IN THE UNITED STATES COURT OF FEDERAL CLAIMS

SANFORD HEALTH PLAN,

Plaintiff,

v.

THE UNITED STATES OF AMERICA,

Defendant.

Case No. 17-1432 C

Related Case: No. 17-357C

COMPLAINT

Plaintiff Sanford Health Plan ("Plaintiff" or "SHP") brings this action seeking damages and other relief for the Defendant's (1) violation of the Risk Corridors Program ("RCP"), as codified in Section 1342 of the Patient Protection and Affordable Care Act ("Section 1342") and 45 C.F.R. § 153.510(b) ("Section 153.510"); and (2) breach of its risk corridors payment obligations under an implied-in-fact contract. This is the second action of this type brought by SHP against the Government. In its first action, *Sanford Health Plan v. United States*, No. 17-357C (Bruggink, J.), SHP is seeking the RCP payments the Government owes it for benefit years 2014 and 2015. This action seeks the RCP payment the Government owes Plaintiff for benefit year 2016.

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

NATURE OF ACTION

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

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

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

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

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

4. In order to facilitate affordability and access to competitive health insurance through the exchanges (also referred to as "marketplaces"), Congress encouraged health insurance issuers to offer qualified health plans in the individual and small group markets. A qualified health plan ("QHP") is a health plan that meets certain standards established by the Centers for Medicare & Medicaid Services ("CMS") in order to be sold to consumers through the exchanges.

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

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

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

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

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

9. Specifically, the Act's framework compares "allowable costs" (essentially claims costs and adjustments for quality improvement activities, reinsurance, and risk adjustment charges or payments) with a "target amount" (the QHP's premium less its allocable administrative costs). If the ratio of a QHP issuer's allowable costs to the target amount is greater than 1, then it experiences losses; if the ratio is less than 1, then it experiences gains. The RCP mandates that if an insurer's allowable costs "for any plan year" exceeded the target amount, the Government "shall pay to the plan" a portion of such excess allowable costs pursuant to the payment-calculation formula set forth in the ACA. And, conversely, the statute requires that plans that incurred allowable costs below the target amount in the benefit year "shall pay" a portion of their realized savings to the Government, as calculated according to the same statutory formula.

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

11. Despite these express and binding obligations, the RCP—like the ACA as a whole—was targeted by congressional opponents who, lacking the votes to amend the law itself, sought to impede, through appropriations, CMS's ability to administer the program as mandated by the ACA. In particular, in the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. No. 113-235) ("2015 Spending Rider"), the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Rider"), and the Consolidated Appropriations Act, 2017 (Pub. L. No. 115-31) ("2017 Spending Rider," collectively, the "Spending Riders"), Congress prohibited CMS and HHS from using certain accounts to fund the Government's risk corridors payment obligations. Specifically, Congress prohibited CMS from using the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, as well as funds transferred from other accounts funded by the Spending Riders to the CMS Program Management account, for the applicable fiscal years.

12. The practical effect of the Spending Riders was that CMS chose not to pay QHP issuers their full risk corridor receivable amounts due for 2014, 2015, and 2016. During 2014, QHP issuers incurred almost $2.9 billion in losses that were compensable under the risk corridor

provisions of the ACA. The QHP issuers on the whole incurred even greater compensable losses in 2015 and 2016 which CMS has not paid because of the Spending Riders.

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

14. Plaintiff in this action is a nonprofit corporation organized under the laws of South Dakota, with its principal place of business in Sioux Falls, South Dakota. Plaintiff is a QHP issuer under the ACA.

15. In 2016, Plaintiff provided health insurance to its members on the North Dakota, South Dakota, and Iowa marketplaces.

16. Plaintiff is owed $13,254,651.00 for its participation in the North Dakota, South Dakota, and Iowa marketplaces for benefit year 2016.

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

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

JURISDICTION

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

153.510(b) is a money-mandating regulation that implements Section 1342 and thus also obligates payment from the federal government to QHP issuers that satisfy certain criteria.

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

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

PARTIES

22. Plaintiff, SHP, is a nonprofit corporation organized under the laws of South Dakota, with its principal place of business in Sioux Falls, South Dakota.

23. SHP is a nonprofit QHP issuer participating in the exchanges in North Dakota, South Dakota, and Iowa. Overall, SHP has nearly 180,000 members through its fully insured and self-funded health care benefits offered to individuals, families, and businesses. SHP is accredited as a Commercial and Marketplace health maintenance organization with the National Committee for Quality Assurance. SHP began providing affordable, high-quality health plans in South Dakota in 1998.

