Receipt number AUSFCC-6541035

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

PIEDMONT COMMUNITY HEALTHCARE, INC.,	)	
and	)	
PIEDMONT COMMUNITY HEALTHCARE HMO, INC.,	)	
Plaintiffs,	)	
v.	)	**CLAIM NO** 20-1431 C
UNITED STATES OF AMERICA, acting through the UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES and CENTERS FOR MEDICARE AND MEDICAID SERVICES,	)	
Defendant.	)	

COMPLAINT

Plaintiffs, Piedmont Community Healthcare, Inc. ("PCHC") and Piedmont Community Healthcare HMO, Inc. ("PHMO") (as used herein, "Piedmont" refers to PCHC and PHMO, collectively, or to PCHC or PHMO, individually, as the context requires), bring this complaint against Defendant United States of America, acting through the United States Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"). The Defendant has (1) refused to remit risk corridors payments owed and payable to Piedmont under a federal money-mandating statute and its implementing regulations, and (2) breached its contracts with Piedmont, directly and proximately causing Piedmont to suffer over two million dollars in damages. Piedmont alleges as follows:

NATURE OF THE ACTION

1. When it enacted the sweeping healthcare reforms in the Patient Protection and Affordable Care Act (the "ACA"), Congress recognized that health insurers faced enormous financial risks and uncertainty if they participated in the new marketplace for health coverage created by the ACA. To guarantee Americans access to affordable health plans regardless of medical history, health insurers would have to depart from decades of established underwriting practices. For the first time, insurers would be prohibited by law from adjusting individual premiums based on an applicant's health status. Participating insurers would be required to price their health plans with little to no data about the health status and potential medical costs of their new (and previously uninsured) customers. And for the first time, health insurance products would be sold through federally regulated internet marketplaces or exchanges ("Exchanges"), which would require insurers to implement a host of technological, personnel, and compliance changes. Given the uncertainties of this new market, with an unknown number of enrollees and limited information to price their products effectively, many health insurers initially declined to participate. But not Piedmont.

2. From 2015 onward, Piedmont agreed to support the ACA's vision of healthcare reform. It did so, in part, because Congress took steps to ensure that the government would share some (though not all) of the enormous financial risks of early participation in the Exchanges.

3. Recognizing it could not force health insurers to participate—and hoping to encourage them to *choose* to join the Exchanges—Congress adopted the ACA's "risk corridors" provision, 42 U.S.C. § 18062, which ensured that the federal government would share some of the risk borne by participating insurers in each of the first three years (2014–2016) of the Exchanges.

4. The ACA's risk corridors provision requires the federal government to pay a defined amount to a participating insurer if the insurer incurs greater-than-expected claims and health-quality-improving costs relative to premiums ("Excess Costs") and, conversely, to collect a defined amount from an insurer that incurs lower-than-expected claims and health-quality-improving costs relative to premiums ("Excess Gains"). By limiting the degree of an insurer's losses or gains when costs were difficult to predict, the risk corridors provision was intended to stabilize premiums during the initial years of healthcare reform (2014-2016). The contracts between Piedmont and the federal government incorporated that basic bargain, and Piedmont reasonably expected and relied upon the federal government to live up to its part of the deal.

5. Indeed, the ACA *mandated* that the federal government share Excess Costs with health insurers participating in the Exchanges (like Piedmont), which, in the language of the statute, are known as issuers of Qualified Health Plans (or "QHPs"). The ACA is unequivocal that "for calendar years 2014, 2015, and 2016": (1) QHP issuers "shall participate" in the risk corridors program; (2) the Secretary of HHS "shall pay" for QHP issuers' greater-than-expected *costs*; and (3) QHP issuers, in turn, "shall pay" the Secretary for excess *gains*. *See*, 42 U.S.C. § 18062.

6. This statutory requirement was reinforced by HHS regulations. Throughout 2013—during the period when insurers were deciding whether to join the Exchanges—HHS publicly affirmed its commitment to pay issuers any risk corridors obligations in full. That same year, HHS issued a final rule that echoed the language of the statute, stating unambiguously that the Secretary "**shall make payment**" under the risk corridors provision to compensate for a fraction of large losses that may be incurred in the first benefit year—2014. The final rule emphasized the agency's commitment to prompt and full risk corridors payments to promote

"greater payment stability," to "protect against uncertainty in rate setting," and to limit "the extent of issuers' financial losses."

