IN THE UNITED STATES COURT OF FEDERAL CLAIMS

QCC INSURANCE COMPANY, KEYSTONE HEALTH PLAN EAST, INC., AMERIHEALTH INSURANCE COMPANY OF NEW JERSEY, & AMERIHEALTH HMO, INC., [1]	FILED SEP 22, 2017 U.S. COURT OF FEDERAL CLAIMS
Plaintiffs,	**No.** 17-1312 C
v.	
THE UNITED STATES OF AMERICA,	
Defendant.	

COMPLAINT

Plaintiffs QCC Insurance Company ("QCC"), Keystone Health Plan East, Inc. ("Keystone"), AmeriHealth Ins. Company of New Jersey ("AmeriHealth New Jersey"), and AmeriHealth HMO, Inc. ("AmeriHealth HMO") (collectively "Plaintiff Insurers" or "Plaintiffs") bring this action against the United States Government ("United States" or "Government" or "Defendant") for money damages resulting from the United States' failure to make full payments to Plaintiff Insurers in order to compensate them for certain losses resulting from their sale of qualified health plans for calendar years 2014 and 2015, as mandated by Section 1342 of the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") and the risk corridors program administered by the U.S. Department of Health and Human Services ("HHS" or "Secretary"). Plaintiff Insurers state and allege as follows:

[1] As a result of corporate restructuring effective July 1, 2014, Independence Health Group, Inc., became the ultimate parent corporation of several entities including the entities bringing suit herein, namely, QCC Insurance Company, Keystone Health Plan East, Inc., AmeriHealth Insurance Company of New Jersey, and AmeriHealth HMO, Inc.

NATURE OF THE CASE

1. Section 1342 of the Affordable Care Act mandates a risk corridors program through which issuers of qualified health plans ("QHPs"), such as Plaintiff Insurers, and the United States must annually share in losses and profits exceeding certain thresholds from the sale of QHPs during the first three benefit and calendar years 2014, 2015, and 2016 ("CY 2014," "CY 2015," and "CY 2016" respectively), the first three years of operation of the health insurance exchanges established by the ACA (the "Marketplaces"). Pub. L. No. 111-148 § 1342, 124 Stat. 119, as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010) [42 U.S.C. § 18062].

2. Section 1342 mandates that when "a participating plan's [*i.e.*, QHP issuer's] allowable costs for any plan year are more than 103 percent . . . of the target amount," defined as "total premiums . . . reduced by the administrative costs of the plan," the "Secretary *shall pay* to the plan an amount" specified by a statutory formula. 42 U.S.C. §§ 18062(b)(1)(A), (c)(2) (emphasis added). When, on the other hand, a QHP issuer's allowable costs are *less* than the target amount by a certain percentage, then "the plan [*i.e.*, the QHP issuer] shall pay to the Secretary an amount" set by statute. *Id.* at § 18062(b)(2)(A).

3. The United States has admitted its obligations to make payments to Plaintiff Insurers pursuant to the risk corridors program but has failed to pay the full amount due for CY 2014 and has failed to pay any amounts due to Plaintiffs for CY 2015.

4. The ACA created a new health insurance market – the Marketplaces – to expand access to affordable healthcare coverage, including to individuals who previously were unable to obtain or to afford such coverage, such as individuals with pre-existing conditions. Health insurance issuers such as Plaintiff Insurers lacked reliable data and experience in assessing the risks and setting premiums for this new population of insureds created by the ACA, including

their health status and health care needs. The ACA therefore mandated implementation of three premium-stabilization programs – including the risk corridors program – to support the launch of the new Marketplaces. These programs were intended, *inter alia*, to encourage health insurance issuers to participate in the Marketplaces, to reduce the likelihood that the insurers would include in their premium development an additional amount to guard against the risk and uncertainty of insuring this new and unknown population, and to provide for some year-over-year stability in premiums for consumers, particularly during the initial years of the Marketplaces' operations.

5. The Centers for Medicare & Medicaid Services ("CMS"), which is part of HHS, is charged with implementing the risk corridors program. CMS has explained that the program requires "the Federal Government and [QHP issuers] to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016." 78 Fed. Reg. 15,410, 15,412 (March 11, 2013) (Exhibit 1). It is designed to permit issuers such as Plaintiff Insurers "to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Id.* at 15,413.

6. Between the enactment of the ACA in 2010 and the launch of the Marketplaces on January 1, 2014, Plaintiff Insurers designed and priced QHPs to be sold on the Marketplaces. Plaintiff Insurers recognized the substantial uncertainty regarding the cost of providing health coverage to a previously uninsured population. Consistent with the plain terms of the ACA, its regulations, and the assurances provided by CMS and HHS, Plaintiff Insurers understood that the United States would annually share in their losses and profits from the sale of QHPs during CY 2014, CY 2015, and CY 2016.

