IN THE UNITED STATES COURT OF FEDERAL CLAIMS

COMMON GROUND HEALTHCARE COOPERATIVE, Plaintiff, on behalf of itself and all others similarly situated, vs. THE UNITED STATES OF AMERICA, Defendant.	No. 17-877 C **FIRST AMENDED CLASS ACTION COMPLAINT**

Plaintiff Common Ground Healthcare Cooperative ("CGHC" 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"); (iii) violation of Section 1402 of the Patient Protection and Affordable Care Act ("Section 1402"); (iv) violation of 45 CFR § 156.430 ("Section 156.430"); and (v) violation of other applicable law, damages, and other relief, and alleges as follows:

NATURE OF THE ACTION

Risk Corridor Claims

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. No. 111-148) (the "Affordable Care Act" or the "Act" or "ACA") and the Health Care and Education Reconciliation Act (Pub. L. No. 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 and health plan providers 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 health plan providers regarding who would sign up for coverage and what the medical cost for caring for this new population would be. In particular, health plan providers 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. Preventive care benefits previously subject to copays, deductibles and other cost-sharing mechanisms, or even exclusion from payment, 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 health plan providers 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 health plan providers to participate by offering qualified health plans on the ACA's new insurance exchanges. Section 1342 of the ACA contained two related mandatory terms for all qualified health plan ("QHP") issuers: (1) any QHP issuer 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 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 a health plan provider was, the new demographics of insureds within the exchanges meant there was an unpredictable level of risk in how the market would operate. Health plan providers 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 health plan providers in business, provide time to learn about the dynamics of this new market, and adjust pricing accordingly. Meanwhile, health plan providers that priced their premiums higher than the total medical cost plus estimated profit, and/or had lower-than-expected numbers of costly insureds purchase plans, would be required to pay the government a portion of their profit while the newly created insurance market stabilized. Issuers 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 ACA and its implementing federal regulation, 45 CFR § 153.510(b), are unequivocal about the payments the Government must make. If the QHP issuers' losses in any year from 2014-2016 exceed certain defined amounts, then the Government must pay those QHP issuers a defined portion of those losses. Conversely, if the QHP issuers' profits in any year from 2014-2016 exceed certain defined amounts, then those QHP issuers 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 QHP issuers 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, 2015 (Pub. L. No. 113-235) ("2015 Spending Bill"), a year later in the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Bill"), and yet again the following year in the Consolidated Appropriations Act, 2017 (Pub. L. No. 115-31) ("2017 Spending Bill," collectively with the 2015 Spending Bill and the 2016 Spending Bill, the "Spending Bills"), 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 Spending Bills was to prevent CMS and HHS from paying QHP issuers their full risk corridor receivables due for the 2014, 2015, and 2016 plan years. This created an extraordinary burden on QHP issuers because, as many industry experts predicted, each of those plan years were incredibly tumultuous in the new market. During 2014 and 2015, QHP issuers incurred almost $8.67 billion in losses that were compensable under the risk corridor provisions of the ACA, and losses for the 2016 plan year total another $3.95 billion. However, due to the Spending Bills, over $12 billion of those mandatory risk corridor payments for 2014-2016 were not paid.

11. When CMS and HHS were unable to pay the QHP issuers their full risk corridor receivables for 2014-2016, many QHP issuers experienced cash flow problems and/or were unable to meet regulatory reserve requirements. This required QHP issuers to satisfy their cash flow and reserve shortfalls, or risk going out of business. Not all companies were able to remedy the cash flow and/or reserve shortfalls and did go out of business, forcing hundreds of thousands of Americans to switch to other carriers, often with less attractive pricing and/or different

provider networks, which required these insureds to switch doctors in order to retain insurance coverage and remain compliant with the individual mandate under the ACA.

12. This "bait and switch" paradigm has required QHP issuers 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 2016 plan year risk corridor payments it is entitled to under the ACA. 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 QHP issuers to function and survive while the new health insurance market stabilized and they obtained more risk and cost data. The law is clear: the Government must abide by its statutory obligations. Plaintiff respectfully seeks to compel it to do so.

Cost Sharing Reduction Reimbursement Claims

14. In addition to the Three Rs, the ACA includes other features designed to make affordable health insurance coverage available to millions of Americans, including subsidies to reduce premiums and out-of-pocket costs for low- and middle-income Americans purchasing insurance on the exchanges. One of those features is the cost-sharing reduction ("CSR") reimbursements created by Section 1402 of the ACA. Pursuant to Section 1402, QHP issuers pay a portion of eligible insureds' out-of-pocket costs, such as deductibles, co-pays, and similar expenses. This makes health insurance for those insureds more affordable, a concept embodied

in the name of the Act establishing the exchanges in which many of those insureds were able to obtain health insurance for the first time.

15. In exchange for offering QHPs in the ACA exchanges and abiding by Section 1402's requirements, the same section states that the Government will reimburse QHP issuers for any CSR payments they make. Specifically, the ACA requires that the Secretaries of HHS and the Treasury "***shall make*** periodic and timely payments to the [QHP] issuer equal to the value of the reductions." Pub. L. No. 111-148 § 1402(c)(3)(A) [42 U.S.C. § 18071] (emphasis added).

16. Appropriations legislation following the passage of the ACA failed explicitly to appropriate funds for Section 1402 CSR reimbursements. Nevertheless, between January 2014 and September 2017, the Government made periodic and timely payments to QHP issuers, as required by Section 1402. These advance payments were made on a monthly basis to QHP issuers.[1]

17. On November 21, 2014, the United States House of Representatives filed a complaint against HHS and the Treasury, alleging that the Obama administration had been spending billions of dollars of unappropriated funds to support the ACA, including by making CSR reimbursements to QHP issuers when no funds had been appropriated for that purpose. *See* Complaint, *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. 1 (D.D.C. filed Nov. 21, 2014). In response, the executive branch argued that the ACA amended 31 U.S.C. § 1324 to

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[1] *See* Cost-Sharing Reductions Reconciliation, HHS, March 2013, at 4 ("HHS will pay a per member per month CSR advance payment amount for each plan variation (issuers will receive the same amount for all enrollees with a plan variation, each month)."), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/pages_from_csr_recon_cleared-a.pdf; *see also* Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015, CMS, March 16, 2016, at 27 ("Payments to issuers of estimated monthly amounts began in January 2014."), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf.

provide a permanent appropriation for both Section 1401's premium tax credits and Section 1402's CSR reimbursements. *See* Defendants' Mem. ISO Mot. for Summary Judgment, *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. 55-1 (D.D.C. 12/2/2015), at 11. On May 12, 2016, the district court entered judgment in favor of the House of Representatives, finding that 31 U.S.C. § 1324 did not constitute a permanent appropriation for Section 1402 CSR reimbursements and Congress had not appropriated any other funds to satisfy the Government's obligations under Section 1402's CSR reimbursements. *House v. Burwell*, 185 F. Supp. 3d 165, 168, 174-75 (D.D.C. 2016). The district court entered an injunction preventing any further reimbursements under Section 1402, but stayed the injunction pending resolution of any appeal. *Id.* at 189. The Obama administration appealed the ruling to the D.C. Circuit, but the appeal was held in abeyance following the 2016 presidential election.