7. Relying on these statutory and regulatory mandates, Piedmont entered into contracts with Defendant to issue QHPs on the Exchanges in 2015 and 2016. The language of those contracts reflected the parties' symmetrical obligations to make risk corridors payments. The contracts defined Piedmont as an issuer of QHPs and incorporated by reference applicable provisions of the ACA and its accompanying regulations. As part of the contracting process, Defendant required Piedmont to formally attest to its understanding of its obligations under the risk corridors provision as a QHP issuer, underscoring the parties' mutual understanding that the risk corridors payments were fundamental to the bargain. Having reached a binding agreement with the government, Piedmont made good on its end of the bargain. It invested a significant amount of time, money, and resources to develop and sell new kinds of insurance products that conformed to the ACA's novel standards for coverage and to build, pay for, and expand a healthcare provider network on the Exchanges. Piedmont ultimately provided quality health insurance coverage and services through the Exchanges to over 7,000 ACA beneficiaries in 2015 and 2016.

8. But when the risk corridors bill came due, the Defendant balked and breached its agreements. Although it has conceded that it owes Piedmont over two million dollars under the two years of the risk corridors program in 2015 and 2016 (*i.e.*, the portion of Piedmont's losses for which the government was partly responsible), the government has failed to meet its obligations. Ignoring both the statute and its contracts with Piedmont, as well as its prior regulatory pronouncements, Defendant has chosen to administer the risk corridors program in a "budget neutral" manner, meaning that the portion of Piedmont's losses covered under the risk

corridors formula can be paid only from other issuers' payments into the program. In other words, instead of spreading the risk between the government and health insurers as required by Congress, the government has reversed itself, changed the bargain, and taken the position that the risk corridors program spreads the risk *among insurers alone*. Defendant adopted this "budget neutral" payment criteria only *after* executing its first contracts with Piedmont and only *after* Piedmont had already covered the healthcare costs of more than 7,000 residents in Virginia who purchased policies through the Exchanges.

9. Specifically, CMS determined that if costs (*i.e.*, the risk corridors obligations owed by the Secretary to QHP issuers) exceed gains (*i.e.*, the risk corridors obligations owed by QHP issuers to the Secretary), then CMS would only pay QHP issuers (like Piedmont) their risk corridors losses on a *pro rata* basis. In accordance with this decision, by the close of the three years of the risk corridors program (2014-2016), CMS had paid none of its obligations to Piedmont for benefit years 2015 and 2016.

10. As determined as a matter of law by the United States Supreme Court in its recent decision dated April 27, 2020, in the case *Maine Community Health Options v. United States*, 140 S. Ct. 1308, 206 L. Ed. 2d 764 (2020), the Defendant was legally obligated under Section 1342 of the ACA to make *full* risk corridor reimbursement payments to Piedmont, and that obligation was not repealed or otherwise set aside by subsequent appropriations riders. Furthermore, the United States Supreme Court has held that insurers like Piedmont could sue the Defendant for damages under the Tucker Act (28 U.S.C. §1491) in order to fully recover amounts due and owing to them. That decision is controlling in this case as a matter of law. For the reasons set forth below, Piedmont should be awarded a full and final judgment in the amount demanded herein.

JURISDICTION AND VENUE

11. This is an action for damages and declaratory relief based on the violation of a money-mandating statute and for breach of contract under the Tucker Act, 28 U.S.C. § 1491.

12. This Court possesses subject matter jurisdiction over this action under 28 U.S.C. § 1491(a)(1), and venue is proper before the U.S. Court of Federal Claims because Plaintiffs seek damages from the United States in excess of $10,000.

THE PARTIES

13. Plaintiff Piedmont Community Healthcare, Inc. is, and at all times mentioned herein was, a corporation organized and existing under the laws of the Commonwealth of Virginia with an office and principal place of business in Lynchburg, Virginia.

14. Plaintiff Piedmont Community Healthcare HMO, Inc. is, and at all times mentioned herein was, a corporation organized and existing under the laws of the Commonwealth of Virginia with an office and principal place of business in Lynchburg, Virginia.

15. Defendant is, and was at all times relevant hereto, a governmental entity organized under federal law with the capacity to enter contracts, sue, and be sued. Defendant acted through CMS and HHS. HHS is, and at all times relevant hereto was, an agency of the United States, and is statutorily charged with administering and implementing the ACA. HHS is headquartered at 200 Independence Avenue, S.W., Washington, District of Columbia 20001. CMS is, and at all times relevant hereto was, an agency of the United States, operating as an instrumentality of HHS. CMS administers the Medicare program and works in partnership with state regulators to administer Medicaid and other programs, including implementation of the ACA. CMS is headquartered at 7500 Security Boulevard, Baltimore, Maryland 21244.

FACTUAL BACKGROUND

A. HEALTHCARE REFORM

16. On March 23, 2010, President Barack Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act. The following week, the president signed into law H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which amended H.R. 3590. Together, this legislation effected sweeping reforms to the national health insurance marketplace.