7. For CY 2014, the first year of the Marketplaces and the risk corridors program, QHP issuers who made profits in excess of a certain threshold paid in the aggregate a total of

$362 million into the risk corridors program. In the Individual Market in CY 2014, QCC paid $1,308,105.69 into the risk corridors program and AmeriHealth New Jersey paid $2,318,123.55 into the program. AmeriHealth HMO and Keystone suffered losses in the CY 2014 Individual Market, triggering the United States' obligation under the program to compensate them in the amount of $3,360,296.37 and $14,274,873.45 respectively. In the CY 2014 Small Group Market, Plaintiff Insurers suffered losses triggering the Government's obligation to compensate them in the amounts of $10,769,563.46 (QCC), $14,996,681.97 (Keystone), $138,744.96 (AmeriHealth HMO), and $1,157,648.85 (AmeriHealth New Jersey). In total, 2014 QHP issuers that experienced excess losses requested compensation of $2.87 billion under the risk corridors program.

8. For CY 2015, the second year of the Marketplaces and the risk corridors program, QHP issuers who made profits in excess of a certain threshold were again required to pay into the program. As with CY 2014, however, Plaintiff Insurers suffered losses in the CY 2015 Individual Market triggering the United States' obligation under the program to compensate them for the Government's share of those losses in the amount of $7,891,991.13 (QCC), $17,725,832.87 (Keystone), $5,486,703.07 (AmeriHealth HMO), and $12,445,206.11 (AmeriHealth New Jersey). In the CY 2015 Small Group Market, Plaintiff Insurers also suffered eligible losses in the amount of $11,108,682.39 (QCC), $22,879,073.98 (Keystone), $1,333,811.00 (AmeriHealth HMO), and $2,462,716.68 (AmeriHealth New Jersey).

9. Before and after Plaintiff Insurers decided to offer QHPs in the individual market in 2014, CMS and HHS repeatedly acknowledged that "the Affordable Care Act requires the Secretary to make full payments to issuers." 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (Exhibit 2); *see also* 78 Fed. Reg. at 15,473 ("Regardless of the balance of payments and

receipts, HHS will remit payment as required under section 1342 of the Affordable Care Act.") (Exhibit 1). Despite the unequivocal mandate in the ACA that the United States must annually share profits and losses with issuers, the United States has not paid Plaintiff Insurers in full for the Government's share of their CY 2014 and CY 2015 losses.

10. Instead, for CY 2014, CMS prorated the $362 million of payments received from QHP issuers across the $2.87 billion in due compensation for the Government's share of losses under the risk corridors program. In late 2015, CMS announced that Plaintiff Insurers would be paid only about 12.6% of what they were owed under the program for CY 2014. *See* CMS, Risk Corridors Payments for the 2014 Benefit Year, Nov. 19, 2015 (Exhibit 3). CMS advised that it was "recording those amounts that remain unpaid" for CY 2014—$9,410,674.32 for QCC, $25,578,109.63 for Keystone, $1,011,578.26 for AmeriHealth New Jersey, and $3,057,536.97 for AmeriHealth HMO—as fiscal year 2015 obligation[s] of the United States Government for which full payment is required."[2] *Id*.

11. In September 2016, CMS and HHS stated that "all 2015 benefit collections [would] be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." *See* CMS, Risk Corridors Payments for 2015, Sept. 9, 2016 (Exhibit 4).

12. On November 18, 2016, CMS and HHS announced the issuer-level risk corridors payments and charges for CY 2015. *See* CMS, Risk Corridors Payments and Charge Amounts for the 2015 Benefit Year, Nov. 18 2016 (Exhibit 5). CMS announced that QCC would be paid only $357,746.79 of the approximately $9,410,674.32 it was still owed for CY 2014; Keystone

[2] As of 12/31/2015, CMS had not fully paid to issuers the prorated $362 million and as such, the amounts recorded as unpaid should have been greater than listed above. The amount unpaid was $9,603,093 for QCC, $26,101,102 for Keystone, $1,032,262 for AmeriHealth New Jersey, and $3,120,054 for AmeriHealth HMO.

would be paid only $972,351.85 of the approximately $25,578,109.63 it was still owed; (3) AmeriHealth New Jersey would be paid only $38,455.14 of the $1,011,578.26 it was still owed; and AmeriHealth HMO would be paid only $116,232.27 of the $3,057,536.97 it was still owed. CMS also announced that Plaintiff Insurers would not be paid in 2016 for any eligible losses in the CY 2015 markets: $19,000,673.52 for QCC, $40,604,906.85 for Keystone, $14,907,922.79 for AmeriHealth New Jersey, and $6,820,514.07 for AmeriHealth HMO.