18. The Trump administration initially continued the Obama administration's practice of paying CSR reimbursements. However, these payments became politicized as a "bailout" for insurers, rather than a reimbursement for costs QHP issuers incurred in order to reduce the out-of-pocket costs for eligible low- and middle-income insureds.[2] On October 11, 2017, Attorney General Sessions submitted a letter to the Department of Treasury and HHS advocating a new position for the executive branch on this issue: that 31 U.S.C. § 1324 could not be used to fund CSR reimbursements. (Ex. 1, Oct. 11, 2017 Ltr. from Sessions to Secretary of Treasury and Acting Secretary of HHS.) The next day, on October 12, 2017, HHS announced that "[i]n light of [Attorney General Session's] opinion—and the absence of any other appropriation that could

[2] *See* Robert Pear, *A Key Republican Demands Subsidies to Calm Insurance Markets*, THE NEW YORK TIMES, June 8, 2017 (noting President Trump's budget director refers to CSR reimbursements as "Obamacare bailout payments"), *available at* https://www.nytimes.com/2017/06/08/us/politics/kevin-brady-republican-insurance-subsidies.html.

be used to fund CSR payments—CSR payments to issuers must stop, effective immediately. CSR payments are prohibited unless and until a valid appropriation exists." (Ex. 2, Oct. 12, 2017 Mem. from E. Hargan to S. Verma re Payments to Issuers for Cost-Sharing Reductions (CSRs).)

19. However, as with the risk corridors amounts, Congress's failure to appropriate funds to pay Section 1402 CSR reimbursements did not change the Government's obligation to pay QHP issuers the amounts mandated by Section 1402. Whether Congress failed explicitly to appropriate funds for Section 1402 payments or did so pursuant to 31 U.S.C. § 1324 and is now taking the position that it need not pay CSR reimbursements from that appropriation, the result is the same—the Government owes QHP issuers CSR reimbursements pursuant to a money-mandating statute.

20. The Government's failure to pay CSR reimbursements to QHP issuers has already harmed QHP issuers, and will cause catastrophic damages to those issuers, their insureds, and the overall health insurance marketplace. Despite the Trump administration's refusal to pay CSR reimbursements, QHP issuers are still required by law to reduce out-of-pocket costs for eligible insureds. ACA § 1402(a)(2) [42 U.S.C. § 18071]. Thus, QHP issuers are now required to forego collecting billions of dollars from eligible insureds each year without receiving promised reimbursements from the Government. This will have wide-ranging consequences in the insurance exchanges. For example, some QHP issuers will likely need to raise premiums to recover some of these costs, while other QHP issuers may decide to leave the exchanges entirely. Either of these results will directly harm those the CSR was designed to aid: low- and middle-income Americans purchasing insurance on the insurance exchanges.

21. By this lawsuit, Plaintiff seeks, on behalf of itself and all others similarly situated, full payment of CSR reimbursements to which QHP issuers are entitled under the ACA.

JURISDICTION

22. This Court has jurisdiction over the subject matter of this action pursuant to the Tucker Act, 28 U.S.C. § 1491. The statutory bases for invoking jurisdiction are Sections 1342 and 1402 of the ACA, which are money-mandating statutes that require payment from the Government to QHP issuers that satisfy certain criteria, and 45 CFR §§ 153.510(b) and 156.430, which are similarly money-mandating and require payment from the Government to QHP issuers that satisfy certain criteria.

23. This controversy is ripe because CMS and HHS have stated that they will not pay Plaintiff and the Risk Corridors Class the full risk corridor amounts they are owed for the 2016 plan year within the annual cycle required by Section 1342 and Section 153.510. This controversy is further ripe because CMS and HHS have stated that they will not pay Plaintiff and the CSR Class the CSR reimbursements they are owed pursuant to Section 1402 and Section 156.430, and in fact ceased making CSR reimbursement payments as of October 2017.

PARTIES

24. Plaintiff CGHC is a nonprofit corporation organized under the laws of the State of Wisconsin, with its principal place of business at 120 Bishop's Way, Suite 150, Brookfield, Wisconsin 53005. CGHC began providing QHPs on the state-based health exchange in Wisconsin in January of 2014. Throughout 2014, 2015, 2016 and 2017, CGHC continued to provide QHPs on the ACA exchange. On November 13, 2017, CMS announced the risk corridor

amounts that would be paid for the 2016 benefit year.[3] CMS determined that CGHC was owed just under $27 million in risk corridor receivables for the individual market in the 2016 benefit year and over $660,000 in risk corridor receivables for the small group market in the 2016 benefit year.[4] However, CMS announced it would be paying CGHC just under $400,000, a pro rata amount that would be applied to the remaining amounts owed to CGHC for the 2014 benefit year.[5]

25. Pursuant to CMS statements, 2014 and 2015 unpaid risk corridor amounts will be paid before 2016 risk corridor payments are made. As a result, CMS plans to use risk corridor payments made by QHP issuers with an obligation to pay the Government under the criteria of the risk corridor program for 2016 to pay remaining 2014 and 2015 risk corridor obligations before making 2016 risk corridor payments. That will lead to insufficient payments for the 2016 plan year because it will shortchange the amounts for 2016, and CMS has stated unequivocally it will not draw on any other funds to pay outstanding risk corridor amounts.

26. Based upon the persisting losses experienced by QHP issuers in the individual market nationally, risk corridor payments due to the Government for the 2016 plan year were again very low, creating yet again a deficit for the risk corridor program. Indeed, the payments due to the Government are so much lower than the payments owed to QHP issuers that the 2016 amounts collected from QHP issuers are still being used to reduce 2014 amounts owed: "HHS

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[3] Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, CMS, Nov. 13, 2017, *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

[4] *Id.* at 20.

[5] *Id.*

intends to collect the full 2016 risk corridors charge amounts . . . however, the 2014 payment amounts listed . . . will be reduced pro rata based on collections received."[6]

27. Collectively, QHP issuers offering individual or small group plans on the exchanges are owed over $3.95 billion in risk corridors receivables for the 2016 benefit year.[7] However, CMS will apply all of the amounts collected from other QHP issuers for the 2016 benefit year toward unpaid risk corridor receivables from the 2014 benefit year (reducing 2014 amounts owed by just $24.9 million).[8] In other words, the Government has paid (and will pay) ***nothing*** toward amounts owed to QHP issuers for the 2016 benefit year.

28. As required by Section 1402 of the ACA, CGHC reduced out-of-pocket costs for eligible insureds. Pursuant to the payment methodology established by CMS, beginning in January 2014, CGHC received monthly advance payments from the Government to cover projected CSR amounts, and then reconciled those advance payments at the end of the benefit year to the actual CSR amounts. However, CGHC has not received CSR reimbursements from the Government to compensate it for these costs since September 2017. For the 2017 plan year, CGHC estimates that it will be owed $12-13 million from the Government in unpaid CSR reimbursements. As a small health plan with approximately 65% of its members enrolled in a CSR plan design, the lack of CSR reimbursements in 2017 will have an adverse impact on CGHC's 2017 financial results. Further, CGHC has already committed to providing individual coverage on the exchanges in 2018, and will be required to provide cost sharing reductions to its eligible insureds for that plan year as well. However, the Government has already stated that it will not reimburse CGHC or any other QHP issuer for these costs. CGHC does not yet know

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[6] *Id.* at 1-2.

[7] *Id* at 2-21.

[8] *Id.* at 2-21.

how much the Government will owe it in unpaid CSR reimbursements for 2018, but estimates it to be around $60 million.

