Receipt number 9998-5563852

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

EMBLEMHEALTH, INC., HEALTH INSURANCE PLAN OF GREATER NEW YORK, INC., and CONNECTICARE BENEFITS, INC.,

Plaintiffs,

v.

THE UNITED STATES OF AMERICA,

Defendant.

No. 19-1164 C

COMPLAINT

Plaintiffs EmblemHealth, Inc. and its subsidiaries Health Insurance Plan of Greater New York, Inc. ("HIP") and ConnectiCare Benefits, Inc. ("ConnectiCare") (collectively, "EmblemHealth") bring this action against the United States of America (the "Government") for money damages arising out of the Government's failure to make required payments to EmblemHealth for cost-sharing reductions mandated by § 1402 of the Patient Protection and Affordable Care Act ("ACA" or "Affordable Care Act"), and implemented by the United States Department of Health and Human Services ("HHS" or "Department") and the Centers for Medicare and Medicaid Services ("CMS"), with respect to the 2018 plan year.

NATURE OF THE ACTION

1. The Affordable Care Act significantly altered the regulation of health insurance coverage in the United States by imposing a new set of minimum federal standards for how health insurers (including EmblemHealth) developed, sold, and marketed commercial health insurance to both individuals and employers.

2. In particular, the ACA mandated the creation of health insurance marketplaces. These marketplaces – also known as exchanges – are online platforms through which insurers sell Qualified Health Plans ("QHPs").

3. QHPs, which must meet certain minimum value and benefit design standards, are certified by the exchanges. Insurers that issue QHPs are required to: (i) offer a variety of plans based on actuarial value, measured in metal-level tiers (*i.e.*, platinum, gold, silver, and bronze); (ii) cover federally determined essential health benefits, as well as any additional state-mandated benefits; and (iii) charge premium rates that are approved by the state insurance regulator consistent with federal rate review requirements.

4. At the same time, the ACA also imposed a new set of insurance market reforms that applied to individual and small group market coverage generally. These reforms had significant effects on the way insurers priced and sold insurance products, and marked a stark departure from the pre-ACA regulatory regime.

5. For example, the ACA's new federal rating rules prevented insurers from setting rates in the individual and small group insurance markets based on health status of the individuals seeking insurance. Rather, the new rules imposed a modified community rating requirement that limited rating factors to age, tobacco usage and whether coverage was for an

individual or an individual and his or her family. Simultaneously, the ACA prohibited insurers from excluding coverage for pre-existing conditions.

6. Under this approach, insurers were required to base the underlying rate on the total risk anticipated by the insurer for all individuals covered within a given market in a geographic area, *i.e.*, the single risk pool. Pre-existing condition exclusions that had protected insurers from adverse selection (and the risk of higher than anticipated claims experience) caused by covering individuals who selected a certain plan or policy based on a disease or condition that would be more generously covered in a given plan were no longer permitted.

7. QHP enrollees were generally expected to be individuals that did not have group health plan coverage through their employers and limited access to individual coverage due to premium costs in excess of financial capacity to pay or due to medical histories that had rendered them unable to qualify for individual insurance prior to the ACA.

8. However, to encourage healthy individuals – as well as those individuals who were previously unable to purchase adequate coverage for financial and/or medical history reasons – to purchase QHPs through an exchange, the ACA offered advanced-payable premium tax credits ("APTCs"). APTCs subsidized the premium for individuals whose income was at or below 400 percent of the federal poverty line and who were not enrolled in Medicaid.

9. Congress provided additional support for individuals with income less than 250 percent of the federal poverty line, but more than 100 percent of the federal poverty line. Those individuals were also eligible for cost-sharing reductions ("CSRs"), which limited the out of pocket costs of the plan in which the individual enrolled.

10. Operationally, under the ACA's CSR provision, insurers that offered QHPs were required to develop and offer one silver-level plan that reduced cost-sharing imposed on CSR-

eligible enrollees, with the government reimbursing insurers through periodic payments in an amount equal to the CSRs paid by the insurers on behalf of the enrollees.

11. The statute is clear that the Department must make payments to insurers to reimburse them for the CSRs that insurers were required to provide on behalf of their CSR-eligible enrollees. Nowhere does the statute condition reimbursement to insurers by the Department on the appropriation of sufficient funds from Congress, or condition the payment of CSRs by insurers on the appropriation of sufficient funds from Congress.

