ORIGINAL

#9998-3208432

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH REPUBLIC INSURANCE COMPANY,

Plaintiff,
on behalf of itself and all others similarly situated,

vs.

THE UNITED STATES OF AMERICA,

Defendant.

No. 16-259 C

CLASS ACTION COMPLAINT

Plaintiff Health Republic Insurance Company ("Health Republic" or "Plaintiff"), on behalf of itself and all those similarly situated, as defined below, brings this class action for the Defendant's (i) violation of Section 1342 of the Patient Protection and Affordable Care Act ("Section 1342"), (ii) violation of 45 CFR § 153.510(b) ("Section 153.510"); and (iii) violation of other applicable law, damages, and other relief, states and alleges as follows:

NATURE OF THE ACTION

1. In late March 2010, the federal government of the United States of America ("Defendant," or the "Government") changed the face of healthcare in the nation by enacting The Patient Protection and Affordable Care Act (Pub. L. 111-148) (the "Affordable Care Act" or the "Act" or "ACA") and The Health Care and Education Reconciliation Act (Pub. L. 111-152). Together, these acts are often colloquially known as "Obamacare" and represent the most significant healthcare statutes in recent U.S. history.

2. Before these laws went into effect, health insurers were (among other things) permitted to deny coverage to individuals and families, exclude pre-existing conditions from insurance coverage, and vary insureds' premiums based on their individual health status. After the two acts went into effect, such practices were prohibited, beginning with plans offered in the

2014 individual market. This was a dramatic change from the pre-ACA rules governing health insurance in most states—especially in the individual insurance market—and created a huge amount of uncertainty for insurers regarding who would sign up for coverage and what the medical cost for caring for this new population would be. In particular, insurers had no data or tools to predict the needs of the newly-insured beneficiaries signing up for plans starting in 2014, nor a model to price these ACA plans to reflect the medical costs associated with this new and untested marketplace.

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

4. In recognition of these uncertainties, the Affordable Care Act included three risk-sharing programs intended to mitigate the risk to insurers inherent in this new marketplace. Known as the "Three Rs," these programs included a permanent risk-adjustment program ("risk adjustment"), a transitional reinsurance program designed to run from 2014-2016 ("reinsurance"), and a temporary risk corridor program that was also supposed to run from 2014-2016 ("risk corridor"). This case is about the third program: risk corridors.

5. A "risk corridor" is a program designed to mitigate risk for participants in a new insurance market by limiting both unexpectedly high gains ***and*** losses. Modeled after a similar program enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act that was signed into law in 2003 under President George W. Bush, the Affordable Care Act's risk corridor program helped entice insurers to participate by offering Qualified Health Plans ("QHPs") on the ACA's new insurance exchanges.[1] Section 1342 of the Affordable Care Act contained two related mandatory terms for all QHP issuers: (1) any QHP issuer/insurer agreeing to operate on an exchange would receive compensation from the Government if its losses exceeded a certain defined amount due to high utilization and high medical costs; and (2) the QHP issuers/insurers were required to ***pay*** the government a percentage of any profits they made over similarly-defined amounts.

6. This structure encouraged competition and attracted participants by limiting the risk arising from entering the exchange market during the early years of its implementation. No matter how experienced an insurer was, the new demographics of insureds within the exchanges meant there was an unpredictable level of risk in how the market would operate. Insurers that were unable to accurately estimate and price that risk due to the lack of pre-existing information about the market, and/or had an unexpectedly high number of sick insureds purchase their plan, would receive risk corridor payments to buffer the losses due to above-average risk. The temporary nature of the risk corridor program was meant to provide a safety net sufficient to keep insurers in business, provide time to learn about the dynamics of this new market, and adjust pricing accordingly. Meanwhile, insurers that priced their premiums higher than the total medical cost plus estimated profit, and/or had lower-than-expected numbers of costly insureds

[1] For convenience, throughout this Complaint, issuers of Qualified Health Plans will be referred to as "QHPs."

purchase plans, would be required to pay the government a portion of their profit while the newly-created insurance market stabilized. Insurers offering qualified health plans under the Affordable Care Act were supportive of this program because it would allow them to comply with the Affordable Care Act while providing a safety net against extreme losses.

7. Section 1342 of the Affordable Care Act and its implementing federal regulation, 45 CFR § 153.510(b), are unequivocal about the payments the Government must make. If the QHPs' losses in any year from 2014-2016 exceed certain defined amounts, then the Government must pay those QHPs a defined portion of those losses. Conversely, if the QHPs' profits in any year from 2014-2016 exceed certain defined amounts, then those QHPs must pay the Government a defined portion of those profits.