13. CMS unambiguously stated that it would not make full and timely risk corridors payments to owed issuers for CY 2015 in 2016. *See id.* ("Today, we are confirming that all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments."). This deferral of payment violates the ACA and its implementing regulations. The risk corridors program requires payment on an annual basis. The risk corridors program was designed for issuers to share with the Government the financial risk of offering QHPs in the new Marketplaces for CY 2014, CY 2015, and CY 2016 and thus to encourage issuers to offer QHPs at lower premiums in the first three years of the Marketplaces. The effectiveness of the risk corridors program necessitates that the Government and participating health insurance issuers share financial risk *on an annual basis* in order to encourage issuers against building into premiums for QHPs sold in each of CY 2014, CY 2015, and CY 2016 an additional financial cushion due to the unknown cost of providing health insurance to the newly-covered population.

14. Pursuant to the Tucker Act, 28 U.S.C. § 1491, Plaintiff Insurers bring this action for money damages resulting from the United States' failure to pay their share of their losses from the sale of QHPs in CY 2014 and CY 2015, as required by a money-mandating statute, §

1342 of the ACA, a money-mandating regulation, 45 C.F.R. § 153.510(b), its implied-in-fact contracts with Plaintiff Insurers, and its express contracts with Plaintiff Insurers.

PARTIES

15. Plaintiff QCC Insurance Company ("QCC") is a corporation organized under the laws of Pennsylvania with its principal place of business at 1901 Market Street, Philadelphia, Pennsylvania 19103. QCC has offered and continues to offer QHPs on the Pennsylvania Marketplace since its launch in 2014.

16. Plaintiff Keystone Health Plan East, Inc. ("Keystone"), is a corporation organized under the laws of Pennsylvania with its principal place of business at 1901 Market Street, Philadelphia, Pennsylvania 19103. Keystone has offered and continues to offer QHPs on the Pennsylvania Marketplace since its launch in 2014.

17. Plaintiff AmeriHealth Insurance Company of New Jersey ("AmeriHealth New Jersey") is a corporation organized under the laws of New Jersey with its principal place of business at 259 Prospect Plains Road, Building M, Cranbury, New Jersey 08512. AmeriHealth New Jersey has offered and continues to offer QHPs on the New Jersey Marketplace since its launch in 2014.

18. Plaintiff AmeriHealth HMO, Inc. ("AmeriHealth HMO"), is a corporation organized under the laws of Pennsylvania with its principal place of business at 259 Prospect Plains Road, Building M, Cranbury, New Jersey 08512. AmeriHealth HMO has offered and continues to offer QHPs on the New Jersey Marketplace since its launch in 2014.

19. Defendant is the United States of America. HHS and CMS are agencies of Defendant.

JURISDICTION

20. Jurisdiction and venue in this Court are proper pursuant to the Tucker Act, 28 U.S.C. § 1491(a), which allows the United States Court of Federal Claims to hear claims for monetary damages against the United States "founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort."

21. Jurisdiction is founded on Section 1342 of the ACA, which specifies that the "Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," 42 U.S.C. § 18062(a); HHS's regulation implementing the risk corridors program, which provides that "QHP insurers will receive payment from HHS in the following amounts, under the following circumstances," 45 C.F.R. § 153.510; the implied-in-fact contracts with the United States for payment of certain losses under the risk corridors program; and the express contracts with the United States to include the full amount of the risk corridors payments due in its monthly payments and collections reconciliation process.

22. This controversy is ripe because CMS and HHS have recognized that additional amounts are presently due to Plaintiff Insurers for CY 2014 and CY 2015, but the Government has not paid those amounts in the manner required by Section 1342 of the ACA and its implementing regulations.

STATUTORY AND REGULATORY FRAMEWORK

23. The ACA substantially altered the rules governing the provision of health insurance coverage, including the pricing and benefits of health insurance coverage. Among other things, 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." 42 U.S.C. §§ 300gg-1(a). The ACA also bars issuers from charging higher premiums on the basis of a person's gender or health status, including pre-existing conditions. *See* 42 U.S.C. §§ 300gg-1. To prevent adverse selection that occurs when consumers wait to obtain coverage until they have an injury or illness, the ACA imposes a financial penalty on individuals who do not obtain health care coverage.

24. The ACA established the Marketplaces through which consumers purchasing coverage in the individual or small group markets could compare different QHPs. The Marketplaces provide a number of mechanisms, also established by the ACA, to make QHPs more affordable; these mechanisms include the availability of premium tax credits and cost-sharing subsidies for eligible consumers purchasing certain QHPs.

25. As a result of the ACA's changes, insurers expected that a substantial number of people who had not previously had health insurance would purchase QHPs. Like all QHP issuers, Plaintiff Insurers faced substantial uncertainty as to who would enroll, the health status of new enrollees, and the cost of providing health care coverage for these newly-insured individuals. At the time, neither the insurance industry, including Plaintiff Insurers, nor the Government, had data or models to accurately predict the total cost to provide this new coverage.