29. The defendant is the Government, acting through the Centers for Medicare & Medicaid Services and the United States Department of Health & Human Services.

FACTUAL ALLEGATIONS

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

30. 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 health plan providers in the individual and small group markets that have enrolled lower-risk enrollees and transfers the funds to health plan providers that have enrolled higher risk enrollees; a three-year reinsurance program, which collects contributions from all commercial health plan providers based upon the number of people each carrier insures, and pays out those funds to health plan providers 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 concluded at the end of 2016.

31. 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.
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> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary ***shall provide under the program established under subsection (a)*** that if—
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> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
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> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

Pub. L. No. 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).

32. 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***:
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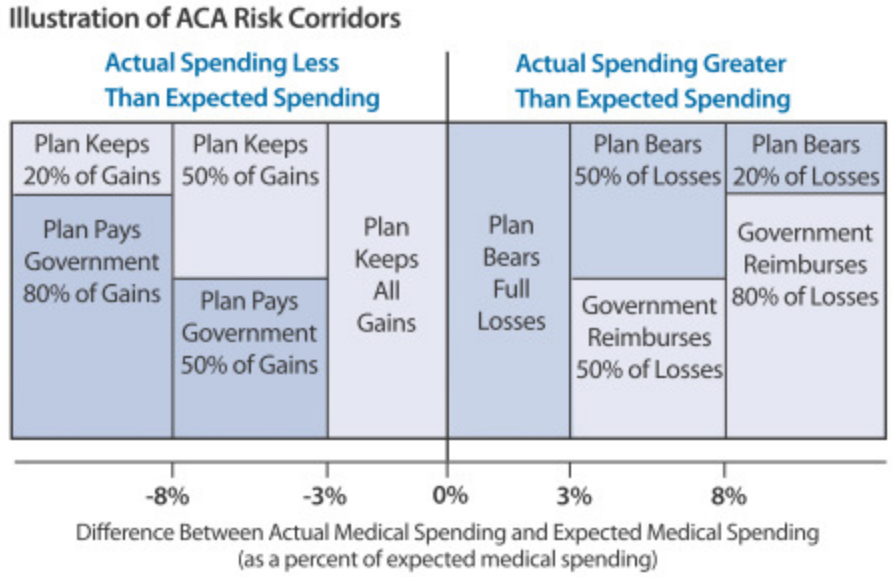
> > (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, ***HHS will pay the QHP issuer*** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
> >
> > (2) When a QHP's allowable 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).

33. This payment regulation, as well as a companion regulation regarding the risk corridor requirements (45 CFR § 153.530), further mandates that QHP issuers 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 QHP issuers 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.

34. Section 1342 and Section 153.510 provide that if a QHP issuer's actual claims in a year covered by the risk corridor program are at least 3% greater than the claims projected

when the issuer set rates for that year, the Government must reimburse the issuer 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 QHP issuers' corresponding obligation to pay the Government if their profits exceed certain amounts):[9]



35. 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 QHPs, it also provides a strong incentive for issuers to participate in the health insurance exchanges set up by the ACA. Lastly, it provides an incentive for issuers to manage their administrative costs optimally."[10]

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[9] *Fact Sheet: ACA Risk-Sharing Mechanisms, The 3Rs (Risk Adjustment, Risk Corridors, and Reinsurance) Explained*, 2013 American Academy of Actuaries, *available at* https://www.actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf.

[10] *See* Doug Norris, Mary van der Heijde and Hans Leida, *Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details*, Health Watch, October

36. Put simply, the risk corridor program recognizes that QHP issuers 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 issuers and help keep premiums at manageable levels while those issuers 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 issuers 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.

37. Based on the risk corridor program and the other two "Three Rs," hundreds of issuers 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 QHP issuers 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.

2013, *available at* http://us.milliman.com/uploadedFiles/insight/2013/Risk-corridors-under-the-ACA.pdf.

B. The Risk Corridor Program Is Politicized Just as It Begins

38. 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. Since Congress enacted the Affordable Care Act, it has not amended or otherwise attempted to modify the actual risk corridor program itself.

39. Despite this, the Defendant has taken several steps to frustrate the entire point of the risk corridor program: timely and complete payment to QHP issuers 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.

40. 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 indicating that the agency would apply a budget neutral approach. 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.[11]

Similar language regarding budget neutrality was found throughout the rule on Exchange and Insurance Market Standards for 2015, published March 2, 2014. However, HHS made the exact opposite statements—indicating it would not apply budget neutrality to the program, because it could not—for several years prior. *See* HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules, 78 Fed. Reg. 15,410, at 15,473 (March 11, 2013) ("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."); Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, at 30,260 (May 27, 2014) (". . . HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, at 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation[12] of the United States Government for which full payment is required.").

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[11] HHS Notice of Benefit and Payment Parameters for 2015, 79 FR 13743, at 13787 (March 11, 2014).

[12] The recording of risk corridor payments as an "obligation" has independent significance. Pursuant to the guidance set forth in the GAO's Red Book, an agency should record as an

41. 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." CMS, "Risk Corridors and Budget Neutrality" (April 11, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. This document further stated that future guidance would explain what would happen if there was still a shortfall after 2016.

42. 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, QHP issuers owed money under the program would only receive pro rata shares of what was paid in by other QHP issuers. If there was a similar shortfall in 2015 and/or 2016, then CMS and HHS would kick the can further down the road and let issuers know only in 2017 (if ever) what the Government planned to do to make them whole.

43. 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 QHP issuers specific amounts if they meet the statutory requirements, and that those QHP issuers "will receive payment from HHS" if they meet the stated requirements.

"obligation" non-discretionary expenditures "imposed by law." GAO, *Principles of Federal Appropriations Law*, 3d Ed., Vol. II, 2006 rev., p. 7-43, GAO-06-382SP.

Nowhere in either Section does it say that the risk corridor payments will come from payments to the Government by other issuers. 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* QHP issuers within 30 days after notification of the amounts they owe under the program. *See* 45 CFR § 153.510(d).)

44. 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. No. 113-235 at 362.

45. The 2015 Spending Bill was enacted on December 16, 2014, nearly a year after Plaintiff and the hundreds of QHP issuers in the Class began offering insurance on the ACA exchanges and eighteen or more months after they had submitted rates for regulatory approval.

Faced with this new development, the QHP issuers 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.

46. 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. No. 114-113 at 383.

47. 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 "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. No. 114-113 at 384 (emphasis added).[13]

48. Then, in 2017, Congress once again enacted the same limitation to specific funds from the 2016 Spending Bill in the 2017 Spending Bill. Pub. L. No. 115-31 at Sec. 223.

49. As discussed below, the Spending Bill Provisions effectively tied CMS's and HHS's hands with respect to their obligations to make risk corridor payments for each of the 2014-2016 plan years. 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 QHP issuers have satisfied their obligations pursuant to Section 1342 and Section 153.510).

C. Constrained by the Spending Bill Provisions, CMS and HHS Default on Majority of 2014 Risk Corridor Payments to QHP issuers and 100% of 2015 and 2016 Payments, Causing Significant Market Disruption

50. 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 2014, 2015, and 2016 plan years and, for the first two plan years, submitted all required data for the risk corridor calculations by 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 in late 2015 and late 2016.

[13] 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."