8. Despite these express and binding obligations, there have been numerous attempts to frustrate the Government's timely payments to the QHPs insuring millions of previously uninsured and under-insured Americans. From its inception, the Affordable Care Act has been a major point of political disagreement, and the risk corridor program in particular, has been unlawfully and inappropriately interfered with via political spending bill disputes and appropriations acts.

9. In the Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. 113-235) ("2015 Spending Bill") and, a year later, in the Consolidated Appropriations Act, 2016 (Pub. L. 114-113) ("2016 Spending Bill"), Congress included a parallel set of riders that prohibited the Government from paying risk corridor amounts from the funds established for and/or appropriated to the Centers for Medicare & Medicaid Services ("CMS") and its parent department, the United States Department of Health & Human Services ("HHS").

10. The practical effect of the 2015 Spending Bill was to prevent CMS and HHS from paying QHPs their full risk corridor receivable due for 2014. This created an extraordinary burden on QHPs because, as many industry experts predicted, 2014 was an incredibly tumultuous year in the new market. During 2014, QHPs incurred almost $2.9 billion in losses that were compensable under the risk corridor provisions of the ACA. However, due to the 2015 Spending Bill, over $2.5 billion of those mandatory risk corridor payments for 2014 were not paid. On information and belief, the QHPs incurred even greater compensable losses in 2015 that CMS and HHS cannot pay as a result of the 2016 Spending Bill.

11. When CMS and HHS were unable to pay the QHPs their full risk corridor receivables for 2014, many insurance companies experienced cash flow problems and/or were unable to meet regulatory reserve requirements. This required insurance companies to satisfy their cash flow and reserve shortfalls, or risk going out of business. Some companies were unable to remedy the cash flow and/or reserve shortfalls, and, as a consequence, went out of business. This, in turn, forced hundreds of thousands of Americans to switch to other carriers, often with less attractive pricing and/or different provider networks. Many of these insureds had to switch doctors in order to retain insurance coverage and remain compliant with the individual mandate under the ACA.

12. If not remedied, this paradigm will require insurers to sharply raise their rates and decrease benefits to protect against potential losses from this new risk pool that needs more time to stabilize, resulting in much higher costs to American taxpayers in the long run than the temporary risk corridor program itself, seemingly for perceived political gain.

13. By this lawsuit, Plaintiff seeks, on behalf of itself and all others similarly situated, full payment of the risk corridor payments it is entitled to under the ACA and the Government

currently owes. Despite its after-the-fact politicization, the risk corridor program is far and away the smallest of the Three Rs. Yet, it is simultaneously the most important of those programs in these early crucial years, because it was contemplated by the Affordable Care Act as a necessary component to allow QHPs to function and survive while the new health insurance market stabilized and insurers obtained more risk and cost data. The law is clear: the Government must abide by its statutory obligations. Plaintiff respectfully seeks to compel it do so.

JURISDICTION

14. This Court has jurisdiction over the subject matter of this action pursuant to the Tucker Act, 28 U.S.C. § 1491. The statutory basis for invoking jurisdiction is: Section 1342, which is a money-mandating statute that requires payment from the federal government to QHPs that satisfy certain criteria; and Section 153.510(b), which is similarly money-mandating and requires payment from the federal government to QHPs that satisfy certain criteria.

15. This controversy is ripe because CMS and HHS have stated that they will not pay Plaintiff and the Class the full amounts they are owed for 2014 and 2015 within the annual cycle required by Section 1342 and Section 153.510.

PARTIES

16. Plaintiff Health Republic Insurance Company is a nonprofit corporation organized under the laws of the State of Oregon, with its principal place of business at 4000 Kruse Way Pl. #2-300, Lake Oswego, Oregon 97035. Health Republic began providing health insurance to insureds on the state-based health exchange in Oregon in January of 2014. Throughout 2014 and 2015, Health Republic continued to provide health insurance to its insureds until October 2015, when it learned the Government would pay only 12.6% of its 2014 risk corridor receivable. At that time, Health Republic had determined it was owed $7,068,851 under the risk corridor

program for 2014. It has since estimated that it is owed approximately $15,000,000 under the risk corridor program for 2015. The precise 2015 risk corridor receivable will be determined after the submission of final data to CMS later in 2016.