17. Among its reforms, the ACA required the establishment of Exchanges in each state for the purchase of insurance in the individual and small-group markets. Health plans offered on the Exchanges must satisfy specific criteria set by CMS and, in some cases, state regulators. *See* 45 C.F.R. § 155.1000 (certification standards for QHPs). And CMS must approve QHPs offered through Exchanges operated by CMS. *See id*. To expand coverage and decrease costs for millions of Americans, the ACA enacted a set of insurance-market regulations that, effective January 1, 2014, barred health plans from denying coverage or charging higher premiums to individuals based on factors such as health status or gender (*i.e.*, "community rating" and "guaranteed issue" requirements). *See* 42 U.S.C. §§ 300gg (health insurance premiums), 300gg-1 (guaranteed availability of coverage).

18. Congress recognized that these groundbreaking reforms posed substantial financial risk to participating health insurers. Historically, insurers set premium rates annually based upon their past experience and anticipated costs related to their pool of enrollees. Health insurers, contemplating participation on the Exchanges in its initial years, faced significant uncertainty regarding, among other things, who would buy insurance through the new Exchanges, the volume of insurance that would be purchased, the medical history of enrollees, and a host of

other data points that typically inform premium rate-setting. Moreover, because the central purpose of the ACA was to provide insurance for people who were previously uninsured, many new enrollees were expected to have untreated medical needs, chronic conditions, and other ailments requiring immediate and significant medical care at great cost.

B. THE RISK CORRIDORS PROGRAM

19. Defendant recognized that, absent government intervention, health insurers would respond to this uncertainty by including a margin in their premium pricing to offset the potentially high cost of insuring new enrollees, especially during the early years of the Exchanges. This pricing strategy, in turn, would make the offered health plans less affordable and discourage enrollment in the new Exchanges, frustrating one of the primary purposes of the ACA.

20. The ACA's risk corridors provision established a temporary premium stabilization program that was intended to be in effect for the first three years of the Exchanges (2014-2016). *See*, 42 U.S.C. § 18062. To encourage participating insurers to set premiums for QHPs that were neither too high nor too low, the ACA created a system under which HHS was to make payments to QHP issuers that incurred annual costs in excess of a specified percentage of premiums, and to receive payments from QHP issuers that realized annual gains in excess of a specified percentage of premiums. *Id.* § 18062(b); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744, 13746 (Mar. 11, 2014) ("2015 Final Rule") ("Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that provides for the *sharing in gains or losses* resulting from inaccurate rate setting from 2014 through 2016 *between the Federal government and certain participating plans*.") (emphasis added).

21. Specifically, Section 1342(a) of the ACA provides that QHP issuers "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 1342(a), 124 Stat. 211 (Mar. 23, 2010) *codified at* 42 U.S.C. § 18062(a).

22. Section 1342(b)(1) provides that "the Secretary **shall** pay" to the QHP issuer a given amount to compensate for certain costs the plan incurs as a result of its allowable costs exceeding its premiums. *Id.* § 18062(b)(1) (emphasis supplied). Section 1342(b)(2), in contrast, provides that a QHP issuer "shall pay to the Secretary" a given amount to account for certain gains the plan recognizes because the amounts it collects in premiums exceed its allowable costs. *Id.* § 18062(b)(2).

23. The risk corridors provision specifies a clear mandate to remit and collect payments, with defined parameters of payment, for the Secretary to follow. 42 U.S.C. § 18062(b)(1)(A) ("The Secretary shall provide under the [risk corridors] program that if . . . a participating plan's allowable costs for any benefit 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 . . . ."). Although the payment and receipt formulas are symmetrical, the text of the risk corridors provision does not cap total payouts or total receipts. *Id.* § 18062. Thus, by its terms, the statute could result in *no* QHP issuer paying into the program, but *all* issuers receiving risk corridors payments. And conversely, it could also result in *all* issuers paying into the program, but *no* issuers receiving payments. In short, the risk corridors program was not structured to operate in a budget-neutral fashion.

24. On March 11, 2013, HHS issued the Notice of Benefit and Payment Parameters for 2014. This notice was the final rule for 2014 payments related to the risk corridors provision. *See generally*, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15410 (Mar. 11, 2013) ("2014 Final Rule").

25. In the 2014 Final Rule, HHS recognized that the risk corridors provision was designed to "provide issuers with greater payment stability as insurance market reforms are implemented and [to] facilitate increased enrollment." *Id.* at 15411. HHS reiterated that the risk corridors program "will protect against uncertainty in rate setting [by QHPs] by limiting the extent of issuers' financial losses and gains." *Id.* HHS also stated that "the premium stabilization programs (risk adjustment, reinsurance, and risk corridor) decrease the risk of financial loss that health insurance issuers might otherwise expect in 2014." *Id.* at 15414.