51. 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 each of the plan years covered by the risk corridors program. Based on the Government's own official calculations, QHP issuers generated only around $457 million in risk corridor gains for the Government in 2014 and 2015, but suffered over $8.67 billion in compensable risk corridor losses in those same years. In CMS's October 1, 2015 and November 18, 2016 statements, it informed Plaintiff and the Class that they would receive just a small fraction of the amounts they were owed under the risk corridor program, which reflected a prorated distribution of the few hundred million dollars received from the few issuers that were required to pay the Government for the 2014 and 2015 plan years. 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.

52. As it became clear QHP issuers would only receive a tiny fraction of what they were owed under the risk corridor program, many began to fail. For example, nearly every consumer operated and oriented plan (CO-OPs) created under the Affordable Care Act announced they were unable to meet cash flow and/or regulatory reserve requirements and many closed their doors due to the deficit of risk corridor payments. As a young insurer, CGHC did not have the cash reserves to cover the degradation of the risk corridors receivable, which meant that CGHC's Risk Based Capital was reduced to company action levels and CGHC's publicly available financial statements showed a loss rather than a gain on its 2015 year-end financials.

Because CMS's announcement regarding its change in the risk corridors program in October 2015 occurred after all plans and rates for 2014, 2015 and 2016 were filed and approved, CGHC had no ability to account for this change in its budget or build it into CGHC's pricing. As a result, CGHC suffered further losses in 2016.

53. A number of other insurance companies have also failed due to the Government's default on the risk corridor amounts it owed, and many more (including several of the nation's largest health plan providers) have withdrawn from the ACA exchanges entirely.

54. 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 QHP issuers ***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 issuers. Although NAIC—and, in several QHP issuers' case, their independent financial auditors—was likely correct to institute this guidance (as the Government's subsequent non-payments demonstrate), it created an incredible burden on QHP issuers. Had QHP issuers been permitted to record the risk corridor payments as balance sheet assets, many would not have run afoul of their regulatory reserve requirements and many would still be providing QHPs on the ACA exchanges today. But even for those QHP issuers that have survived notwithstanding the current market turmoil, the uncertainty the non-payments have caused means that QHP issuers—especially smaller issuers that cannot spread losses associated with the risk corridors across premiums in other channels or other markets—have had to offer health plans at higher prices than before to ensure they are protected from the unknown risk this nascent market still

embodies. This is exactly the opposite of the risk corridors and other Three R programs' intended result.

D. The Government Will Not Make Any Payments Toward 2016 Risk Corridor Amounts

55. Similar to the 2015 and 2016 Spending Bills, the 2017 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 QHP issuers for the 2016 risk corridor results to first pay down the $8.6 billion shortfall from the 2014 and 2015 plan years.

56. As in prior years, QHP issuers continued to lose money on the ACA exchanges in 2016. As disclosed in their 2016 annual and fourth-quarter earnings, the nation's largest health plan providers suffered another year of large losses in the ACA exchanges. For example, Aetna reported pretax losses of $450 million on its public exchange business last year. Humana reported $168 million in estimated risk corridors receivables for the first three quarters of 2016, and UnitedHealth's 2016 losses were steep enough that it is participating in only three individual public exchanges in 2017, down from 34 in 2016. Anthem likewise reported losses in its public exchange business for 2016, pointing to "significant disruptions" on the public exchange market and insurers' "significant losses" on them that prompted many QHPs to withdraw entirely from states' individual exchanges for 2017.

57. These results are consistent with other current data, the sum total of which has caused market analysts to predict that the risk corridor program will continue to experience underfunding for 2016. *See*, *e.g.*, Bannerjee, D., Sung, J., & Marinucci, J., "The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer,"

at 2-5, *Standard & Poor's RatingsDirect* (Dec. 22, 2016). 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.[14]

58. As predicted, the 2016 risk corridor payments to the Government are insufficient to satisfy the Government's full obligations to Plaintiff and the Class for each of 2014-2016, and are insufficient to satisfy the obligations from all three years combined. On November 13, 2017, CMS announced that QHP issuers offering individual or small group plans on the exchanges are owed over $3.95 billion in risk corridors receivables for the 2016 benefit year.[15] However, the Government announced it would only be paying out a total of $24.96 million, and that this would be applied to outstanding 2014 risk corridor amounts, rather than used to reduce 2016 amounts.[16]

59. 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 QHP issuers this year. Plaintiff and the Class are thus in a worse position than when the 2014 and 2015 shortfalls were first announced and have already been told that the Government will not resolve the situation despite its statutory obligations.

60. 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 QHP issuers relied upon the risk corridor program in designing and pricing their 2014, 2015, and 2016 plans, as was the

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

[15] Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, CMS, Nov. 13, 2017, at 2-21, *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

[16] *Id.* at 1-2 ("HHS intends to collect the full 2016 risk corridors charge amounts . . . however, the 2014 payment amounts listed . . . will be reduced pro rata based on collections received.")

intent of the program, Plaintiff, on behalf of itself and the Class, seeks the immediate payment in full of risk corridor receivables for 2016 to enable QHP issuers to survive and continue to offer Americans high-quality, affordable health insurance as contemplated by the Affordable Care Act.

E. The Affordable Care Act Provided Other Ways to Make Health Insurance Affordable, Including the CSR Program, Which Reimbursed QHP Issuers for Payments They Made to Reduce Costs for Low- and Middle-Income Insureds

61. In addition to the Three Rs, the ACA further attempted to stabilize the health insurance market and decrease the cost of health insurance by helping offset certain costs consumers must pay: insurance premiums and out-of-pocket expenses. Section 1401 of the ACA provides premium tax credits for individuals with household income between 100% and 400% of the federal poverty level who purchase health insurance through ACA exchanges and meet certain other requirements. ACA § 1401 [26 U.S.C. § 36B]. Section 1402 of the ACA requires QHP issuers to reduce out-of-pocket costs for eligible insureds (those who are eligible to receive tax credits under Section 1401 and whose household income is below 250% of the poverty level). Section 1402 then requires the Government to reimburse QHP issuers for the costs of those reductions.

62. Section 1402 of the ACA provides as follows:

> In the case of an eligible insured enrolled in a qualified health plan – (1) the Secretary shall notify the issuer of the plan of such eligibility; and (2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

ACA § 1402(a) [42 U.S.C. § 18071]. "Cost-sharing" includes "deductibles, coinsurance, copayments, or similar charges." ACA § 1302(c)(3)(A)(i) [42 U.S.C. § 18022]. QHP issuers must reduce cost sharing for eligible insureds who enroll in "silver plans" through the exchanges, ACA § 1402(c)(2),[17] and QHP issuers must offer at least one "silver" plan in order to participate in the exchanges, ACA § 1301(a)(1)(C)(ii) [42 U.S.C. § 18021].

63. Section 1402 of the ACA further requires the Secretaries of HHS and the Treasury to reimburse QHP issuers for these cost-sharing reductions:

> An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary **shall make periodic and timely payments to the issuer equal to the value of the reductions.**

ACA § 1402(c)(3)(A) [42 U.S.C. § 18071] (emphasis added).