17. Pursuant to CMS rules, 2014 unpaid risk corridor amounts must be paid before 2015 risk corridor payments can be made. As a result, risk corridor payments made by insurers with an obligation to pay the Government under the criteria of the risk corridor program for 2015 will be used to pay 2014 risk corridor obligations *prior* to making 2015 risk corridor payments.

18. Based upon the persisting losses experienced by insurers in the individual market nationally, risk corridor payments due to the Government are estimated to be very low, creating yet again a deficit for the 2015 risk corridor program.

19. Due to the Government's failure to pay Health Republic its 2014 risk corridor payment, and the estimates for the payment of the 2015 risk corridor amounts owed, Health Republic found itself at great risk of falling below statutory reserve requirements and was compelled to announce it would close its doors. Health Republic exited the 2016 market and is currently in the wind down phase for its 2015 insurance plans. The defendant is the Government, acting through the Centers for Medicare & Medicaid Services and United States Department of Health & Human Services.

FACTUAL ALLEGATIONS

A. In 2010, the Government Established a "Risk Corridor" Program Designed to Entice Insurers to Participate in the New Affordable Care Act Insurance Exchanges

20. With its passage in March 2010, the Affordable Care Act established three insurance premium stabilization programs. The Three Rs (as they are colloquially known) include: a permanent risk adjustment program, which collects funds from insurers in the individual and small group markets that have enrolled lower-risk enrollees and transfers the

funds to insurers that have enrolled higher risk enrollees; a three-year reinsurance program, which collects contributions from all commercial insurers based upon the number of people each carrier insures, and pays out those funds to insurers based upon their high-cost claims in the individual and small group markets; and a three-year risk corridor program. Both the reinsurance and risk corridor programs began in 2014 and will conclude at the end of 2016.

21. Section 1342 of the Affordable Care Act mandates the risk corridor program. In relevant part for this lawsuit, it 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. 111-148 § 1342 [42 U.S.C. § 18062] (emphasis added). Section 1342 also includes a provision requiring qualified health plans to pay escalating portions of any outsized profits they make from 2014-2016. *Id.* § 1342(b)(2). For both the "payments out" and "payments in" provisions of Section 1342, the terms "allowable costs" and "target amount" are defined by the statute. *Id.* § 1342(c).

22. As directed by the ACA, HHS implemented the risk corridor program in the Code of Federal Regulations. 45 CFR § 153.500 provides definitions for all necessary terms (including, among others, "qualified health plan," "risk corridors," "allowable costs," and "target amount"), and 45 CFR § 153.510 establishes the regulations implementing the risk corridor program. In relevant part, 45 CFR § 153.510 states:

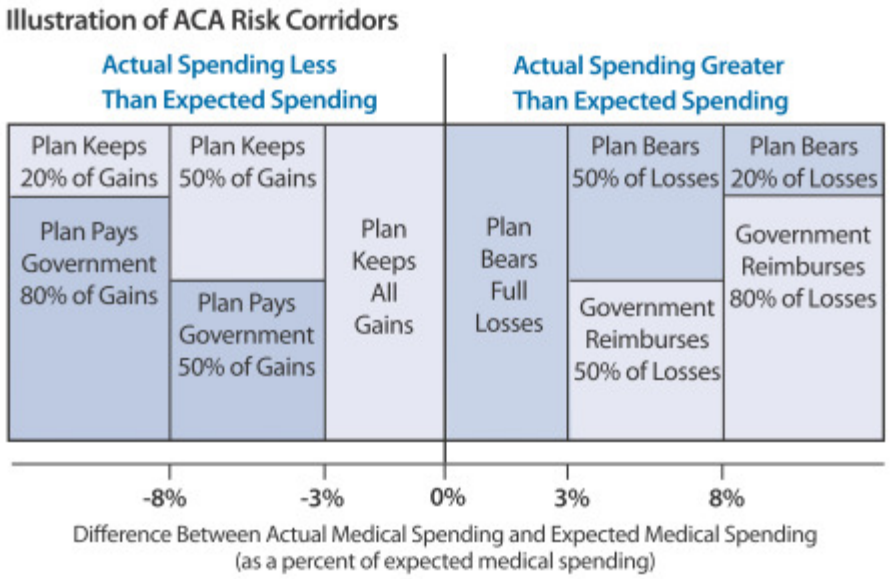
> (b) HHS payments to health insurance issuers. ***QHP issuers will receive payment from HHS in the following amounts, under the following circumstances***:
>
> > (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, ***HHS 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.