12. Beginning in January 2014, insurers (including EmblemHealth) that offered QHPs have provided reduced cost-sharing to CSR-eligible enrollees. Consistent with the language of the statute, the Department consistently made payments on a monthly basis from the beginning of the program in January 2014 through October 2017 to insurers to reimburse them for the CSRs they provided to enrollees.

13. On October 12, 2017, the Department announced that pursuant to a legal opinion issued by the Department of Justice, there were no appropriations made by Congress for the cost-sharing reduction reimbursements to insurers from the government, and that any future reimbursements to reimburse insurers for the CSRs they provided on behalf of enrollees would cease in the absence of an express appropriation by Congress.

14. The final CSR reimbursements were made to insurers on October 22, 2017. No reimbursements have been made by the Department for CSRs since that date.

JURISDICTION AND VENUE

15. This is an action for damages based on the violation of a money-mandating statute and regulation, breach of contract, and violation of the Fifth Amendment to the United States Constitution under the Tucker Act, 28 U.S.C. § 1491.

16. This Court has jurisdiction over this action pursuant to the Tucker Act, 28 U.S.C. § 1491(a), which allows the United States Court of Federal Claims to hear claims for money damages against the United States "founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." Additionally, as discussed more fully herein, the cost-sharing reductions statute, Section 1402 of the ACA, codified at 42 U.S.C. § 18071, the cost-sharing reductions regulation, 42 C.F.R. § 156.430, EmblemHealth's implied-in-fact contract with the Government, and EmblemHealth's Takings Claim in violation of the Fifth Amendment to the United States Constitution create a right to money damages.

17. Venue is proper before the U.S. Court of Federal Claims because EmblemHealth seeks damages from the Government in excess of $10,000.

18. This dispute is ripe because the Government has failed to pay cost-sharing reduction reimbursements presently due to EmblemHealth.

PARTIES

19. EmblemHealth, Inc. is a not-for-profit New York corporation with its principal place of business at 55 Water Street, New York, New York 10041. EmblemHealth, Inc., through its health insurance subsidiaries – including HIP and ConnectiCare – provides medical and dental insurance plans in New York and Connecticut.

20. The Government is responsible for the ACA and the payment of cost-sharing reduction reimbursements, including all related actions taken by the Department, CMS, and the United States Department of the Treasury.

FACTUAL ALLEGATIONS

The Affordable Care Act

21. The Affordable Care Act, Pub. Law 111-148, as amended by the Health Care and Education Reconciliation Act, Pub. Law 111-152, adopted broad-based structural changes to the manner in which the federal government and, as a result, state governments regulated the sale of health insurance. The ACA included significant new substantive requirements, the so-called market reforms, which set federal minimum standards that insurers must meet in order to sell health insurance. *See* ACA §§ 1001, 1201 (amending the Public Health Service Act (the "PHSA")). The ACA also included new incentives for previously uninsured individuals to purchase insurance in the form of tax credits and cost-sharing reductions. *See* ACA §§ 1401, 1402, and 1412. Additionally, the ACA required that the states establish health benefit exchanges to facilitate the sale of insurance, and that the Secretary develop minimum standards for both the exchanges and the certification of QHPs sold through the exchanges. ACA § 1311(b) and (c).

22. Among the market reforms, insurers were: precluded from relying on individuals' medical history in setting premium rates (PHSA § 2701); required to guarantee sale of coverage to individuals and small employers (PHSA § 2702); prohibited from imposing pre-existing condition exclusions (PHSA § 2704); and required to cover essential health benefits in the individual and small group markets (PHSA § 2707). In combination, these provisions created a minimum level of benefit for individuals purchasing coverage through an exchange by mandating covering both individuals (through the guaranteed issue requirement) and conditions (through the pre-existing conditions and essential health benefit provisions).

23. The ACA also imposed a mandate on individuals who failed to maintain minimum essential coverage, either through their employer, enrolling in a governmental program, or purchasing coverage on the commercial markets. 26 U.S.C. § 5000A(a).

24. Congress incentivized purchase of coverage for individuals with income at or below 400 percent of the federal poverty level through the premium tax credits paid directly to the insurer to reduce the premium cost to the individual. *See* ACA § 1412 and 26 U.S.C. § 36B. For lower income individuals, Congress also provided cost-sharing reductions which significantly increased the value of coverage for individuals whose income was at or below 250 percent of federal poverty. ACA § 1402(c). Like the APTCs, the generosity of the cost-sharing subsidy increases for individuals at lower incomes.