64. Section 1412 of the ACA established a program for making "advance payments" to QHP issuers for both the premium tax credits established by Section 1401 of the ACA and the CSR reimbursements provided by Section 1402. ACA § 1412 [42 U.S.C. § 18082]. With respect to the cost sharing reduction reimbursements, Section 1412 provides that the "Secretary of the Treasury **shall make such advance payment** at such time and in such amount" as specified by HHS. *Id.* at § 1412(c)(3) (emphasis added). The details of this program are set out in implementing regulations. *See e.g.*, 45 C.F.R. § 156.430(b)(1) ("QHP issuer **will receive** periodic advance payments") (emphasis added).

65. Following the ACA's implementation, the Government established a CSR reimbursement schedule under which the Government would provide periodic advance payments

[17] In a "silver" plan, the QHP issuer pays 70% of the average enrollee's health care costs, leaving the enrollee responsible (before application of any subsidy) for the other 30% through cost sharing. *See* 42 U.S.C. § 18022(d)(B).

to QHP issuers, which are then periodically reconciled to the actual amount of cost-sharing reductions provided to enrollees and providers. *See* ACA § 1412 [42 U.S.C. § 18082]; 45 C.F.R. § 156.430(b)-(d). Specifically, CMS established "a payment approach under which HHS would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts."[18] "After the close of the benefit year, QHP issuers must submit to HHS information on the actual value of the cost-sharing reductions provided" and HHS "would then reconcile the advance payments and the actual cost-sharing reduction amounts."[19] Finally, the Government would reimburse the QHP issuer "any amounts necessary to reflect the CSR provided or, as appropriate, the issuer [would] be charged for excess amounts paid to it."[20]

F. Appropriations for Cost Sharing Reduction Reimbursements (or Lack Thereof)

66. As discussed above, Section 1401 of the ACA added a new section to the Internal Revenue Code providing eligible insureds with premium tax credits to cover their health insurance premiums. ACA § 1401 [26 U.S.C. § 36B]. The ACA also amended the pre-existing, permanent appropriation embodied in 31 U.S.C. § 1324. Section 1324 establishes a permanent appropriation of "[n]ecessary amounts…for refunding internal revenue collections as provided by law," including "refunds due from" specified provisions of the tax code. 31 U.S.C. § 1324. Section 1401 of the ACA amended the list in Section 1324 to include "refunds due from" Section

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[18] HHS Notice of Benefit and Payment Parameters for 2014, CMS (March 11, 2013), at 7, *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/payment-notice-technical-summary-3-11-2013.pdf.

[19] *Id.*

[20] Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015, CMS, March 16, 2016, at 28, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf; *see also* 45 C.F.R. 156.430(e).

36B. ACA § 1401. The Obama administration relied on the appropriation in Section 1324 to pay amounts owed under both Sections 1401 and 1402.

67. In April 2013, the Office of Management and Budget ("OMB") submitted a budget request to Congress for fiscal year 2014 that included a request for a line item appropriation designating funds for the payment of cost-sharing reductions. *See* Fiscal Year 2014 Budget of the United States Government, Appendix at 448 (Apr. 10, 2013). The same day, HHS separately submitted its justification to Congressional appropriations committees stating that "CMS requests an appropriation in order to ensure adequate funding to make payments to issuers to cover reduced cost-sharing in FY 2014." *See* HHS, Fiscal Year 2014, CMS, Justification of Estimates for Appropriations Committees at 184 (Apr. 10, 2013) *available at* https://www.cms.gov/about-cms/agency-information/performancebudget/downloads/fy2014-cj-final.pdf.

68. Congress did not provide the line item appropriation requested by HHS. *See* S. Rep. No. 113-71, 113th Cong. at 123 (July 11, 2013) (stating that "[t]he Committee recommendation does not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the ACA") *available at* https://www.congress.gov/113/crpt/srpt71/CRPT-113srpt71.pdf. No subsequent Congressional action has explicitly appropriated money for Section 1402 CSR reimbursements. However, Congress never repealed or amended the CSR provision, and the October 2013 legislation references the existence of CSR reimbursements. *See* Continuing Appropriations Act, 2014, Pub. L. No. 113-46, Div. B, § 1001(a), 127 Stat. 558, 566 (Oct. 17, 2013) (requiring HHS to certify that a program was in place to verify that applicants were eligible for "premium tax

credits . . . and reductions in cost-sharing" before "making such credits and reductions available").

69. Congress has never included any language in appropriations or other bills preventing HHS, CMS, or the Treasury from accessing certain funds or accounts to make CSR payments.

70. In January 2014, the Obama administration began making monthly advance payments to reimburse QHP issuers for cost sharing reductions.[21] The Obama administration cited Section 1324 as the appropriation for these payments.[22]

G. Legal Challenge By House of Representatives

71. On November 21, 2014, the United States House of Representatives filed a complaint against HHS and the Treasury seeking an injunction preventing the executive branch from "making any further Section 1402 Offset Program payments to Insurers unless and until a law appropriating funds for such payments is enacted." *See* Complaint, at 27, *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. 1 (D.D.C. filed 11/21/2014). According to the House of Representatives' Complaint, "Congress has not, and never has, appropriated any funds (whether through temporary appropriations or permanent appropriations) to make any Section 1402 Offset Program payments to Insurers." *Id.* at ¶ 28. However, the Complaint does not allege that Congress amended or repealed the CSR reimbursements. *See generally id.*

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[21] *See* Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015, CMS, March 16, 2016, at 27 ("Payments to issuers of estimated monthly amounts began in January 2014."), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf.

[22] *See* Letter from Sylvia M. Burwell, Dir., OMB, to Senators Ted Cruz and Michael S. Lee, at Responses p. 4 (May 21, 2014), ("cost-sharing subsidy payments are being made through the advance payments program and will be paid out of the same account from which the premium tax credit portion of the advance payments for that program are paid"), *available at* http://www.cruz.senate.gov/files/documents/Letters/20140521_Burwell_Response.pdf.

72. The Obama administration moved for summary judgment, asserting that 31 U.S.C. § 1324 provided a permanent appropriation for both Section 1401 premium tax credits and Section 1402 CSR reimbursements. *See* Defendants' Mem. ISO Mot. for Summary Judgment, *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. 55-1 (D.D.C. Dec. 2, 2015) at 11. The Obama administration argued that CSR reimbursements and premium tax credits "are legally intertwined," and both "are made by the same payer (the Department of the Treasury), to the same recipient (the insurer), on behalf of the same person (the eligible insured), and for the same statutory purpose—'to reduce the premiums payable by individuals eligible for such credit.' 42 U.S.C. § 18082(a)." *Id.* at 2.

73. The district court ruled in favor of the House of Representatives, finding that 31 U.S.C. § 1324 did not constitute a permanent appropriation for Section 1402 CSR reimbursements: "The Affordable Care Act unambiguously appropriates money for Section 1401 premium tax credits but not for Section 1402 reimbursements to insurers." *House v. Burwell*, 185 F. Supp. 3d 165, 168 (D.D.C. 2016). Further, the district court found no other source of appropriation for Section 1402 payments: "Congress authorized reduced cost sharing but did not appropriate monies for it, in the FY 2014 budget or since." *Id.* at 174-75. The district court in *House v. Burwell* entered an injunction preventing any further reimbursements under Section 1402, but stayed the injunction pending resolution of any appeal. *Id.* at 189.