(emphasis added).

23. This payment regulation, as well as a companion regulation regarding the risk corridor requirements (45 CFR § 153.530), further mandates that QHPs must adhere to the requirements set by HHS for participants in the risk corridor program, must satisfy certain requirements with respect to defining their premium data, allowable costs, and administrative costs, and must submit all necessary information for the risk corridor payment calculations by certain points established by statute, regulation, and HHS. 45 CFR §§ 153.510, 153.530. If QHPs abided by these requirements and satisfied the necessary criteria, they were eligible for "payments out" from the risk corridor program once the payments were calculated.

24. Section 1342 and Section 153.510 provide that if an insurer's actual claims in a year covered by the risk corridor program are at least 3% greater than the claims projected when the insurer set rates for that year, the Government must reimburse the insurer for half of the

excess. If actual claims jump 8% beyond projected claims, the Government covers 80% of the excess. The following chart from the American Academy of Actuaries graphically demonstrates this obligation (and the QHPs' corresponding obligation to pay the Government if their profits exceed certain amounts):



25. As another set of actuaries explained, "The goal of the risk corridor program is to protect health insurance issuers against this pricing uncertainty of their plans, temporarily dampening gains and losses in a risk-sharing arrangement between issuers and the federal government. Since the protection is only available for [qualified health plans], it also provides a strong incentive for issuers to participate in the health insurance exchanges set up by the [Affordable Care Act]. Lastly, it provides an incentive for issuers to manage their administrative costs optimally."

26. Put simply, the risk corridor program recognizes that insurers generally have less experience in how to accurately price policies in the individual market rather than the group market, and no relevant experience estimating benefit utilization, risk pool composition, and medical spending costs for insurance policies to the post-ACA market, which included a new

demographic and new mandatory coverage requirements. The risk corridor program was designed to draw in insurers and help keep premiums at manageable levels while those insurers developed enough experience to properly price plans without a safety net. The ultimate goal was to create what is known as a "virtuous cycle"; *i.e.*, by keeping premiums low, more people would enroll in the new health plans, which would enable insurers to develop necessary utilization, cost, and risk pool experience, which would help them accurately set premiums and offer more expansive health plans, which would draw in more insureds. A broad collection of economists, health policy experts, insurance companies, and regulators agreed with the fundamental principles underlying the program and therefore strongly supported its inclusion in the Affordable Care Act.

27. The risk corridor program, both alone and in conjunction with the other of the Three Rs, directly benefited the Government as well. For example, the Government agreed to subsidize lower-income insureds through Advance Payment of Premium Tax Credits ("APTC") and Cost Sharing Reduction ("CSR"). APTC is a tax credit to assist individuals below 400% of the federal poverty line in paying for a health insurance plan purchased through the health insurance exchange. CSR is a discount that lowers the amount insureds have to pay out-of-pocket for deductibles, coinsurance, and copayments. Ordinarily, insurers facing unknown risk raise premiums and shift costs to insureds in order to protect against that risk. The Three Rs allowed insurers to offer quality, affordable insurance plans, despite their uncertainty, because they understood they would be reimbursed for outsized losses through at least the risk corridor program. Without these programs—and the risk corridor program in particular—the Government would have sustained a much higher cost for the APTC and CSR programs.

28. Based on the risk corridor program and the other two of the Three Rs, hundreds of insurers offered thousands of qualified health plans on the Affordable Care Act exchanges. They began offering insurance under the law's new mandate at the beginning of 2014. In the time since, it has become clear that the risk corridor program is—as predicted—highly necessary for many of the QHPs to survive these early, tumultuous years of the new insurance market. However, it bears noting, even at full payment, the risk corridor program is by far the smallest of the Three R premium stabilization programs.

B. The Risk Corridor Program is Politicized Just as it Begins

29. The Affordable Care Act and the Health Care and Education Reconciliation Act have created (and continue to create) substantial debate in the Government and populace. Indeed, the Affordable Care Act has twice withstood scrutiny before the Supreme Court of the United States, and still faces certain legal and political challenges. Despite this debate, however, the risk corridor program went largely uncontested during the drafting process. This is likely because, as noted above and explicitly stated in Section 1342, it was modeled after a similar program enacted under President George W. Bush. As noted above, the Three R programs collectively helped reduce the Government's expense by encouraging insurers to offer quality plans with lower premiums where, had the plans required greater cost shift to consumers with higher premiums, the Government would have subsidized the difference for lower-income insureds. Since Congress enacted the Affordable Care Act, it has not amended or otherwise attempted to modify the actual risk corridor program itself.