26. To mitigate the financial risk insurers faced due to these uncertainties, ACA Section 1342 mandates a temporary risk corridors program through which all QHP issuers and the Government share in losses and profits exceeding certain thresholds for QHPs offered during the first three years of the Marketplaces' operations. By enacting Section 1342 of the ACA, Congress recognized that, due to uncertainty about the population entering the Marketplaces during the first few years, QHP issuers may not be able to predict their risk accurately, and their

premiums may reflect assumptions regarding costs that are ultimately lower or higher than anticipated.

27. Congress intended the ACA's three-year risk corridors program to be an important protection for consumers and health insurance issuers as millions of Americans obtained newly available, affordable coverage in newly established Marketplaces. The risk corridors program was one of three premium stabilization programs intended to induce participation in the Marketplaces by reducing the potential financial loss posed to health insurers when estimating enrollments and costs for the unknown population gaining access to affordable health care coverage. This risk mitigation program provided for sharing of the financial risk between the Government and issuers of QHPs in each of the first three years of the Marketplace.

28. The risk corridors program is designed to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013) (Exhibit 1). In addition, the program is designed to maintain affordability in the first three years of the health insurance exchanges by "permit[ting] issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Id.* at 15,413. It does so by permitting the "Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016." *Id*. at 15,412.

29. Section 1342(a) is the statutory mandate for the risk corridors program:

> (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.

42 U.S.C. § 18062(a) (emphasis added).

30. Section 1342(b)(1) specifies when and how the Government must reimburse QHP Issuers, such as Plaintiff Insurers, for a share of losses sustained during CYs 2014, 2015, and 2016:

> (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.

Id. § 18062(b)(1) (emphasis added). The "target amount" is premiums net the administrative costs of the QHP. *Id*. § 18062(c)(2).

31. Section 1342(b)(2) specifies when and how QHP issuers must pay a share of profits earned during CYs 2014, 2015, and 2016 to the Government:

> (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.

Id. § 18062(b)(2). Section 1342 of the Affordable Care Act has not been amended or repealed since its enactment in 2010.

32. Consistent with Section 1342(a) of the ACA, HHS and CMS established regulations to further clarify their implementation of the risk corridors program. *See* 45 C.F.R. §§ 153.500 *et seq*.

33. Section § 153.510 of the Code of Federal Regulations specifies the circumstances when the United States must pay QHP issuers for losses pursuant to the risk corridors program:

> (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 (emphasis added).

34. QHP issuers are obligated to bear the risk of potential gains and losses for offering QHPs on the Marketplaces *up to a specific threshold* set forth in Section 1342. Issuers of QHPs that pay more in benefits than they collect in premiums by a pre-determined percentage, though, are entitled under the risk corridors program to receive a payment from the Government, and issuers of QHPs that pay less in benefits than they collect in premiums by a pre-determined percentage must make a payment to the Government under the program. Thus, the risk corridors program allows issuers of QHPs and the United States to annually share in the risk of inaccurate calculation of premiums for QHPs during the first three years of the Marketplaces.

35. If a QHP issuer such as Plaintiff Insurers owes the Government money under the program, the issuer must make that payment within 30 days after being notified of the amount owed. 45 C.F.R. § 153.510(d). The ACA equally calls for CMS and HHS to remit payment annually to QHP issuers on behalf of the United States.

36. HHS and CMS acknowledged in the Federal Register on July 15, 2011 and again on March 23, 2012, that "QHP issuers who are owed these amounts will want prompt payment" and that risk corridors "payment deadlines should be the same for HHS and QHP issuers." 76 Fed. Reg. 41930, 41943 (July 15, 2011) (Exhibit 7); 77 Fed. Reg. 17220, 17238 (Mar. 23, 2012) (Exhibit 8). This prompt payment of amounts due for a prior benefit year is necessary to effectuate the purpose of the risk corridors program, to share between the Government and QHP issuers the financial risk associated with offering QHPs during the initial years of the Marketplaces and to encourage QHP issuers to refrain from increasing premiums in CYs 2014, 2015, and 2016 to account for the cost uncertainty in connection with the same.

37. In Section 1342(a), Congress instructed that the ACA risk corridors program "shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act." The referenced program is colloquially known as "Medicare Part D" – the program that provides Medicare coverage of outpatient prescription drugs. *See* Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 42 U.S.C. §§ 1395w-101 *et seq*. (2003). Under Medicare Part D, HHS makes annual risk corridors payments to Part D Plan Sponsors without regard for budget neutrality. *See* Government Accountability Office, Report GAO-15-447, at 14 (April 2015) ("For the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions.") (Exhibit 9). Although the

statutory language for the ACA risk corridors program differs slightly from the Medicare Part D risk corridors program, the differences do not equate to an intentional departure from annual payments for the ACA risk corridors program. Rather, the express direction that the risk corridor program "shall be based on . . ." the Part D risk corridors program indicates Congress intended to incorporate into the ACA risk corridors program the key features of the Part D risk corridors program, including annual payments into and out of the program by the Government and participating issuers, and the absence of budget neutrality in such payments.

