funds.

93. In 2016, NMHC's losses entitled it to $23,434,595.00 in risk corridors payments. To date, the Government has not paid any of these funds.

94. The total amount of unpaid risk corridors payments owed to NMHC is $46,116,878.00.

95. On information and belief, there are no required administrative avenues NMHC is required to take before bringing this action. Even if there were, to the extent required,

Plaintiff has exhausted any required non-judicial avenues to remedy the Government's failure to provide the full and timely mandated risk corridors payments or any such avenues are futile.

COUNT I

Violation of Federal Statutory and Regulatory Mandate to Make Payments

96. Plaintiff realleges and incorporates by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

97. Section 1342(b)(l) of the ACA mandates compensation, expressly stating that the Secretary of HHS "shall pay" risk corridors payments to QHPs in accordance with the payment formula set forth in the statute.

98. HHS and CMS's implementing regulation at 45 C.F.R. § 153.510(b) also mandates compensation, expressly stating that HHS "will pay" risk corridors payments to QHPs in accordance with the payment formula set forth in the regulation, which formula is mathematically identical to the formula in Section 1342(b)(1) of the ACA.

99. HHS and CMS's regulation at 45 C.F.R. § 153.510(d) requires a QHP to remit charges to HHS within 30 days after notification of such charges.

100. HHS and CMS's statements in the Federal Register on July 15, 2011, and March 23, 2012, state that risk corridors "payment deadlines should be the same for HHS and QHP issuers." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,929, 41,943 (proposed July 15, 2011); Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. at 17,238.

101. NMHC was a QHP in 2014, 2015 and 2016 was qualified for and entitled to receive mandated risk corridors payments from the Government in each year.

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

103. In the 2014 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling $4,211,650.45 that the Government concedes it owes NMHC for 2014. *See* RISK CORRIDORS PAYMENT AND CHARGE AMOUNTS FOR BENEFIT YEAR 2014 18-19, *supra*.

104. In the 2015 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling $18,987,011.00 that the Government concedes it owes NMHC for 2015.

105. In the 2016 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling $23,434,595.00 that the Government concedes it owes NMHC for 2016.

106. The United States has failed to make full and timely risk corridors payments to NMHC.

107. Congress's failure to appropriate sufficient funds for risk corridors payments due did not and could not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridors payments to QHPs, including Plaintiff.

108. The Government's failure to make full and timely risk corridors payments to NMHC constitutes a violation and breach of the Government's mandatory payment obligations under Section 1342(b)(l) of the ACA and 45 C.F.R. § 153.510(b).

109. As a result of the United States' violation of Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b), NMHC has been damaged in the amount of $46,116,878.00.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment in its favor and against the Defendant, the United States of America, and requests the following relief:

(1) That the Court award monetary relief in the amount Plaintiff is entitled to under Section 1342(b)(l) of the ACA and 45 C.F.R. § 153.510(b) regarding the 2014, 2015 and 2016 unpaid risk corridors payments;

(2) That the Court award Plaintiff such additional damages and other monetary relief as is available under applicable law;

(3) That the Court award all available interest, including, but not limited to, post-judgment interest, to Plaintiff;

(4) That the Court award all available attorneys' fees and costs to Plaintiff; and

(5) That the Court award such other and further relief to Plaintiff as the Court deems just and proper.

Dated: June 12, 2020

Respectfully submitted:

/s/ *Barak A. Bassman*

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