30. Despite this, the Defendant has taken several steps to frustrate the entire point of the risk corridor program: timely and complete payment to QHPs, in order to permit them to survive and learn this new market in its early years. The first such step was in early 2014, when CMS and HHS suddenly took the position that the risk corridor program needed to be self-

funding—or "budget neutral"—even though there is no such indication in the Affordable Care Act itself nor in its implementing regulations.

31. For example, on March 11, 2014, HHS's final Notice of Benefit and Payment Parameters for 2015 included, *for the first time*, language in the rule commentary about budget neutrality. The rule stated:

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

Similar language regarding budget neutrality was found throughout the rule on Exchange and Insurance Market Standards for 2015, published March 2, 2014.

32. Then, on April 11, 2014, CMS issued a statement entitled "Risk Corridors and Budget Neutrality," in which it stated that, "if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year 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." This document further stated that future guidance would explain what would happen if there was still a shortfall after 2016.

33. In essence, both CMS and HHS stated, without basis in the Affordable Care Act or any modifying statutes, that the risk corridors program would become budget neutral and that, if 2014 resulted in a shortfall, QHPs owed money under the program would only receive pro rata shares of what was paid in by other QHPs. If there was a similar shortfall in 2015, then CMS and HHS would kick the can further down the road and let insurers know only in 2016 what the Government planned to do to make them whole.

34. At the time CMS and HHS made these decisions, the Government faced a major debate on congressional appropriations and spending. Budget neutrality may have been CMS's solution to a difficult situation imposed by the ongoing spending debates, but it is not supported by the law. Section 1342 and Section 153.510 each affirmatively state that the Government "shall" and "will" pay QHPs in specific amounts if they meet the statutory requirements, and that those QHPs "will receive payment from HHS" if they meet the stated requirements. Nowhere in either Section does it say that the risk corridor payments will come from payments to the Government by other insurers. Nor does either Section state that the Government may put off the payments they owe until the next year's collections. (Indeed, the Government expects risk corridor payments ***from*** QHPs within 30 days after notification of the amounts they owe under the program. *See* 45 CFR § 153.510(d).)

35. Regardless of CMS's and HHS's attempted solutions to portions of the spending debate, certain members of the Government soon took a far more drastic step. Toward the end of 2014, Congress negotiated a massive spending bill to address numerous aspects of the Government's budget. During this process, a small contingent of Representatives and Senators opposed to the Affordable Care Act attached a rider to what eventually became the 2015 Spending Bill. This rider was aimed at cutting off CMS's and HHS's ability to make risk corridor payments from Government funds. The 2015 Spending Bill contained the following provision:

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

Pub. L. 113-235 at 362.

36. The 2015 Spending Bill was enacted on December 16, 2014, nearly a year after Plaintiff and the hundreds of QHPs in the Class began offering insurance on the Affordable Care Act exchanges and eighteen or more months after they had submitted rates for regulatory approval. Faced with this new development, the QHPs continued to abide by their obligations to the Government and their insureds, but they received little immediate guidance as to what would happen with the risk corridor payments.

37. Another provision was inserted into the following year's spending bill. The relevant portion of the 2016 Spending Bill states:

> SEC. 225. 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) or Public Law 111-148 (relating to risk corridors).

Pub. L. 114-113 at 383.

38. This time, however, the 2016 Spending Bill went one step further and specifically noted that special amounts appropriated to CMS and HHS in 2016 could ***not*** be used to fund the risk corridors program. In relevant part, the Bill stated:

> SEC. 226. In addition to the amounts otherwise available for the "Centers for Medicare and Medicaid Services, Program Management," the Secretary of Health and Human Services may transfer up to $305,000,000 to such account from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to support program management activity related to the Medicare Program: ***Provided, that except for the foregoing purpose, such funds may not be used to support any provision of Public Law 111-148*** or Public Law 111-152 (or any amendment made by either such Public Law) ***or to supplant any other amounts within such account***.

Pub. L. 114-113 at 384 (emphasis added).[2]

[2] Section 227 of the 2015 Spending Bill, as well as Sections 225 and 226 of the 2016 Spending Bill, are collectively referred to in this Complaint as the "Spending Bill Provisions."