26. HHS also explicitly acknowledged in the 2014 Final Rule that the ACA risk corridors provision did *not* require budget neutrality and that the risk corridors program was designed to share risk between the health plans and the federal government: "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." *Id.* at 15473 (emphasis added).

C. CONTRACTING PROCESS TO OFFER HEALTH PLANS ON EXCHANGES

i. *Benefit Year 2015.*

27. Following its representations regarding the risk corridors programs, on April 5, 2013, HHS issued a "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" (the "Letter to Issuers") soliciting health insurers to offer plans on the Exchanges and outlining the process for doing so. In the Letter to Issuers, HHS stated that it had "provided guidance on

market-wide and QHP certification standards, eligibility and enrollment procedures, and other Exchange-related topics in several phases." HHS advised issuers "to consult these materials in conjunction with the Letter to ensure full compliance with the requirements of the [ACA]." An appendix to the letter contained what HHS described as "the most relevant regulations and guidance documents" and included statutory and regulatory provisions governing the risk corridors program.

28. The Letter to Issuers provided detailed instructions on the necessary steps issuers had to take to offer health plans on the Exchange. The Letter to Issuers explained the different processes for issuers operating on Federally-Facilitated Exchanges ("FFEs"), as opposed to those operating on State Partnership Exchanges ("SPEs"). For FFEs, CMS would conduct the review of health plans and make its own evaluations regarding plan approval. For SPEs, CMS would take recommendations from the state as to each plan and then decide whether to approve the plans as QHPs.

29. As detailed in the Letter to Issuers, the first step in the process was for issuers to submit a QHP Application. The Application consisted of a number of submissions detailing the issuer's operations and administrative information, as well as their plan offerings.

30. Significantly, the Letter to Issuers explained that the certification process would be completed with a "signed QHP Agreement," designed to "highlight and memorialize many of the QHP issuer's statutory and regulatory requirements and [to] serve as an important reminder of the relationship between the QHP issuer and CMS."

31. The Letter to Issuers also required all applicants to submit Attestations in which issuers certified their ability to adhere to certain requirements set forth in the ACA and its implementing regulations. The Attestations specifically required each applicant to "attest[] that

it will adhere to the risk corridor standards and requirements set by HHS as applicable for (a) risk corridor data standards and annual HHS Notice of Benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 C.F.R § 153.510); and (b) remit charges under the circumstances described in 45 C.F.R. § 153.510(c).” The Attestations, therefore, incorporated the regulations mandating annual risk corridors payments to QHP issuers participating in the Exchanges.

32. On or around May 2, 2014, Piedmont submitted its QHP Application for Virginia.

33. On July 10, 2014, Piedmont submitted its Attestations to the Virginia Bureau of Insurance (“VBI”).

34. QHP applicants were also required to submit proposed rates for approval, as well as a memorandum detailing their reasoning and justifications for the proposed rate. *See* 45 C.F.R. § 154.215(b)(3), (f). Each Actuarial Memorandum certified, based on certain assumptions outlined in the Memorandum, that “the proposed rates would be adequate if the assumptions [were] realized.” The Actuarial Memorandum explained that “[i]n the best of circumstances, there is inherent uncertainty in health insurance pricing assumptions,” and that the new regulatory framework created by the ACA “introduce[d] unprecedented risk and uncertainty into the rate development process.” The risk corridors program—which would help to defray Piedmont’s losses in the event that these “unprecedented risks” were realized—was material to Piedmont’s decision to participate in the Exchanges in 2015 and 2016.

35. Piedmont submitted its final proposed rates to CMS (or the relevant state regulator) on July 7, 2014.

36. Later in 2014, CMS confirmed to Piedmont that CMS (or the relevant state regulator) had reviewed and approved Piedmont’s QHP Application.

37. The Defendant then sent to Piedmont a Qualified Health Plan Issuer ("QHPI") Agreement and instructed Piedmont to complete, sign, and return the QHPI Agreement. A true and correct copy of the fully executed QHPI Agreement for the Piedmont plans for 2015 which was executed by Piedmont on October 20, 2014, is attached hereto as **Exhibit A.**

38. The QHPI Agreement between CMS and Piedmont for 2015 noted that the relationship between the parties was founded on the ACA and its related regulations: "Section 1301(a) of the Affordable Care Act ('ACA') provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish." (*See, e.g.*, Ex. A at 1.)

39. The QHPI Agreement stated that the contract was entered "in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge." (*Id.*)

40. Among other points, the QHPI Agreement memorialized the parties' commitment to a monthly "reconciliation process" through which amounts owed between the parties would be transmitted: "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) *with respect to offering of QHPs*, including the following types of payments: APTC [advance payment of tax credits], advance payments of CSRs, and payment of Federally-facilitated Exchange user fees." (*See, e.g., id.* at 5 (emphasis added).)