FACTUAL BACKGROUND

38. Since the enactment of the ACA, HHS and CMS have publicly acknowledged their statutory and regulatory obligation to make full and timely payments under the risk corridors program to Plaintiff Insurers and other QHP issuers.

39. These public statements by HHS and CMS were made by representatives of the Government who had actual authority to bind the United States, including but not limited to Kevin Counihan, Director of the CMS Center for Consumer Information and Insurance Oversight ("CCIIO") and CEO of the Health Insurance Marketplaces, and his predecessors in that position; Andrew Slavitt, Administrator of CMS, and his predecessors in that position; and/or other CMS officials, all of whom had actual authority to bind the Government.

40. In March 2013, HHS issued the Notice of Benefit and Payment Parameters for 2014, the first year of the Marketplaces and the risk corridors program. HHS and CMS stated, "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." *See* 78 Fed. Reg. at 15,473 (Exhibit 1).

41. Plaintiff Insurers decided to participate in the 2014 and 2015 individual market by selling QHPs both "on" and "off" the Pennsylvania and New Jersey Marketplaces. In designing and pricing its QHPs, Plaintiff Insurers relied on the Government's representation that it would share in the risk of providing universal QHP coverage on the Marketplace by making annual payments under the risk corridors program.

42. For CY 2014, Plaintiff Insurers had to elect to participate on the Marketplaces by September 2013, with open enrollment beginning on October 1, 2013. They designed and priced their QHPs for CY 2014 in the spring and summer of 2013, and began selling these QHPs in October 2013. Coverage under the QHPs was effective on January 1, 2014.

43. On March 11, 2014, after Plaintiff Insurers had already designed, priced, and sold many of their CY 2014 QHPs, and could no longer withdraw from selling QHPs for CY 2014, HHS proposed that its implementation of the risk corridors program would be budget neutral—that is, payments out under the program would be funded only by payments in. HHS's proposed rulemaking stated:

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

79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014) (Exhibit 10).

44. One month later, however, CMS abandoned its proposal to fund risk corridors payments solely by risk corridors receipts. Instead, CMS explained that "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 . . . ." CMS, Risk Corridors Budget Neutrality, A1, Apr. 11,

2014 (Exhibit 11). HHS later explained that it "recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (Exhibit 2). HHS stated that if "risk corridors collections . . . are insufficient to make risk corridors payments" after 2016, then "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." *Id.*

45. For CY 2015, QHP issuers had to elect to participate by October 2014, with open enrollment beginning on November 15, 2014. Plaintiff Insurers designed and priced their CY 2015 QHPs in the spring and summer of 2014, and began selling CY 2015 QHPs in November 2014; the coverage was effective January 1, 2015.

46. In December 2014, Congress passed the Consolidated and Further Continuing Appropriations Act of 2015, which included an appropriations rider that prohibited CMS and HHS from using three specific sources of funds to make ACA risk corridors program payments:

> SEC. 227. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Pub. L. No. 113-235, at 362.

47. Congress's failure to appropriate sufficient funds for the risk corridors program payments due for CY 2014 and the restrictions enacted on the use of funds "made available by this Act" did not modify or repeal ACA Section 1342 and did not affect the United States' statutory obligation under Section 1342 to make a fully and timely risk corridor payment to Plaintiff Insurers. Moreover, the passage of the appropriations rider in December 2014 came more than a year *after* Plaintiff Insurers agreed to offer (and had priced, designed and sold) QHPs through the Pennsylvania and New Jersey Marketplaces and only two weeks before the

end of Plaintiff Insurers' provision of health coverage under those plans for 2014. Thus, Plaintiff Insurers already had determined the premiums for QHPs sold in CY 2014 and already had incurred significant losses by paying for health care services covered under these QHPs prior to the passage of the appropriations rider.

48. Furthermore, at the time of the enactment of the appropriation in December 2014, QHP issuers that intended to offer QHPs on the Marketplaces in CY 2015 had already been required to commit to participate in the Marketplaces for CY 2015. *See* 45 C.F.R. § 155 Subpart K; CCIIO, 2015 Letter to Issuers in Federally-facilitated Marketplaces, at 8, 27 (Mar. 14, 2014) (requiring issuers to commit by September 2014 to offer plans for the upcoming plan year) (Exhibit 12).

49. Once a QHP issuer has signed its QHP agreement with CMS, the issuer may not withdraw any of its QHPs from the Marketplaces and must accept all eligible applicants for coverage. *See* 45 C.F.R. § 156.290(a)(2); 45 C.F.R. § 147.104. Thus, by the time the December 2014 appropriations rider was enacted, Plaintiff Insurers already had incurred significant losses associated with offering QHPs in CY 2014, had already designed and priced the QHPs Plaintiff Insurers would offer in CY 2015, and already had committed to providing such QHPs for CY 2015. Plaintiff Insurers could not reverse their losses for CY 2014, nor could they withdraw their CY 2015 QHPs from the Marketplace, nor change the pricing for such QHPs, nor deny any eligible applicants such coverage.