39. As discussed below, Spending Bill Provisions effectively tied CMS's and HHS's hands with respect to their obligations to make risk corridor payments in 2014, and have done so again with respect to the 2015 payments. But the text of the Spending Bill Provisions is important, because they only state CMS and HHS *cannot use certain sources of funds* to satisfy the Government's obligations. The Provisions do not speak to the continuing existence of the Government's obligations, nor could they under applicable law (particularly given that the QHPs have satisfied their obligations pursuant to Section 1342 and Section 153.510).

C. Constrained by the Spending Bill Provisions, CMS and HHS Default on 87% of the 2014 Risk Corridor Payments to QHPs, Causing Significant Market Disruption

40. Pursuant to their obligations under the Affordable Care Act and 45 CFR § 153.500 *et seq.*, Plaintiff and the Class members complied with their statutory requirements throughout the year and submitted all required data for the risk corridor calculations by July 31, 2015, the statutory deadline. *See* 45 CFR § 153.530(d). The Government then calculated the risk corridor payments in and out, and, after notifying the market of a month extension, announced the results on October 1, 2015.

41. Due to a variety of factors—including, among other things, the expected pricing risks in a new insurance market with dramatically new demographics and new benefit requirements, as well as a higher-than-expected percentage of sick individuals due to certain policy changes in 2013 that allowed consumers to renew non-ACA compliant health plans even after the Affordable Care Act became effective—Plaintiff and the Class suffered substantial losses in 2014. Based on the Government's own official calculation, QHPs generated $362 million in risk corridor gains for the Government, but suffered $2.87 billion in compensable risk corridor losses. In CMS's October 1, 2015 statement, it informed Plaintiff and the Class that they would receive just 12.6% of the amounts they were owed under the risk corridor program,

which reflected a prorated distribution of the $362 million received from the few insurers that were required to pay the Government for the 2014 program year. CMS also reiterated its previous statement that it would be forced to maintain "budget neutrality" for the risk corridor program on a go forward basis.

42. As it became clear QHPs would only receive a small fraction of what they were owed under the risk corridor program, many began to fail. For example, eight consumer operated and oriented plans (CO-OPs) created under the Affordable Care Act (including Plaintiff here) announced they were unable to meet cash flow and/or regulatory reserve requirements and closed their doors due to the deficit of risk corridor payments. A number of other insurance companies have also failed due to the Government's default on the risk corridor amounts it owed.

43. Additionally, due to the severe limitations placed upon CMS's and HHS's ability to pay the risk corridor payments in full, the National Association of Insurance Commissioners ("NAIC") issued guidance to state insurance commissioners recommending that QHPs ***not*** be permitted to admit risk corridor payments as balance sheet assets for purposes of meeting regulatory reserve requirements. Given CMS's budget neutrality guidance and the Spending Bill Provisions, the payments were too uncertain and therefore likely to overstate the financial health of insurers. Although NAIC—and, in Health Republic's case, its independent financial auditor—was likely correct to institute this guidance (as the Government's subsequent non-payments demonstrate), it created an incredible burden on QHPs. Had insurers been permitted to record the risk corridor payments as balance sheet assets, many QHPs would not have run afoul of their regulatory reserve requirements. But, even for those QHPs that have survived notwithstanding the current market turmoil, the uncertainty the non-payments have caused means

that QHPs—especially smaller insurers that cannot spread losses associated with the risk corridors across premiums in other channels or other markets—will likely offer health plans at higher prices than before to ensure they are protected from the unknown risk this nascent market still embodies.

44. Health Republic's personal experience demonstrates the cascading, fatal effects the Spending Bill Provisions have had, even on companies that did everything right. When it began providing insurance coverage under the Affordable Care Act, Health Republic offered plans with bronze, silver, gold and platinum-level coverage all at extremely competitive prices. It bears noting that Health Republic was not the lowest priced plans in the market; their rates were in the middle of the pack of the 10 carriers listing on the Oregon insurance exchange. Had Health Republic known the risk corridors could not be relied upon as a safety net, it would have increased its rates – not to cover expected losses, but to cover the risk of *greater* than expected losses.