41. The QHPI Agreement between Piedmont and Defendant for 2015 reflects the understanding that Piedmont was a contractor to Defendant. For example, the agreement required Piedmont to "assume ultimate responsibility" for any services and functions "that are assigned or

subcontracted," and ensure that any "subcontractor . . . will perform all functions in accordance with all applicable requirements." (*See, e.g.*, *id*. at 7 (emphasis added).)

42. The QHPI Agreement is "governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws, statutes or rules." (*See, e.g.*, *id.* at 8.) Those laws and regulations include the ACA and the regulations codified thereunder, including those specifically governing the risk corridors program. *See, e.g.*, 42 U.S.C. §18062(a); 45 C.F.R. § 153.510(d).

43. Kevin J. Counihan, Acting Deputy Director, Operations, for CMS's Center for Consumer Information & Insurance Oversight ("CCIIO"), David J. Nelson, Deputy Chief Operating Officer and Chief Information Officer for CMS, and Todd A. Lawson, Acting Director for the Office of E-Health Standards and Services and Acting Senior Official for Privacy Centers for CMS, with authority to bind the government in contract, executed the QHPI Agreement for 2015 with Piedmont on October 28, and 29, 2014 (*See, e.g.*, Ex. C at 11.) The contract was effective that same day. (*Id*. at 5.).

ii. *Benefit Year 2016.*

44. As benefit year 2015 was underway, Piedmont and CMS engaged in a similar negotiation process, culminating in CMS's acceptance of Piedmont's plan offerings (both through Piedmont Community Healthcare, Inc. and through Piedmont Community Healthcare HMO, Inc.) and execution of another QHPI Agreement for benefit year 2016.

45. Like the process for benefit year 2015, Piedmont submitted an Attestation for the 2016 benefit year in 2015.

46. Through the 2016 Attestation, Piedmont again agreed to comply with several terms related to the ACA and its implementing regulations; to create a compliance plan; to comply with rate requirements; to adhere to rules for enrollment of insureds; to be bound by certain regulations governing user fees; and to report to the Exchanges the data and information required by HHS.

47. Like the process for the prior benefit year 2015, Piedmont submitted and CMS returned countersigned QHPI Agreements to Piedmont dated September 20, 2015, and October 8, 2015 (for both PPO and HMO) for benefit year 2016. A true and correct copy of the fully executed 2016 QHPI Agreements for the Piedmont plan are collectively attached hereto as **Exhibit B.**

48. The 2016 QHPI Agreements again noted that the relationship between the parties was founded on the ACA and its implementing regulations: "Section 1301(a) of the Affordable Care Act ('ACA') provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish." (*See, e.g.,* Ex. B at 1.)

49. The 2016 QHPI Agreements again described the Piedmont plan: "QHPI is an entity licensed by an applicable State Department of Insurance ('DOI') as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs." (Ex. B at 1.)

50. The 2016 QHPI Agreements again stated that it was entered "in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge." (Ex. B at 1.)

51. The 2016 QHPI Agreements again memorialized the parties' commitment to a monthly "reconciliation process" through which amounts owed between the parties would be

transmitted: "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) *with respect to offering of QHPs*, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees." (*See, e.g.*, Ex. B at 5 (emphasis added).)

52. The 2016 QHPI Agreements again reflected the understanding that Piedmont was a contractor of Defendant. For example, the Agreement required Piedmont to "assume ultimate responsibility" for any services and functions "that are assigned or *subcontracted*," and ensure that all "subcontractors . . . will perform all functions in accordance with all applicable requirements." (*See, e.g.*, Ex. B at 7 (emphasis added).)

53. The 2016 QHPI Agreements again specified that they were "governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws, statutes or rules." (*See, e.g.*, Ex. B at 7.) Those laws and regulations include the ACA and the regulations codified thereunder, including those specifically governing the risk corridors program. *See, e.g.*, Pub. L. No. 111-148, § 1342(a); 42 U.S.C. §18062(a); 45 C.F.R. § 153.510(d).

D. CONGRESS RESTRICTS DEFENDANT'S USE OF CERTAIN FUNDING SOURCES TO SATISFY DEFENDANT'S RISK CORRIDORS PAYMENT OBLIGATIONS.

54. As 2014 drew to a close, after Piedmont and CMS had entered into the QHPI Agreement for 2015, and after Piedmont was beginning to duly perform its obligations under its

agreement for the upcoming 2015 benefit year, Congress attempted to block certain sources of payments that had previously been set forth in the ACA and previous proposed rules.