50. On July 21, 2015, CMS issued a letter to state insurance commissioners for consideration as premium rates for CY 2016 were being finalized. The letter includes a paragraph entitled "CMS remains committed to the risk corridor program" and states a belief that the 2014 risk corridors payments should be taken into account before decisions are made on final

rates for 2016. Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 21, 2015) (Exhibit 13).

51. In 2014, the Government's share of Plaintiff Insurers' claimed losses under the risk corridors program is $44,697,809.06, meaning it was due that amount from CMS under the risk corridors program for CY 2014, although Plaintiff Insurers incurred greater losses from offering QHPs in CY 2014. CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, Nov. 19, 2015, at Table 43 (Exhibit 6).

52. On November 19, 2015, CMS announced that it would pay $5,639,909.88 to Plaintiff Insurers during the winter of 2015-2016, which is only about 12.6 percent of payments due from the United States. *Id*. The Government calculated this percentage by prorating the $363 million paid into the program by QHP issuers across the $2.8 billion due to QHP issuers for 2014.

53. Prior to this CMS announcement on November 19, 2015, CMS had required issuers like Plaintiff Insurers to design and price their CY 2016 QHPs, to decide whether to participate in the Marketplaces for CY 2016 and to begin selling CY 2016 QHPs. *See* CCIIO, FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 20, 2015) (setting the deadline for commitment to offer plans by September 25, 2015 and the commencement of open enrollment as November 1, 2015) (Exhibit 14). Plaintiff Insurers were thus locked into participation in the Marketplace for each of the CYs 2015, and 2016 prior to HHS or CMS issuing statements that the full risk corridors program payment due for 2014 would not be paid and that Plaintiff Insurers would receive only a small pro rata share of the payment due.

54. In December 2015, Congress passed the Consolidated Appropriations Act, 2016, which included an appropriations rider that again prohibited CMS and HHS from using three specific sources of funds to make ACA risk corridors program payments:

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

Pub. L. No. 114-113.

55. Again, this restriction on the use of funds "made available by this Act" did not modify or repeal Section 1342 of the Affordable Care Act or otherwise change the United States' statutory obligation to make payment to Plaintiff Insurers under Section 1342.

56. In September 2016, CMS announced that it would make additional risk corridors payments to QHP issuers during the winter of 2016-2017 for their CY 2014 losses. CMS, Risk Corridors Payments for 2015, Sept. 9, 2016 (Exhibit 4). CMS further announced that it would make no risk corridors payments for CY 2015 losses during the winter of 2016-2017. *Id*.

57. On November 18, 2016, CMS confirmed that none of its CY 2015 risk corridors collections would be used to pay CY 2015 risk corridors payments. CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, Nov. 18, 2016 (Exhibit 5).

58. On November 18, 2016, CMS announced that it would pay an additional $1,484,786.05 to Plaintiff Insurers for their CY 2014 losses, beginning in December 2016 (as collections are received). *Id*.

59. Plaintiff Insurers offered QHPs for each of the CYs 2014, 2015, and 2016 to which the risk corridors program applies, and they complied in all material respects with all of the statutory and regulatory requirements to be eligible for the Government's payment of its

share of their losses under the risk corridors program, but they have not been paid. *See* 45 C.F.R. §§ 153.500 *et seq*.

60. Congress' failure to appropriate sufficient funds for risk corridors payments due for CYs 2014 and 2015, without modifying or repealing Section 1342 of the ACA, did not eliminate or abrogate the United States' obligation to make full and timely risk corridors payments to QHP issuers, including Plaintiff Insurers.

61. HHS recorded the 2014 amounts "that remain unpaid . . . as fiscal year 2015 obligation[s] of the United States Government for which full payment is required." CMS, Risk Corridors Payments for the 2014 Benefit Year, Nov. 19, 2015 (Exhibit 3). In September 2016, HHS announced that it was recording the 2014 and 2015 amounts that would remain unpaid as fiscal year 2016 obligations for which full payment is required. *See* CMS, Risk Corridors Payments for 2015, Sept. 9, 2016 (Exhibit 4). Payment is thus presently due for the remainder of the Government's share of Plaintiff Insurers' eligible losses in CYs 2014 and 2015. No appropriation is available, however, for HHS to make the payment. Although the calculations of risk corridor payments for CY 2016 have not yet been made, Plaintiff Insurers anticipate that the Government will be required to make substantial risk corridor payments for that plan year as well.

COUNT I

Violation of Statutory and Regulatory Mandates to Make Payments

62. Plaintiff Insurers incorporate by reference paragraphs 1 through 61 above as if fully set forth herein.

63. Pursuant to Section 1342 of the ACA and its implementing regulations, the United States "shall establish" a risk corridors program under which 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" for calendar year 2014.