45. Nevertheless, Health Republic planned for the worst and structured its business plan so that it needed to only receive 50% of its 2014 compensable risk corridor payments in order to meet cash flow and regulatory reserve requirements. But even this extraordinarily conservative business plan proved unable to withstand the Spending Bill Provisions, as they forced the Government to pay only 12.6% of the 2014 risk corridor amounts owed to all QHPs. Faced with the inevitable fate these non-payments caused, Health Republic acted as a responsible corporate citizen and, rather than close its doors in the middle of a plan year and go into receivership, voluntarily withdrew from the 2016 market and provided notice of this decision to its insureds in the autumn of 2015, and honored all eligible claims for 2015. This is the exact result the risk corridors program was designed to avoid.

D. The Government Has Indicated That It Will Not Make the Full 2015 Risk Corridor Payments

46. Similar to the 2015 Spending Bill, the 2016 Spending Bill prevents CMS and HHS from making any risk corridor payments from Government funds. As a result, the agencies have indicated that they will continue to treat the risk corridor program as budget neutral, and use any funds received from QHPs for the 2015 risk corridor results to first pay down the $2.5 billion shortfall from 2014.

47. The Government has effectively indicated it will fail to meet its risk corridor obligations for 2015 as well. As disclosed in their 2015 annual and fourth-quarter earnings, the nation's largest health insurers suffered another year of large losses in the ACA compliant individual market. UnitedHealth Group, for example, lost more than $720 million on its public exchange business last year and Anthem, which operates Blue Cross and Blue Shield plans in 14 states, said that health plans on the exchanges caused profits to fall 64% on the fourth quarter of the year. Aetna also recently disclosed that its exchange business "remained unprofitable" in 2015.

48. These results are consistent with other current data, the sum total of which has caused market analysts to predict that the amount of risk corridor underfunding for 2015 will be at or near the same $2.5 billion level as 2014. *See*, *e.g.*, Bannerjee, D., Weir, C., & Sung, J., "The ACA Risk Corridor Will Not Stabilize The U.S. Health Insurance Marketplace in 2015," at 2-3, *Standard & Poor's RatingsDirect* (Nov. 5, 2015). This is consistent with analysts' additional prediction that it will take at least three years for the Affordable Care Act exchange market to stabilize. *Id.* at 3.[3]

[3] Congress, of course, made the same prediction when enacting the risk corridor program, since the program is only meant to run for three years: 2014-2016.

49. For these reasons, on information and belief, Plaintiff and the Class are currently owed even more risk corridor payments than the official 2014 calculations and will prove the exact amount in this case. Furthermore, the 2015 risk corridor payments to the Government will be insufficient to satisfy the Government's full obligations to Plaintiff and the Class for each of 2014 and 2015, and it will be insufficient to satisfy the obligations from both years combined. Compounding this, CMS and HHS have indicated—as they must, due to the Spending Bill Provisions—they will not pay any amounts above what comes in from QHPs this year. Plaintiff and the Class are thus in a worse position than when the 2014 shortfall was first announced, and have already been told that the Government will not resolve the situation despite its statutory obligations.

* * * * *

50. The Government's failure to satisfy its monetary obligations and make its required risk corridor payments will have wide-reaching effects on millions of Americans in the form of restricted health plans and higher insurance premiums. Given QHPs relied upon the risk corridor program in designing and pricing both their 2014 and 2015 plans, as was the intent of the program, Plaintiff, on behalf of itself and the Class, seeks the immediate payment in full of risk corridor receivables for 2014 and immediate payment of risk corridor receivables for 2015, once they are determined, to enable QHPs to survive and continue to offer Americans high-quality, affordable health insurance as contemplated by the Affordable Care Act.

CLASS ACTION ALLEGATIONS

51. Plaintiff brings this action as a class action under Rule 23(a) and (b) of the Federal Rules of Civil Procedure, on behalf of itself and others similarly situated. The proposed "Class" is defined as:

> All persons or entities offering Qualified Health Plans under the Patient Protection and Affordable Care Act in 2014 and 2015, and whose allowable costs were more than 103 percent of their target amounts (as those terms are defined in the Patient Protection and Affordable Care Act). Excluded from the Class is the Defendant and its members, agencies, divisions, departments, and employees.

52. There are hundreds of Class Members as described above, making the Class so numerous and geographically dispersed that joinder of all Class Members is impracticable.

53. There are questions of law and fact common to the Class that relate to the Government's actions and the type and common pattern of injury sustained as a result thereof, including, but not limited to:

a. whether Section 1342 of the Affordable Care Act is a money-mandating statute;

b. whether 45 CFR § 153.510 is a money-mandating regulation;

c. whether the Government's failure to appropriate funds sufficient to make risk corridor payments to Plaintiff and the Class absolve it of its statutory obligations;

d. whether the Government violated its obligations to pay Plaintiff and the Class risk corridor amounts in a reasonable time following the official calculation of those amounts; and

e. whether the Government is liable to Plaintiff and the Class for failing to make risk corridor payments within a reasonable time following the official calculation of those amounts.