74. The Obama administration appealed the ruling to the D.C. Circuit, and filed its opening brief in October 2016. However, in November 2016, Republican Donald Trump was elected President and the Republican-controlled House of Representatives filed a request that the appeal be "temporarily [held] in abeyance" to "provide the President-Elect and his future Administration time to consider whether to continue prosecuting or to otherwise resolve this

appeal." Appellee's Mot. to Hold Briefing in Abeyance, *House v. Burwell*, Case No. 16-5202, Dkt. #1647228 (D.C. Cir. 11/21/2016) at 1-2. The D.C. Circuit granted the request and the appeal remains in abeyance.

H. The Trump Administration Now Refuses to Pay Cost Sharing Reduction Reimbursements

75. Until October 2017, the Trump administration continued the Obama administration's practice of paying CSR reimbursements. However, on October 11, 2017, Attorney General Sessions submitted a letter to the Department of Treasury and HHS advising that 31 U.S.C. § 1324 could not be used to fund CSR reimbursements. (Ex. 1, Oct. 11, 2017 Ltr. from Sessions to Secretary of Treasury and Acting Secretary of HHS.) Attorney General Sessions concluded that Section 1401 premium tax credits and Section 1402 cost sharing reduction reimbursements were two distinct programs, and the permanent appropriation in Section 1324 only provided funding for the Section 1401 premium tax credits. (*Id.* at 1-2.)

76. The next day, on October 12, 2017, HHS announced that it would stop making CSR reimbursements: "In light of [Attorney General Session's] opinion—and the absence of any other appropriation that could be used to fund CSR payments—CSR payments to issuers must stop, effective immediately. CSR payments are prohibited unless and until a valid appropriation exists." (Ex. 2, Oct., 12, 2017 Mem. from E. Hargan to S. Verma re Payments to Issuers for Cost-Sharing Reductions (CSRs).) The Executive Branch submitted a Notice in the *House v. Burwell* appeal referencing the October 12 HHS Memorandum and noting that "[t]he upcoming October 18 [CSR reimbursement] payment thus will not occur." Notice, *House v. Burwell*, Case No. 16-5202, Dkt. #1698827 (D.C. Cir. Oct. 13, 2017) at 1.

I. Failure to Pay Promised Cost-Sharing Reduction Reimbursements Harms QHP Issuers and Insurance Markets

77. Regardless of whether the Government reimburses QHP issuers for CSR payments, QHP issuers are still required by law to provide such reductions to eligible insureds. These unreimbursed costs are enormous. The CBO estimates that CSR reimbursements to QHP issuers will be $7 billion in fiscal year 2017, $10 billion in 2018, and rise to $16 billion by 2027.[23] An April 2017 study analyzing the potential effect of ending CSR reimbursements predicted that "[m]any insurers might react to the end of subsidy payments by exiting the ACA marketplaces. If insurers choose to remain in the marketplaces, they would need to raise premiums to offset the loss of the payments."[24]

78. While the CSR reimbursements ended only five weeks ago, it is already clear that the Government's failure to make these payments to QHP issuers is wreaking havoc in the insurance markets and with QHP issuers' bottom lines. The anticipated cessation of CSR reimbursements has already caused QHP issuers to raise premiums 7% to 38%, which has had dramatic effects on low- and middle-income insureds' ability to maintain health insurance coverage.[25] As an October 13, 2017 joint statement from America's Health Insurance Plans (AHIP) and Blue Cross and Blue Shield Association (BCBSA) noted, the decision to end CSR

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[23] *See* Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline at 4, *available at* https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.

[24] Larry Levitt, Cynthia Cox, and Gary Claxton, *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments*, Kaiser Family Foundation, Apr. 25, 2017, *available at* https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/.

[25] Rabah Kamal, *et al*, *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums*, Oct. 27, 2017, Kaiser Family Foundation, *available at* https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

reimbursements has "real consequences," including that "[c]osts will go up and choices will be restricted."[26] These effects are currently playing out in every major ACA exchange across the country.

79. Indeed, in anticipation of, and in response to, the Trump administration's action, some QHP issuers have already decided to exit the exchanges. For example, in August 2017, Anthem announced that it would no longer offer individual coverage via the exchange in Nevada, citing "continual changes and uncertainty in federal operations, rules and guidance, including cost sharing reduction subsidies."[27] Likewise, Molina Healthcare withdrew from the exchanges in Utah and Wisconsin in reaction to the uncertainty of receiving CSR and other reimbursements.[28] *See also* Paul Demko, *GOP uncertainty over Obamacare drives out insurers*, POLITICO, June 8, 2017 ("the Trump administration's refusal to commit to continue paying crucial subsidies—estimated at $7 billion for this year—has made health plans skittish about remaining in the marketplaces as crucial deadlines approach for 2018"), *available at* https://www.politico.com/story/2017/06/08/gop-uncertainty-over-obamacare-drives-out-insurers-239281.

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[26] *Health Plans Issue Joint Statement Regarding Funding for Cost-Sharing Reduction Benefits for Millions of Americans*, Oct. 13, 2017, *available at* https://www.ahip.org/joint-statement-regarding-funding-for-crs/.

[27] *Anthem Statement on Individual Market Participation in Nevada*, Aug. 7, 2017, *available at* https://www.anthem.com/press/nevada/anthem-statement-on-individual-market-participation-in-nevada/.

[28] *See* Bruce Japsen, *Molina Will Pull Obamacare From Wisconsin And Utah Amid Trump Subsidy Threats*, FORBES, Aug. 2, 2017, *available at* https://www.forbes.com/sites/brucejapsen/2017/08/02/molina-will-pull-obamacare-wisconsin-utah-amid-trump-subsidy-threats/#1e5666d736dd; *see also Molina Healthcare Announces Second Quarter Results and Restructuring Plan*, Molina Healthcare, Inc. News Release, Aug. 2, 2017, *available at* https://molinahealthcare.gcs-web.com/news-releases/news-release-details/molina-healthcare-announces-second-quarter-results-and.

80. CGHC is not immune to these harms, and in fact has already suffered, and will continue to suffer, their effects. Like other QHP issuers, CGHC was owed monthly CSR reimbursements in October 2017 and November 2017 that have not been paid. CGHC estimates it will be owed $12-13 million in unpaid CSR reimbursements for 2017, and estimates it will be owed $60 million in CSR reimbursements for 2018. Like other QHP issuers, CGHC is still required by law to provide cost-sharing reductions to eligible insureds, despite not receiving the promised reimbursement from the Government. This has caused CGHC and other QHP issuers to suffer large financial losses that will soon be catastrophic if payments are not resumed. It also leads to instability in the insurance markets and inhibits CGHC's and other QHP issuers' ability to design and price plans for the ACA exchanges.

CLASS ACTION ALLEGATIONS

Risk Corridors Class

81. Plaintiff brings this action as a class action under Rule 23(a) and (b) of the Rules of the United States Court of Federal Claims, on behalf of itself and others similarly situated. The proposed "Risk Corridors Class" is defined as:

> All persons or entities offering Qualified Health Plans under the Patient Protection and Affordable Care Act in the 2016 benefit year, and whose allowable costs in the 2016 benefit year, as calculated by the Centers for Medicare and Medicaid Services, 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.

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

83. There are questions of law and fact common to the Risk Corridors 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 Risk Corridors Class absolves it of its statutory obligations;

d. whether the Government violated its obligations to pay Plaintiff and the Risk Corridors 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 Risk Corridors Class for failing to make risk corridor payments within a reasonable time following the official calculation of those amounts.