55. On December 16, 2014, Congress passed, and the president signed, a continuing resolution funding the government for fiscal year 2015. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (hereinafter "the Act"). The Act prohibited the use of funds from the fiscal year 2015 appropriation for the Medicare trust fund or CMS's Program Management Account to make risk corridors payments to QHP issuers. *Id.* § 227, 128 Stat. at 2491 ("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 corridor).").

56. The Act, however, neither amended nor repealed Section 1342 of the ACA. Thus, while Congress may have restricted the funding sources from which HHS could pay its risk corridors obligations, it left untouched Defendant's statutory obligation to make full risk corridors payments on an annual basis. In *Maine Community Health Options v. United States*, the United States Supreme Court has ruled that these subsequent laws did not retroactively repeal or otherwise set aside the obligations for reimbursement set forth in Section 1342 of the ACA. *See Maine Cmty. Health Options*, 140 S. Ct. at 1323.

E. DEFENDANT FAILED TO REMIT FULL RISK CORRIDORS PAYMENTS TO PIEDMONT.

57. For benefit year 2015, CMS required QHP issuers to submit data for risk corridors payments by August 1, 2016. CMS, *Medical Loss Ratio and Risk Corridors Data Submission*

Deadline for the 2015 Benefit Year (July 26, 2016), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/RC-MLR-FAQ-072616.pdf; *see also* 45 C.F.R. § 153.530(d). Piedmont submitted estimates of risk corridors expected payments and charges for 2015 as required by its contract and applicable regulations. The amount anticipated by Piedmont was $124,064.75.

58. On September 9, 2016, HHS "announc[ed] preliminary information about risk corridors for the 2015 benefit year." It limited risk corridors payments to risk corridors collections, warning that it "anticipate[d] that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments," without paying anything for the 2015 benefit year. Significantly, HHS again "recognize[d] that the Affordable Care Act requires the Secretary to make full payments to issuers" and promised to "record risk corridors payments due as an obligation of the United States Government for which full payment is required." CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF.

59. On November 18, 2016, CMS announced that it had only collected $95.3 million in risk corridors payments for benefit year 2015 and confirmed that all of its collections would be "used to pay a portion of the government's balance" from the 2014 benefit year. *See* CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf.

60. For benefit year 2016, CMS required QHP issuers to submit data for risk corridors payments by July 31, 2017. CMS, *Medical Loss Ratio and Risk Corridors Training Information for the 2016 MLR Reporting Year* (May 9, 2017). *See* 45 C.F.R. § 153.530(d). Piedmont

submitted estimates of risk corridors expected payments and charges for 2016 as required by its contract and applicable regulations. Piedmont estimated the following amounts due under the risk corridors program as follows: (A) Piedmont Community Healthcare, Inc.: $1,215,090.86; (B) Piedmont Community Healthcare HMO, Inc.: $737,160.77.

61. On November 15, 2017, CMS announced that it had only collected $27 million in risk corridors payments for benefit year 2016 and confirmed that all of its collections would be "used to make additional payments toward 2014 benefit year payment balances." *See* CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

62. Therefore, the total amount due from the Defendant and payable to Piedmont at the close of the risk corridors program for benefits years 2015 and 2016 is **$2,076,316.38**.

CLAIMS FOR RELIEF

Count I

Violation of Statutory and Regulatory Mandates to Remit Risk Corridors Payments

63. Plaintiffs incorporate by reference as if set forth fully herein the allegations set forth in Paragraphs 1 through 62 above.

64. As part of its obligations under the ACA, HHS is required to "establish and administer a program of risk corridors for calendar years 2014, 2015 and 2016." 42 U.S.C. § 18062(a). The ACA states that HHS "*shall*" create this risk corridors program for each of the listed calendar years. *Id.* (emphasis added).

65. The ACA further provides that "the Secretary *shall* pay" to an issuer of a QHP a given amount to compensate for certain losses the plan incurs as a result of its allowable costs

exceeding its premiums. 42 U.S.C. § 18062(b)(1) (emphasis added). This payment formula contains no restriction conditioning the Defendant's obligation on the availability of appropriations.

66. The Final Rule governing the risk corridors program for the 2014 benefit year also establishes that risk corridors payments are mandatory, notwithstanding the availability of appropriations. This Rule states that "QHP issuers *will* receive payment from HHS in the following amounts, under the following circumstances: (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount." 45 C.F.R. 153.510(b) (emphasis added).

67. Plaintiffs are QHP issuers, and were certified as such by HHS through CMS, and they operated on the Exchanges through all of 2015 and 2016.