64. Plaintiff Insurers offered certified QHPs on the Pennsylvania and New Jersey Marketplaces in accordance with the processes prescribed by statute and regulation, and Plaintiff Insurers are QHP issuers for purposes of payment under the risk corridors program. *See* 45 C.F.R. §§ 153.500, 155.20.

65. In 2014 and 2015, Plaintiff Insurers' allowable costs exceeded their target amount by more than 108%. Plaintiffs timely submitted all of the necessary data and complied with all other requirements for obtaining a payment under the risk corridors program. *See* 45 C.F.R. § 153.530.

66. Accordingly, ACA Section 1342 and its corresponding regulations mandate compensation by the Government to Plaintiff Insurers in the amount of $44,697,809.06 for CY 2014 and $81,334,017.23 for CY 2015. This mandate confers no discretion to the United States as to the amount or timing of this payment.

67. To date, the United States has not fully compensated Plaintiff Insurers for their eligible CY 2014 losses. For CY 2014, QCC is still owed $9,052,927, Keystone is still owed $24,605,757, AmeriHealth HMO is still owed $2,941,304, and AmeriHealth New Jersey is still owed $973,123.

68. The United States also failed to fully compensate Plaintiff Insurers for their eligible CY 2015 losses. For CY 2015, the Government presently owes $19,000,674 to QCC, $40,604,907 to Keystone, $6,820,514 to AmeriHealth HMO, and $14,907,923 to AmeriHealth New Jersey.

69. The United States' failure to provide full and timely compensation to Plaintiff Insurers in the amounts set forth in paragraph 67 above for CY 2014 and in paragraph 68 above for CY 2015 is a violation of ACA Section 1342 and its implementing regulations, and Plaintiff Insurers have been damaged thereby.

COUNT II

Breach of Implied-In-Fact Contract

70. Plaintiff Insurers incorporate by reference paragraphs 1 through 69 above as if fully set forth herein.

71. Plaintiff Insurers entered into valid implied-in-fact contracts with the United States regarding its obligation to make full and timely payments under the risk corridors program in exchange for Plaintiff Insurers becoming QHP issuers and offering QHPs in each of CYs 2014 and 2015.

72. The Government made an unambiguous offer to contract with Plaintiff Insurers, provided that they fulfilled certain criteria, which they could accept by performance.

73. Specifically, ACA Section 1342 authorized HHS to enter into contracts to share in the profits and losses of issuers who offered QHPs on the Marketplaces in CYs 2014 and 2015. HHS's Notices of Benefit and Payment Parameters represented an offer to Plaintiff Insurers that if they sold QHPs, "[r]egardless of the balance of payments and receipts, HHS will remit payment as required under section 1342 of the Affordable Care Act," 78 Fed. Reg. at 15,473, meaning the United States would reimburse them for a share of their losses if their allowable costs were "more than 108 percent of the target amount," 42 U.S.C. § 18062(b)(1)(B).

74. ACA Section 1342 and its implementing regulations are an objective manifestation of the United States' intent to contract with insurers like Plaintiffs.

75. By complying with their obligations under Section 1342 as well as 45 C.F.R. §§ 153.500, *et seq.*, and submitting all required data for risk corridors calculations by the deadline, Plaintiff Insurers accepted the United States' offer and thereby manifested their assent in the manner required by the ACA.

76. There were implied-in-fact contracts between Plaintiff Insurers and the United States.

77. The implied-in-fact contracts were authorized or ratified by and through the words and actions of Kevin Counihan, Director of CCIIO and CEO of the Health Insurance Marketplaces, and his predecessors in that position; Andrew Slavitt, Administrator of CMS, and his predecessors in that position; and/or other CMS officials, all of whom had actual authority to bind the Government, and were entered into with mutual assent and consideration by the parties.

78. Plaintiff Insurers satisfied and complied with their obligations and/or conditions that existed under the implied-in-fact contracts.

79. Pursuant to the implied-in-fact contracts for CY 2014, the United States presently owes $9,052,927 to QCC, $24,605,757 to Keystone, $973,123 to AmeriHealth New Jersey, and $2,941,304 to AmeriHealth HMO.

80. Pursuant to the implied-in-fact contracts for CY 2015, the United States presently owes $19,000,674 to QCC, $40,604,907 to Keystone, $14,907,923 to AmeriHealth New Jersey, and $6,820,514 to AmeriHealth HMO.

81. On behalf of the United States, CMS and HHS have acknowledged their obligation to render full risk corridors payments for CYs 2014 and 2015.

82. Plaintiff Insurers are entitled to damages equal to the benefit of their bargain with the United States: reimbursement as alleged in this lawsuit.

83. The United States breached its contract with Plaintiff Insurers by failing to timely pay the full amounts owed for CYs 2014 and 2015 in accordance with the terms of the risk corridors program.

84. Plaintiff Insurers have not been paid amounts owed by the United States for CYs 2014 and 2015, which has resulted in injury and damages to them as a result of the United States' breach of its contractual obligations.