24. SHP is part of Sanford Health, a non-profit, integrated health system headquartered in Sioux Falls, South Dakota. Sanford Health is one of the largest health systems in the nation with presence in nine states and four countries, and includes 43 hospitals and nearly 250 clinics. Sanford Health's 27,000 employees, including 1,400 physicians, make it the largest employer in the Dakotas. Sanford Health is a recognized leader in health care and strives to provide patients across its vast geography with convenient access to expert medical care, leading-edge technologies and world-class facilities. In addition to strong clinical care, Sanford Health is committed to education, community

growth and research, with initiatives in genomic medicine and specialized centers researching cures for type 1 diabetes, breast cancer, and other diseases.

25. SHP has conducted and participated in countless outreach and educational sessions throughout its service area on the availability of coverage through the ACA, the mechanics of the marketplace, and the benefit plans it offers.

26. In short, SHP has aggressively pursued the ACA's goal of connecting the people in its service area to insurance coverage opportunities with the understanding that a broader base of insured is better for the individuals within the pool and the overall functioning of the marketplaces

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

FACTUAL ALLEGATIONS

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

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

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

> (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall*** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under part D of title XVIII of the

> Social Security Act.
>
> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 of the target amount, the Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs ***for any plan year*** are more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.

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

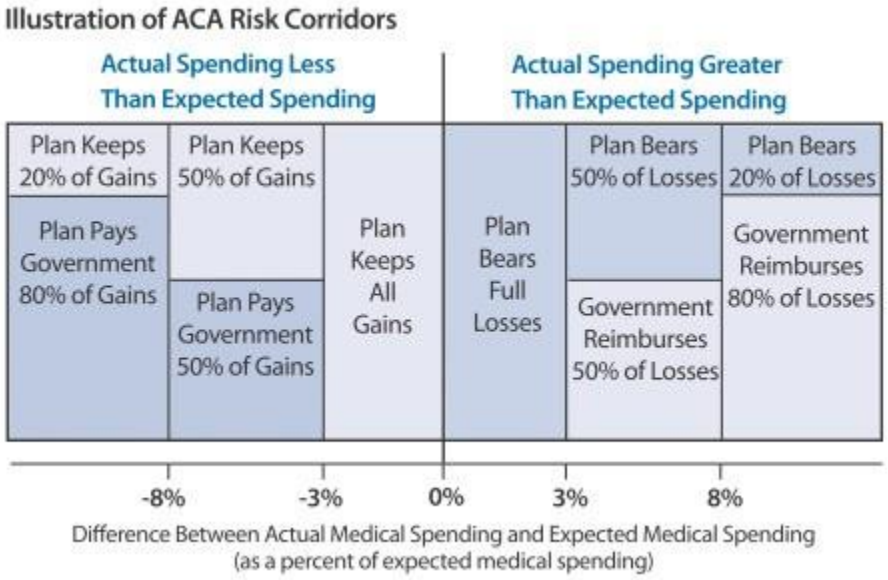
30. HHS implemented the RCP in the Code of Federal Regulations at 45 C.F.R. § 153.510. In relevant part, Section 153.510 states:

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

(Emphases added.)

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

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



33. The purpose of the RCP—in conjunction with the other of the Three Rs—was to induce health insurer participation in the health insurance exchanges by mitigating their risk of loss. Congress recognized that this could only work effectively if the payment obligations were honored on an annual benefit or plan year basis. The program would hardly be able to serve its

purpose of mitigation if, after incurring potentially millions of dollars in unbudgeted expenditures over a plan year, QHP issuers could not timely collect the reimbursements owed to them by the Government pursuant to the statutory formula as soon as the plan's accounting for the preceding year (which established the amounts owed) was finalized.

34. Section 1342 does not establish a fund into which QHP issuers must make payments due or from which payments must be made under the RCP, *i.e.*, the statute does not create a single account to service both payments in and payments out. Nor does the statute provide that the RCP must be budget neutral. In other words, payments out are ***not*** subject to payments in, and vice versa. The statute is clear that the Government will share in the losses for plans with higher-than-anticipated costs so that if, hypothetically, all plans have higher-than-anticipated costs, the Government would need to make payments even though there would be no insurer payments coming in. The program could not have been subject to budget neutrality for the reason stated in the preceding paragraph. Had the program been cabined by budget neutrality concerns, the ACA would have failed to attract sufficient insurers into the marketplace because the venture would have been too risky. HHS's timely payment to plans under the RCP is essential to realizing Congress's intent to stabilize premiums.