68. Plaintiffs satisfied the requirements established by Section 1342 of the ACA, and as a result, Defendant is legally obligated to make the payments required by Section 1342.

69. As held by the United States Supreme Court in the controlling case *Maine Community Health Options v. United States*, 140 S. Ct. 1308, 1331 (2020), Defendant's refusal to remit to Plaintiffs the full amount of the risk corridors payments owed for 2015 and 2016 violates the ACA and its implementing regulations as a matter of law.

70. Defendant has failed and refused, without justification, to perform its statutory obligations by refusing to remit the full risk corridors payments owed to Plaintiffs as required by 42 U.S.C. § 18062 and 45 C.F.R. § 153.510(b).

71. Defendant's violation of the ACA and its implementing regulations proximately caused Plaintiffs to suffer monetary damages, which amount will be proven at trial, but which amount is at least $2,076,316.38.

Count II

Breach of Express Contract

72. Plaintiffs incorporate by reference as if set forth fully herein the allegations set forth in Paragraphs 1 through 71 above.

73. The documents exchanged between Plaintiffs and CMS during the QHP qualification processes for 2015 and 2016 together constitute a valid and enforceable written contract between Plaintiffs and Defendant.

74. Defendant solicited bids to participate in the Exchanges through its "Letter to the Issuers."

75. The documents that Plaintiffs submitted in response to Defendant's solicitation constituted an offer to contract with Defendant to include its health insurance plans on the Exchanges.

76. Defendant accepted Plaintiffs' offer to that each of Plaintiffs' QHPs would be included on the Exchanges and delivering the counter-signed QHPI Agreements.

77. The government representatives who bound Defendant to these contracts had actual authority to do so. At all times relevant here, Defendant's representatives had the actual authority to and did bind HHS to these contractual commitments.

78. The QHPI Agreements "memorialize" the contractual relationship between Plaintiffs and Defendant.

79. The parties mutually exchanged consideration to support the QHPI Agreements. In consideration, Plaintiffs and Defendant agreed to abide by the ACA. As further consideration, Plaintiffs expended significant time, money, and resources to provide affordable healthcare to over 7,000 Americans in benefit years 2015 and 2016, satisfying an essential part of Defendant's regulatory mandate under the ACA. Plaintiffs also undertook to develop and sell new kinds of insurance products that conformed to the ACA's novel standards for coverage on the Exchanges, thereby enabling Defendant to fulfill its statutory mandate. Plaintiffs also built, paid for, and expanded a health care provider network in support of their QHPs. Defendant committed to mitigating Plaintiffs' risk of participating in the Exchanges during the early years of the ACA through the ACA's premium stabilization programs, including a commitment to make any risk corridors payments in full that were required by the statute and regulations. Defendant also committed to administering the Exchanges in conformity with the ACA.

80. Plaintiffs have fully performed their duties under their contracts with Defendant.

81. Defendant's contracts with Plaintiffs incorporate the ACA, including the risk corridors provision and related regulations.

82. These QHPI Agreements define each Plaintiff as a QHP issuer, and QHP issuers are required by Section 1342 of the ACA to participate in the risk corridors program. *Id.*; 42 U.S.C. § 18062(a).

83. Defendant breached its contracts with Plaintiffs by, among other things, failing to fully pay risk corridors payments owed to Plaintiffs for the 2015 and 2016 benefit years.

84. Defendant's breach of its express contracts with Plaintiffs proximately caused Plaintiffs to suffer monetary damages which amount will be proven at trial, but which amount totals at least $2,076,316.38.

Count III

Breach of Implied Contract

85. Plaintiffs incorporate by reference as if set forth fully herein the allegations contained in the Paragraphs 1 through 71 above.

86. In the alternative to Count II, Plaintiffs and Defendant entered into an implied-in-fact contract that risk corridors payments due under the statutory formula detailed in ACA § 1342 and its implementing regulations would be remitted in the years in which they became due and payable.

87. The terms of the offer and acceptance were unambiguously specified in the ACA and its implementing regulations.

88. Defendant's intent to contract is demonstrated by the ACA, the implementing regulations, and Defendant's repeated representation of the risk corridors program as one intended to provide protection for participating QHP issuers, like Plaintiffs, by: stabilizing participating premiums, offsetting early losses, and removing uncertainty in rate setting. Further, Defendant consistently represented that the risk corridors provision was intended to "provide issuers with greater payment stability as insurance market reforms are implemented [and] to facilitate increased enrollment" and to "protect against uncertainty in rate setting [by QHPs] by limiting the extent of issuers' financial losses and gains." 2014 Final Rule, 78 Fed. Reg. at 15411.

89. Defendant's intent to contract is also demonstrated by its negotiations over Plaintiffs' final plan lists and its approval of Plaintiffs' submissions, including the Attestations.