84. Plaintiff's claims are typical of the claims of the other Risk Corridors Class Members. Plaintiff and the Risk Corridors 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 Risk Corridors Class Member were directly caused by Defendant's wrongful conduct in violation of the laws as alleged herein.

85. Plaintiff will fairly and adequately protect the interests of the Risk Corridors Class Members. Plaintiff is an adequate representative of the Risk Corridors Class and has no interests adverse to the interests of absent Risk Corridors Class Members. Plaintiff has retained counsel

competent and experienced in complex class action litigation, including commodity futures manipulation and antitrust class action litigation.

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

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

88. 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 Risk Corridors Class is readily definable and is one for which records should exist in the files of the Defendant, Risk Corridors Class Members, or the public record. Class treatment will also permit the adjudication of relatively small claims by many Risk Corridors 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.

89. This Court has already granted class certification of a nearly identical class of QHP issuers for the 2014 and 2015 benefit years in the related case of *Health Republic Insurance Company v. United States*. *See* Class Certification Order, Case No. 1:16-cv-00259-MMS, Dkt. 30 (Fed. Cl. 1/3/2017).

CSR Class

90. Plaintiff brings this action as a class action under Rule 23(a) and (b) of the Rules of the United States Court of Federal Claims, on behalf of itself and others similarly situated. The proposed "CSR Class" is defined as:

> All persons or entities offering Qualified Health Plans under the Patient Protection and Affordable Care Act in the 2017 or 2018 benefit year, and who made cost-sharing reductions for eligible insureds pursuant to Section 1402 of the Patient Protection and Affordable Care Act, but did not receive a "timely and periodic" payment from the Government of an amount "equal to the value of the reductions" provided to its insureds. Excluded from the Class is the Defendant and its members, agencies, divisions, departments, and employees.

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

92. There are questions of law and fact common to the CSR 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 1402 of the Affordable Care Act is a money-mandating statute;

b. whether 45 CFR § 156.430 is a money-mandating regulation;

c. whether the Government's failure to appropriate funds sufficient to make cost sharing reduction reimbursements to Plaintiff and the CSR Class absolves it of its statutory obligations;

d. whether the Government violated its obligations to pay Plaintiff and the CSR Class cost sharing reduction reimbursement amounts in a periodic and timely fashion; and

e. whether the Government is liable to Plaintiff and the CSR Class for failing to pay cost sharing reduction reimbursements in a periodic and timely fashion.

93. Plaintiff's claims are typical of the claims of the other CSR Class Members. Plaintiff and the CSR 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 CSR Class Member were directly caused by Defendant's wrongful conduct in violation of the laws as alleged herein.

94. Plaintiff will fairly and adequately protect the interests of the CSR Class Members. Plaintiff is an adequate representative of the CSR Class and has no interests adverse to the interests of absent CSR Class Members. Plaintiff has retained counsel competent and experienced in complex class action litigation, including commodity futures manipulation and antitrust class action litigation.

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

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

97. 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 CSR Class is readily definable and is one for which records should exist in the files of the Defendant, CSR Class Members, or the public record. Class treatment will also permit the adjudication of relatively small claims by many CSR

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

(Risk Corridors: Violation of Statutory and Regulatory Mandate to Make Payments)

98. Plaintiff realleges and incorporates the above Paragraphs 1-97 as if fully set forth herein.

99. 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 issuer certain amounts exceeding the target costs they incurred in 2016.

100. Plaintiff and the Risk Corridors Class are QHP issuers 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).

101. 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 and regulations for 2016.

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

COUNT TWO

(Cost-Sharing Reductions: Violation of Statutory and Regulatory Mandate to Make Payments)

103. Plaintiff realleges and incorporates the above Paragraphs 1-102 as if fully set forth herein.

104. As part of its obligations under Section 1402 of the ACA and/or its obligations under 45 CFR § 156.430, the Government is required to, subject to certain explicit statutory and/or regulatory conditions, reimburse any QHP issuer for an amount equal to the value of the cost sharing reductions the QHP issuer provided to eligible insureds.

105. Plaintiff and the CSR Class are QHP issuers under the ACA and, based on their adherence to the ACA, the cost sharing reductions provided to their eligible insureds, and their submission of their actual amounts to CMS, satisfy the requirements for payment from the United States under Section 1402 of the ACA and 45 CFR § 156.430.

106. The United States has failed, without justification, to perform as it is obligated under Section 1402 of the Affordable Care Act and 45 CFR § 156.430 and has affirmatively stated that it will not satisfy those obligations in the time frame required by the statutes and regulations.

107. The United States' failure to provide periodic and timely payments to Plaintiff and the CSR Class is a violation of Section 1402 of the Affordable Care Act and 45 CFR § 156.430, and Plaintiff and the CSR Class have been damaged thereby.

PRAYER FOR RELIEF

Wherefore, Plaintiff and the Class request 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 Rules of the United States Court of Federal Claims, 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 Risk Corridors Class monetary relief in the amounts to which Plaintiff and the Risk Corridors 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 CSR Class monetary relief in the amounts to which Plaintiff and the CSR Class are entitled under Section 1402 of the Affordable Care Act and 45 CFR § 156.430.

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

DATED: November 22, 2017

Respectfully submitted,

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Attorneys for Plaintiff Common Ground Healthcare Cooperative and the Class

EXHIBIT 1

Office of the Attorney General
Washington, D. C. 20530

October 11, 2017

The Hon. Steven Mnuchin, Secretary of the Treasury
U.S Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Don Wright, M.D., M.P.H., Acting Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Mnuchin and Acting Secretary Wright:

You have asked for my legal opinion as to whether the permanent appropriation for "refunding internal revenue collections," 31 U.S.C. § 1324, is available to fund the cost-sharing reduction (CSR) payments authorized by section 1402 of the Affordable Care Act, 42 U.S.C. § 18071. As you are aware, the prior administration originally sought an appropriation to fund CSR payments—suggesting it believed such an appropriation was necessary—but then later concluded that section 1324's permanent appropriation was available. The U.S. House of Representatives sued, contending that Congress had not appropriated funds for CSR payments. The U.S. District Court for the District of Columbia agreed, holding that section 1324 does not appropriate funds for CSR payments. *U.S. House of Reps. v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016). The district court "enjoin[ed] any further reimbursements under Section 1402 until a valid appropriation is in place," but "stay[ed] its injunction pending any appeal by the parties." *Id.* at 189. The prior administration appealed that decision, and the D.C. Circuit has held the appeal in abeyance to allow time for a resolution that would obviate the need for judicial determination of the appeal, including potential legislative action.

The Department of Justice has consulted with your Departments, as well as the Office of Management and Budget, all of which have now expressed the view that section 1324 does not appropriate funds for the CSR program. Although the Department of Justice has previously defended in court the government's decision to use the permanent appropriation in section 1324 for CSR payments, I have concluded that the best interpretation of the law is that the permanent appropriation for "refunding internal revenue collections," 31 U.S.C. § 1324, cannot be used to fund the CSR payments to insurers authorized by 42 U.S.C. § 18071.