COUNT III

Breach of Express Contract

85. Plaintiff Insurers incorporate by reference paragraphs 1 through 84 above as if fully set forth herein.

86. On September 10, 2013, Plaintiff QCC entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 15)

87. On September 19, 2013, Plaintiff Keystone entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 16)

88. On September 19, 2013, Plaintiff AmeriHealth New Jersey entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 17)

89. On September 19, 2013, Plaintiff AmeriHealth HMO entered into a valid written QHP Issuer Agreement with CMS for 2014. (Exhibit 18)

90. On October 21, 2014, Plaintiff QCC entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 19)

91. On October 21, 2014, Plaintiff Keystone entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 20)

92. On October 27, 2014, Plaintiff AmeriHealth New Jersey entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 21)

93. On October 27, 2014, Plaintiff AmeriHealth HMO entered into a valid written QHP Issuer Agreement with CMS for 2015. (Exhibit 22)

94. The 2014 and 2015 QHP Issuer Agreements were executed by a representative of the government who had actual authority to bind the United States, and were entered into with mutual assent and consideration of the parties.

95. The 2014 and 2015 QHP Issuer Agreements require that "[a]s part of a monthly payments and collections reconciliation process," CMS must "net payments due to QHPI against amounts owed to CMS by QHPI . . . with respect to offering of QHPs." 2014 Agreement ¶ II.c; 2015 Agreement ¶ III.b.

96. The "HHS Notice of Benefit and Payment Parameters for 2014" established the payment parameters for payments due with respect to the offering of QHPs in 2014, including with respect to the risk corridors program and other premium stabilization programs. 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013) ("In that rule, we stated that the specific payment parameters for those [premium stabilization] programs would be published in this final rule. In this final rule, we describe these standards, and include payment parameters for these programs.").

97. The payment parameters for risk corridors payments included that full risk corridors payments were owed by HHS, regardless of receipts. 78 Fed. Reg. at 15,473 ("Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.").

98. The QHP Issuer Agreements require CMS to include risk corridors payments due to Plaintiff Insurers in the "monthly payments and collections reconciliation process" because those payments are due "with respect to offering of QHPs." 2014 Agreement ¶ II.c; 2015 Agreement ¶ III.b; *see also* 45 C.F.R. § 156.1215(b).

99. Plaintiff Insurers satisfied and complied with their obligations and/or conditions under the 2014 and 2015 QHP Issuer Agreements.

100. CMS has not, in fact, included the full amount of the risk corridors payments due to Plaintiff Insurers in their monthly payments and collections reconciliation process.

101. The government's failure to include the full amount of the risk corridors payments due in its monthly payments and collections reconciliation process is a material breach of CMS's obligations under the QHP Issuer Agreements.

102. As a result of the United States' material breach of the QHP Issuer Agreements, Plaintiff Insurers have been damaged in the amount of $28,053,601 for QCC, $65,210,664 for Keystone, $15,881,046 for AmeriHealth New Jersey, and $9,761,818 for AmeriHealth HMO.[3]

PRAYER FOR RELIEF

WHEREFORE, Plaintiff Insurers pray for judgment as follows:

A. Award Plaintiff Insurers monetary damages in the amount of $28,053,601 for QCC, $65,210,664 for Keystone, $15,881,046 for AmeriHealth New Jersey, and $9,761,818 for AmeriHealth HMO, as required by Section 1342 of the ACA and 45 C.F.R. §§ 153.500, *et seq*., for CY 2014 and CY 2015 and any such other amounts (see footnote 3) due through the date of judgment;

[3] As of 9/22/2017, the amount still outstanding for risk corridor payments is $28,060,973 for QCC, $65,230,703 for Keystone, $15,881,838 for AmeriHealth New Jersey and $9,764,214 for AmeriHealth HMO.

B. Award post-judgment interest at the maximum rate permitted by law;

C. Award Plaintiff Insurers consequential damages, special damages, or other damages that result as a consequence of the United States' non-performance;

D. Award Plaintiff Insurers costs and attorney's fees as are available under applicable law; and

E. Award such other relief with respect to all risk corridor payments due Plaintiff Insurers under the risk corridors program for CY 2014 through CY 2016 as justice may require.

Dated: September 22, 2017

Respectfully Submitted:

/s Leslie B. Kiernan

Leslie B. Kiernan
AKIN GUMP STRAUSS HAUER & FELD LLP
1333 New Hampshire Avenue, NW
Washington, D.C. 20036
Email: lkiernan@akingump.com
Tel: (202) 887-4000
Fax: (202) 887-4288

Of Counsel:
Robert K. Huffman
AKIN GUMP STRAUSS HAUER & FELD LLP
1333 New Hampshire Avenue, NW
Washington, D.C. 20036
Email: rhuffman@akingump.com
Tel: (202) 887-4000
Fax: (202) 887-4288

Counsel for Plaintiffs