54. Plaintiff's claims are typical of the claims of the other Class Members. Plaintiff and the Class Members sustained damages arising out of Defendant's common course of conduct in violation of law as complained of herein. The injuries and damages of each Class Member were directly caused by Defendants' wrongful conduct in violation of the laws as alleged herein.

55. Plaintiff will fairly and adequately protect the interests of the Class Members. Plaintiff is an adequate representative of the Class and has no interests adverse to the interests of absent Class Members. Plaintiff has retained counsel competent and experienced in complex

class action litigation, including commodity futures manipulation and antitrust class action litigation.

56. The prosecution of separate actions by individual Class Members would create a risk of inconsistent or varying adjudications.

57. The questions of law and fact common to the Class Members predominate over any questions affecting only individual members, including legal and factual issues relating to liability and damages.

58. A class action is superior to other available methods for the fair and efficient adjudication of this controversy. Treatment as a class action will permit a large number of similarly situated persons to adjudicate their common claims in a single forum simultaneously, efficiently, and without duplication of effort and expense that numerous, separate individual actions, or repetitive litigation, would entail. The Class is readily definable and is one for which records should exist in the files of the Defendant, Class Members, or the public record. Class treatment will also permit the adjudication of relatively small claims by many Class Members who otherwise could not afford to litigate the claims alleged herein, including because they have been put out of business by Defendant's conduct. This class action presents no difficulties of management that would preclude its maintenance as a class action.

CLAIMS FOR RELIEF

COUNT ONE

(Violation of Statutory and Regulatory Mandate to Make Payments)

59. Plaintiff realleges and incorporates the above Paragraphs 1-57 as if fully set forth herein.

60. As part of its obligations under Section 1342 of the ACA and/or its obligations under 45 CFR § 153.510(b), the Government is required to, subject to certain explicit statutory and/or regulatory conditions, pay any QHP certain amounts exceeding the target costs they incurred in 2014 and 2015.

61. Plaintiff and the Class are QHPs under the ACA and, based on their adherence to the ACA and their submission of their allowable costs and target costs to CMS, satisfy the requirements for payment from the United States under Section 1342 of the ACA and 45 CFR § 153.510(b).

62. The United States has failed, without justification, to perform as it is obligated under Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b), and has affirmatively stated that it will not satisfy those obligations in the time frame required by the statutes for 2014 and 2015.

63. The United States' failure to provide timely payments to Plaintiff and the Class is a violation of the Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b), and Plaintiff and the Class has been damaged thereby.

PRAYER FOR RELIEF

Wherefore, Plaintiffs requests the following relief:

A. That the Court certify this lawsuit as a class action under Rules 23(a), (b)(2), and (b)(3) of the Federal Rules of Civil Procedure, that Plaintiff be designated as class representative, and that Plaintiff's counsel be appointed as Class counsel for the Class;

B. That the Court award Plaintiff and the Class monetary relief in the amounts to which Plaintiff and the Class are entitled under Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b).

C. That the Court award Plaintiff and the Class consequential damages, special damages, or other damages that result as a consequence of the Defendant's non-performance;

D. That the Court award appropriate injunctive relief, including but not limited to an injunction requiring Defendant to pay all amounts for 2014 and 2015 owed to Plaintiff and the Class under Section 1342 of the Affordable Care Act and 45 CFR § 153.510(b).

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

F. That the Court award appropriate declaratory relief, including but not limited to a declaration and judgment that Defendant's conduct alleged in the complaint violates the laws alleged in the complaint;

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

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

DATED: February 24, 2016

Respectfully submitted,

QUINN EMANUEL URQUHART & SULLIVAN, LLP

/s/ Stephen Swedlow

Stephen Swedlow
500 W. Madison Street, Suite 2450
Chicago, Illinois 60661-2510
Telephone: (312) 705-7400
Facsimile: (312) 705-7401

J.D. Horton
Adam B. Wolfson
865 S. Figueroa Street
Los Angeles, California 90017
Telephone: (213) 443-3000
Facsimile: (213) 443-3100

Attorneys for Plaintiff Health Republic Insurance Company and the Class