First, "[i]f the statutory language is plain," it must be enforced "according to its terms." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). Here, the plain reading of the text is that the ACA permanently appropriated money for section 1401 premium tax credits, but not for section 1402

CSR payments to insurers. As relevant here, the ACA created two distinct programs that both have the broad purpose of providing government funding for the cost of health insurance obtained through ACA exchanges. Section 1401(a) created a program to reduce the health insurance premiums of qualified individuals by providing those individuals with refundable tax credits. Congress appropriated funds for this program in the ACA by: (1) amending the Internal Revenue Code to add a new refundable tax credit provision (§ 36B, entitled "Refundable Credit for Coverage Under a Qualified Health Plan"), *see* ACA § 1401(a); and (2) amending 31 U.S.C. § 1324—a preexisting funding provision that provides a permanent appropriation "for refunding internal revenue collections as provided by law," *id.* § 1324(a)—to include the new Internal Revenue Code § 36B credit in its list of permanently funded tax credits, *see* ACA § 1401(d)(1). That is, Congress amended the funding provision to provide for payment of "refunds due … from section … 36B." 31 U.S.C. § 1324(b)(2).

Separately, the ACA created the section 1402 CSR program, which Congress did not include in the Internal Revenue Code. Section 1402 (1) requires insurers offering policies through ACA exchanges to reduce co-payments and other out-of-pocket costs for certain policyholders (reductions referred to in the ACA as "Cost-Sharing Reductions"), *see* ACA § 1402, codified at 42 U.S.C. § 18071; and (2) authorizes the federal government to make payments directly to insurers to offset the lost revenue these reductions cause, *see* ACA § 1412(c)(3). But unlike with section 1401's refundable tax credit, the ACA did not itself provide an appropriation to directly fund the section 1402 CSR program. The ACA's amendment to the permanent appropriation in 31 U.S.C. § 1324 refers only to section 1401 tax credits (i.e., "refunds due … from [Internal Revenue Code] section … 36B"), and makes no reference to section 1402 payments (i.e., 42 U.S.C. § 18071 payments). As amended by the ACA, that appropriation provision thus supplies funding for Internal Revenue Code § 36B tax credits to insureds, but not for 42 U.S.C. § 18071 CSR payments to insurers.

Second, although the "meaning—or ambiguity—of certain words or phrases may only become evident when placed in context," *King*, 135 S. Ct. at 2489, the statutory context of these provisions is consistent with their plain meaning. As noted above, while the two payment provisions appear sequentially within the ACA, only the section 1401 tax credits are included in the Internal Revenue Code (consistent with their status as tax credits for taxpayers). It is logical that the permanent appropriation in 31 U.S.C. § 1324—which funds a variety of tax expenditures—would fund the ACA's tax credits. But it would make little sense for a provision that appropriates funds for "refunding internal revenue collections," 31 U.S.C. § 1324(a), to also (and without saying so) permanently fund a non-tax program that provides payments to insurers.

The prior administration contended that CSR payments should be deemed "refunds due … from section … 36B" on the ground that both types of payments are essentially two parts of a single program. But the two programs are distinct. Each is authorized by a separate provision in a separate title of the U.S. Code; each has a different focus (tax credits for premiums, CSR payments for out-of-pocket costs); each functions differently; and each has a different eligibility formula. It is true that ACA section 1402(f)(2) provides CSRs are not "allowed … unless … a credit is allowed to the insured … under section 36B," but that provision means only that individuals who are ineligible for a tax credit are likewise ineligible for CSRs. It does not mean that CSR payments are the same as tax credits under section 36B—or even that they have the same

eligibility requirements. *Compare* 26 U.S.C. § 36B(c)(1)(A) (policyholder is eligible for tax credits if household income is between 100 and 400 percent of the federal poverty level), *with* 42 U.S.C. § 18071 (complex CSR formula providing for income-based reductions, adjustments to reductions to maintain actuarial levels, and additional reductions for lower-income insureds); *see also House of Reps.*, 185 F. Supp. 3d at 176. Indeed, the distinction between the programs is reflected throughout the ACA, including in the section providing for advance payments of both tax credits and CSRs to insurers—a provision that bundles the two types of payments together but nonetheless carefully distinguishes between the two programs. *See generally* 42 U.S.C. § 18082.

The issue here is quite different from the statutory question in *King*. There, the Supreme Court held that certain language within the ACA seemed unambiguous in isolation, but did not make sense in the context of the rest of the Act because "the most natural reading of the pertinent statutory phrase" would have prevented two of the ACA's "three major" policy changes from being applicable in certain States—something the Court saw as a "calamitous result that Congress plainly meant to avoid." 135 S. Ct. 2493, 2495-96. Here, the two programs in the ACA that provide government funding for insurance costs function properly when operated according to their terms. Unlike in *King*, practical difficulties do not result from any conflict or inconsistency within the ACA; rather, practical difficulties result, if at all, from Congress's post-ACA decision to not appropriate money for CSR payments. Nothing in *King* suggested that the ACA's plain text can be ignored in order to override the intentional legislative decisions of subsequent Congresses.

Congress has the power of the purse, and it is up to Congress to decide which programs it will and will not fund. *See, e.g.*, *House of Reps.*, 185 F. Supp. 3d at 184 (recounting instance when Congress conferred "permanent authority" on Treasury "to permit prepayment ... to territorial treasuries of estimates of moneys to be collected" but made "no subsequent appropriation," such that "no such money could be spent"). There is no more fundamental power granted to the Legislative Branch than its exclusive power to appropriate funds. And the Executive Branch cannot unilaterally spend money that Congress has not appropriated. Congress's repeated choice to deny funding for CSR payments is thus Congress's prerogative. When Congress refuses to appropriate money for a program, the Executive is required to respect that decision.

Third, the contemporary evidence is consistent with this straightforward interpretation of the ACA's text. The prior administration, in the President's *Fiscal Year 2014 Budget of the U.S. Government*, and in the HHS-submitted House and Senate *Justification of Estimates for Appropriations Committees*, sought an appropriation for section 1402 CSR payments. *See House of Reps.*, 185 F. Supp. 3d at 186. These requests suggest that the prior administration initially believed that—unlike with section 1401 tax credits—it needed an appropriation from Congress to fund section 1402 CSR payments to insurers. It was only months after these submissions that the prior administration adopted an interpretation of the ACA that authorized funding CSR payments out of the permanent appropriation in 31 U.S.C. § 1324.

Finally, it is not surprising the Congress chose to retain the power of the purse, even for an important component of the ACA. After all: "Most current appropriations are adopted on an annual basis and must be re-authorized for each fiscal year. Such appropriations are an integral part of our constitutional checks and balances, insofar as they tie the Executive Branch to the Legislative Branch via purse strings." *House of Reps.*, 185 F. Supp. 3d at 169-70.

In sum, it is my opinion that the best interpretation of the law is that section 1324 does not appropriate funds for the Affordable Care Act's Cost-Sharing Reduction program.

Sincerely,

Jefferson B. Sessions III
Attorney General of the United States

EXHIBIT 2

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

To: Seema Verma, Administrator
Centers for Medicare and Medicaid Services

From: Eric Hargan
Acting Secretary

Date: October 12, 2017

Re: Payments to Issuers for Cost-Sharing Reductions (CSRs)

The Attorney General of the United States has provided the U.S. Department of Health & Human Services (HHS) and the U.S. Department of the Treasury with the attached legal opinion regarding CSR payments made to issuers of qualified health plans. In light of that opinion—and the absence of any other appropriation that could be used to fund CSR payments—CSR payments to issuers must stop, effective immediately. CSR payments are prohibited unless and until a valid appropriation exists.