35. The fact that Section 1342 is expressly modeled on the Medicare Part D program, which is not required to be budget neutral, *see* 42 C.F.R. § 423.336, reinforces how Congress intended the RCP to work.

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

36. For QHP issuers to participate on the marketplaces for the 2014 benefit year (the first year of the ACA's health insurance exchanges), they had to submit their premiums to the appropriate state or federal regulatory authority during calendar year 2013 and their

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

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

C. The Risk Corridors Program is Contravened After Enactment.

38. Since its enactment, Congress has not altered the Government's RCP obligations.

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

[5] CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016), *available at* https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/2015-rc-issuer-level-report-11-18-16-final-v2.pdf; *see also* CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF ("Sept. 2016 Memo").

Despite this, the Government has taken several steps to frustrate the purpose the program was intended to serve: timely and complete payment to QHP issuers in order to retain them in the marketplaces and allow them to learn from and adapt to this uncharted new market.

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

40. The preamble to the 2015 Payment Rule stated:

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

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

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

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

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

corridors-04-11-2014.pdf.

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

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

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

45. On November 19, 2015, Defendant stated that "HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter ***as a fiscal year 2015 obligation of the United States Government for which full payment is required***." CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015). HHS thus concedes that the Government is obligated to make payment to QHP issuers under the RCP, despite to date only paying "12.6 percent" of what is owed toward 2014 and making a vague promise to pay more at some indeterminate point in the future.

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

46. In December 2014, Congress enacted the first of three appropriation riders prohibiting HHS's use of Medicare and certain other trust funds to make risk corridors payments. This "2015 Spending Rider" did not, however, eliminate the use of all funds in the CMS Program Management account, such as fees received by HHS for the federally-facilitated exchanges. And, more importantly, Congress *did not amend Section 1342 to require budget neutrality or to alter the underlying risk corridors obligations of the Government.* Given that the 2015 Spending Rider was enacted on December 16, 2014, nearly a year after QHP issuers began offering insurance on the newly formed exchanges, and approximately 18 months after they had submitted rates for regulatory approval, QHP issuers, including Plaintiff, continued to abide by their obligations to the Government and their insured, even while receiving little immediate guidance as to what would happen with the risk corridors payments.

47. In December 2015, Congress passed the 2016 Spending Rider, which continued the limits on the availability of funding for the RCP. As in the 2015 Spending Rider, the 2016 Spending Rider prohibited CMS from using trust funds and other accounts for the 2016 fiscal year to fund risk corridors payments. But, like the 2015 Spending Rider, *it did not amend*

Section 1342 to require budget neutrality or alter the underlying risk corridors obligations of the Government.

48. On September 9, 2016, CMS issued a memorandum reiterating the agency's understanding that the Government owed "full" payment to insurers. Sept. 2016 Memo. That memorandum was followed by testimony of CMS Acting Administrator Andy Slavitt before the House Energy and Commerce Committee on September 14, 2016. Among other things, Mr. Slavitt stated without equivocation in response to a question posed by a committee member that, notwithstanding the lack of an appropriation to fund the payments due insurers under Section 1342, it was "an obligation of the federal government" to remit full payment to insurers.[6]

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

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

50. SHP is a nonprofit insurer that invests millions of dollars in community endeavors designed to establish adequate health standards. It further promotes expansive benefits coverage and superb quality in its healthcare model and has provided coverage to traditionally underserved populations, particularly rural communities.

51. An issuer of QHPs is required by federal regulations to set its ACA-related health insurance rates well before the year they become effective. This creates a challenge for QHP

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

issuers like SHP, which seek to insure individuals who were previously uninsured and whose use of medical services once covered is difficult to predict.

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

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

54. On November 19, 2015, CMS released a document titled "Risk Corridors Payment and Charge Amounts for Benefit Year 2014," setting forth the amount of money CMS concedes that it owes to insurers (and is owed by insurers) for benefit year 2014 as a result of the risk corridors program. The calculations are separated into individual market and small group market. For benefit year 2014, SHP was *owed* $3,665,695.66 under the risk corridors program as a result of higher-than-expected allowable costs in the individual and small group markets. In total, including initial and subsequent payments, SHP has received $565,755.68 of the amount CMS concedes that it owes to SHP for benefit year 2014.

55. On September 9, 2016, HHS published guidance stating that all benefit year 2015 collections would be used to pay outstanding liabilities for the 2014 benefit year. Sept. 2016 Memo. That is, there would be no payments made for the 2015 benefit year. That decision by

itself demonstrates what HHS knows to be true: the RCP is not supposed to be budget neutral. Were it, there would be no reason for HHS to use payments in for the 2015 benefit year to make catch-up payments out for the 2014 benefit year. Rather, each year would be administered and accounted for based on the payments in for that particular year alone.