90. Throughout the contracting process, Defendant repeatedly confirmed its understanding that the 2015 and 2016 contracts required "full payment" of the risk corridors amounts. This intention was consistent with Plaintiffs' understanding of the 2015 and 2016 QHPI Agreements.

91. Additionally, Defendant first announced that full payments would not be made in November 2015, ***after*** the contracts with Piedmont for 2015 and 2016 were formed. A unilateral statement made after the contracts were formed could not alter their terms (as determined by a matter of law by the United States Supreme Court in *Maine Community Health Options v. United States*).

92. Plaintiffs' intent to contract is demonstrated by their submissions to Defendant, including the Attestations.

93. Based on, and in reasonably reliance upon, Defendant's solicitation to insurers, Plaintiffs offered to provide specific health plans on the Exchanges, and Defendant accepted. Plaintiffs' offer and Defendant's acceptance are demonstrated by Plaintiffs' participation directly with CMS and HHS in the implementation of the risk corridors program. Plaintiffs' offer and Defendant's acceptance are further demonstrated by the parties' mutual execution of the QHPI Agreements.

94. As consideration, Plaintiffs and Defendant agreed to abide by the ACA. As further consideration, Plaintiffs expended significant time, money, and resources to provide affordable health insurance to over 7,000 Americans in benefit years 2015 and 2016, satisfying an essential part of Defendant's regulatory mandate under the ACA. Plaintiffs undertook to develop and sell

new kinds of insurance products that conformed to the ACA's novel standards for coverage on the Exchanges, thereby enabling Defendant to fulfill its statutory mandate. Plaintiffs also built, paid for, and expanded a health care provider network in support of their QHPs on the Exchanges. Defendant committed to mitigating Plaintiffs' risk of participating in the Exchanges during the early years of the ACA through the ACA's premium stabilization programs, including a commitment to pay risk corridors payments in full. Defendant also committed to administering the Exchanges in conformity with the ACA.

95. The government representatives who bound the government to these implied-in-fact contracts had actual authority to do so. At all times relevant here, Defendant's representatives had the actual authority to and did bind HHS to these contractual commitments.

96. At all times relevant herein, Plaintiffs fully performed their contractual obligations.

97. Defendant breached its contractual obligations by failing to promptly remit full risk corridors payments owed to Plaintiffs for benefit years 2015 and 2016.

98. Defendant's breach of its implied contract with Plaintiffs proximately caused Plaintiffs to suffer monetary damages in an amount to be proven at trial, but which amount totals at least $2,076,316.38.

Count IV

Breach of the Implied Covenant of Good Faith and Fair Dealing

99. Plaintiffs incorporate by reference as if set forth fully herein the allegations contained in the Paragraphs 1 through 98 above.

100. The 2014 and 2015 contracts between Defendant and Plaintiffs regarding the issuance of QHPs included an implied duty of good faith and fair dealing. This duty precludes Defendant from acting so as to destroy Plaintiffs' "reasonable expectations of the other party

regarding the fruits of the contract." *Centex Corp. v. United States*, 395 F.3d 1283, 1304 (Fed. Cir. 2005).

101. In contracting with Defendant to offer QHPs on the Exchanges, Plaintiffs reasonably expected that they would receive the full amount of risk corridors payments owed to them under the ACA, regardless of the risk corridors payments that CMS collected from other QHP issuers.

102. Plaintiffs' expectations were based on the mandatory payment provisions of the ACA, as well as HHS's rules and guidance documents reiterating both that payment would be made and the premium stabilization purposes of the risk corridors program.

103. Defendant has breached the implied covenant of good faith and fair dealing by, among other actions, (1) unilaterally determining after these agreements were executed that CMS would make risk-corridor payments in a "budget neutral fashion;" and thereby (2) limiting the risk corridors payments to Plaintiffs for the 2015 and 2016 benefit years to only a fraction of the amounts owed under the ACA.

104. Defendant's breach of this duty of good faith and fair dealing has proximately caused Plaintiffs to suffer monetary damages in an amount to be proven at trial, but which amount totals at least $2,076,316.38.

PRAYER FOR RELIEF

Plaintiffs pray that this Court:

A. Award damages for the outstanding risk corridors payments still due to them for the 2015 and 2016 benefit years, in an amount to be proven at trial but which amount at least totals $2,076,316.38;

B. Award their costs and expenses and any interest allowable by law; and

C. Award them such further and additional relief as is just and proper.

Dated: October 22, 2020

Respectfully submitted,

PIEDMONT COMMUNITY HEALTHCARE, INC.

and

PIEDMONT COMMUNITY HEALTHCARE HMO, INC.

By: /s/ Michael J. Hertz
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