56. On November 18, 2016, CMS released a document titled "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year," setting forth the amount of money CMS concedes that it owes to insurers (and is owed by insurers) for benefit year 2015 as a result of the risk corridors program. The calculations are separated into individual market and small group market. For benefit year 2015, SHP was *owed* $5,869,541.98 under the RCP as a result of higher-than-expected allowable costs in the individual and small group markets. To date, CMS has paid no portion of the full amount CMS concedes that it owes to SHP for benefit year 2015.

57. The amounts the Government owes SHP for benefit years 2014 and 2015 are at issue in Case No. 17-357C.

F. 2016 Risk Corridors Payments Owed to Plaintiff.

58. Consistent with CMS regulations and its policy, Plaintiff began selling QHPs to consumers in North Dakota, South Dakota, and Iowa on or around November 1, 2015, with coverage effective January 1, 2016.

59. Plaintiff complied with its statutory requirements and submitted to HHS all data required by the ACA demonstrating that it experienced higher-than-expected allowable costs under the RCP for benefit year 2016, entitling Plaintiff to payment by HHS in the amount of $13,254,651.00.

60. On information and belief, and based upon the agency's treatment of 2014 and 2015 risk corridors payments due, HHS has no intention of making payment for the 2016 benefit year as required by the ACA. The 2017 Spending Rider prevents CMS and HHS from making

risk corridors payments from certain funding sources. HHS has not modified its position that it will continue to treat the RCP as "budget neutral" (although there is no basis in the ACA for doing so).

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

* * * * *

62. Regardless of HHS's statements that it will manage the RCP in a "budget-neutral" manner, and regardless of the Spending Riders' limiting the availability of certain funds to make payments owed to QHP issuers under the RCP, the fact remains that the obligations of the Government under the ACA RCP *have never been amended*. Section 1342 mandates payment to QHP issuers under certain conditions *without regard to budget neutrality*, and for the very purpose of stabilizing the market by mitigating annual losses of participating plans, a fact especially crucial for new entrants who relied on the promise of Congress that cost overruns would be partially mitigated through reimbursement. Notwithstanding subsequent agency pronouncements, *made only after QHP issuers such as Plaintiff, entered the market*, CMS's implementing regulation (Section 153.510) reflected the mandatory nature of the payments without regard to budget neutrality.

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

64. SHP sustained $13,254,651.00 of losses in the RCP for benefit year 2016,[7] an amount that is owed and presently due to Plaintiff under the express terms of Section 1342 of the ACA. By this lawsuit, Plaintiff seeks the immediate payment in full of risk corridors receivables for the 2016 benefit year so that it can continue to offer affordable health insurance as contemplated by the ACA.

CLAIM FOR RELIEF

COUNT I

(Violation of Statutory and Regulatory Mandate to Make Payments)

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

66. As part of its obligations under Section 1342 of the ACA and its obligations under 45 C.F.R. § 153.510(b), the Government is required to pay any QHP issuer certain amounts exceeding the target costs they incurred in 2016.

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

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

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

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

failures.

COUNT II

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

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

71. Plaintiff entered into a valid implied-in-fact contract with the Government regarding the Government's obligation to make full and timely risk corridors payments to Plaintiff in exchange for Plaintiff's agreements to become a QHP issuer and participate in the North Dakota, South Dakota, and Iowa exchanges.

72. Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's repeated admissions regarding their obligation to make risk corridor payments were made or ratified by representatives of the Government, including, but not limited to, Kevin Counihan, Director of Consumer Information and Insurance Oversight ("CCIIO") and CEO of the Health Insurance Marketplaces; Andrew Slavitt, Administrator of CMS; or other CMS officials, all of whom had actual authority to bind the Government. Section 1342, CMS's implementing regulations, and the repeated admissions by agency officials with authority to bind the Government constitute a clear and unambiguous offer by the Government to make full and timely risk corridor payments to health insurers, including Plaintiff, that agreed to participate as QHP issuers in the ACA marketplaces. This offer evidences a clear intent by the Government to contract with Plaintiff.

73. Plaintiff accepted the Government's offer by agreeing to become a QHP issuer, accepting the obligations, responsibilities, and conditions the Government imposed on QHP issuers under the ACA, *inter alia*, 45 C.F.R. §§ 153.10 *et seq*. and 155.10 *et seq.*, and proceeding

to provide health insurance on the North Dakota, South Dakota, and Iowa exchanges. Plaintiff satisfied and complied with its obligations and conditions which existed under the implied-in-fact contract.

74. The Government's agreement to make full and timely risk corridor payments was a significant factor material to Plaintiff's decision to participate in the North Dakota, South Dakota, and Iowa exchanges.

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

76. The implied-in-fact contract was also supported by mutual consideration: The RCP's protection from uncertain risks and new market instability was a real benefit that significantly influenced Plaintiff's decisions to agree to become a QHP issuer and participate in the North Dakota, South Dakota, and Iowa exchanges. Plaintiff, in turn, provided a real benefit to the Government by agreeing to become a QHP issuer and participating in the North Dakota, South Dakota, and Iowa exchanges, as adequate insurer participation was crucial to the Government achieving the overarching goal of the ACA exchange programs—to guarantee the availability of affordable, high-quality health insurance coverage for all Americans by protecting consumers from increases in premiums due to health insurer uncertainty.

77. The Government induced Plaintiff to participate in the North Dakota, South Dakota, and Iowa exchanges for benefit year 2016 by including the RCP in Section 1342 of the ACA and its implementing regulations, by which the Government committed to help protect

health insurers financially against risk selection and market uncertainty.

78. The Government repeatedly acknowledged its commitments to share risk with QHP issuers and its obligations to make full and timely risk corridors payments to qualifying QHP issuers through its conduct and statements to the public and to Plaintiff and other similarly situated QHP issuers, made or ratified by representatives of the Government who had express or implied actual authority to bind the Government. *See, e.g.*, 77 Fed. Reg. 17,220, 17,238 (Mar. 23, 2012).

79. The Government also induced Plaintiff to participate in the marketplaces during and after HHS and CMS's announcement in 2014 of their intention to implement the RCP in a budget neutral manner, by repeatedly giving assurances to QHP issuers, including Plaintiff, that risk corridors collections will be sufficient to cover all of the Government's risk corridors payments, and that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("We anticipate that risk corridors collections ***will be sufficient*** to pay for all risk corridors payments.") (emphasis added); Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2015) ("***In the unlikely event of a shortfall*** for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, ***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations.") (emphases added).

80. The Government continued to induce Plaintiff to commit to participating in the North Dakota, South Dakota, and Iowa exchanges for benefit year 2016 by providing assurance that QHP issuers will receive full payments regardless of the collection amount. *See, e.g.*, Sept. 2016 Memo ("As we have said previously, in the event of a shortfall for the 2016 benefit year,

HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations.").

81. HHS and CMS acknowledged and published the full risk corridors payment amount of $3,665,695.66 that the Government concedes it owes SHP for benefit year 2014. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015).[8]

82. HHS and CMS also acknowledged and published the full risk corridors payment amount of $5,869,541.98 that the Government concedes it owes SHP for benefit year 2015. *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016).

83. Under the same calculation validated by CMS for benefit years 2014 and 2015, CMS owes Plaintiff $13,254,651.00 for benefit year 2016.

84. Because Plaintiff accepted the Government's unilateral offer by beginning performance in or around October 2015, Congress's *subsequent* failure to appropriate sufficient funds for risk corridor payments in May 2017 did not extinguish the Government's extant contractual obligation to make full and timely risk corridor payments to Plaintiff. This contractual obligation survives and is enforceable regardless of whether the Court believes that the Spending Riders modified or repealed Section 1342 of the ACA. Once the contract became binding, the Government was—and remains—liable to make full payment to Plaintiff, using the Judgment Fund if necessary. Plaintiff is entitled to full payment from the Judgment Fund of the $13,254,651.00 in benefit year 2016 risk corridors payments.

85. The Government's failure to make full and timely risk corridor payments to Plaintiff is a material breach of the implied-in-fact contract, and Plaintiff has been damaged by

[8] For benefit year 2014, SHP "owed" the Government $562,300.01 for lower-than-expected allowable costs in the North Dakota marketplace as a result of the RCP, which SHP timely paid.

this failure. Plaintiff therefore brings a claim for damages of $13,254,651.00 against the Government founded upon the Government's violation of an implied-in-fact contract.

PRAYER FOR RELIEF

Plaintiff requests the following relief:

A. That the Court award Plaintiff monetary relief in the amount of $13,254,651.00 for benefit year 2016 to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b);

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

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

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

October 4, 2017

Respectfully submitted,

/s/ Stephen McBrady

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CERTIFICATE OF SERVICE

I certify that on October 4, 2017, a copy of the forgoing "Complaint" was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

/s/ Stephen McBrady
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