25. Because individuals are only eligible for the subsidies if they purchase coverage sold through the exchanges, the ACA was designed to drive the previously uninsured population into the QHPs sold through exchanges. Accordingly, establishment of exchanges and QHP standards was another essential aspect of the Secretary's role in implementing the Affordable Care Act. Indeed, if the Secretary determined that a state-exchange did not meet federal standards, the Secretary was required to operate an exchange on behalf of the state. ACA § 1321(c). Similarly, it was critical that health insurers agreed to offer QHPs through exchanges; without issuer participation, individuals could not access subsidized coverage.

26. The regulations implementing the ACA's exchange provisions make clear that insurers that offer QHPs on an exchange will receive payment for tax credits for qualified individuals under 26 U.S.C. § 36B. *See* 45 C.F.R 156.460. An insurer will receive those payments after submitting a notice to the exchange that a qualified individual is enrolled, and the insurer has reduced the premium amount to reflect the APTC, notified the exchange of the

reduction, and included the amount of the APTC and the remaining premium in the billing statement to the enrollee. *Id*. at § 156.460(a).

27. Similarly, the Government is required to reimburse QHP issuers for the statutorily-required cost-sharing reductions that they pay to providers on behalf of eligible QHP-enrollees. Section 1402 provides:

> 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.

42 U.S.C. § 18071(c)(3)(A) (emphasis added).

28. Regulations implementing the CSR reimbursement requirement provide that insurers that sell CSR-eligible QHPs to eligible individuals will receive payments directly from the government in the amount of payments made by the insurer to the provider. 42 U.S.C. § §18071, 18082; 45 C.F.R. § 156.430(b).

29. The statutory and regulatory mandates to reimburse QHP issuers for CSRs provided to eligible enrollees are, and have been at all relevant times, effective and have not been repealed.

Cost-Sharing Reduction Program

30. In its Fiscal Year 2014 budget request, the Obama Administration requested discretionary funding for the payment of CSR reimbursements by the Department to QHP issuers. *Fiscal Year 2014 Budget of the United States Government to Congress* (2013)

31. Congress did not include any specific appropriation for the payment of cost-sharing reduction reimbursements to QHP issuers for Fiscal Year 2013. Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5.

32. Nevertheless, the Department began to make payments to QHP issuers for cost-sharing reductions effective January 1, 2014. Letter from Sylvia M. Burwell, Director of the Office of Mgmt. & Budget, to Ted Cruz and Michael S. Lee, U.S. Senators 4 (May 21, 2014), http://www.cruz.senate.gov/files/documents/Letters/20140521_ Burwell_Response.pdf. Reimbursements to insurers were made based on a permanent appropriation for tax refund, and related, payments. 31 U.S.C. § 1324.

33. On November 21, 2014, in the United States District Court for the District of Columbia, the United States House of Representatives (the "House") challenged the payment of CSR reimbursements from the permanent tax refund appropriation in the D.C. District Court on the grounds that HHS' reimbursement of CSRs without an appropriation violated the House's Constitutional right to establish federal payments. Complaint at ¶¶ 25-41, *House of Representatives v. Burwell,* 185 F.Supp.3d 165 (D.D.C. Nov. 21, 2014) (No. 14-1967), 2014 WL 6492097.

34. The District Court in that case agreed with the House's position and entered an injunction against future reimbursements of CSRs unless funds were specifically appropriated by Congress. The injunction was stayed pending the Obama Administration's appeal of the case to the D.C. Circuit, which was filed in July of 2016. The D.C. Circuit granted an abeyance of the appeal while the Trump Administration and the House negotiated a settlement. *United States House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 189 (D.D.C. 2016)

35. On October 11, 2017, Attorney General Sessions provided an opinion to the Department regarding the availability of the permanent tax refund appropriation for ongoing CSR payments, stating that there was no legal basis to make ongoing CSR payments to QHP issuers based upon the permanent tax refund appropriation.

36. On October 12, 2017, and in reliance on the Attorney General's opinion, the Department ceased future payments of CSR reimbursements to QHP issuers effective immediately.

37. This abrupt discontinuance in CSR payments materially harmed EmblemHealth by eliminating statutorily required payments to EmblemHealth by the Government.

EmblemHealth's QHPs

38. Congress's enactment of the ACA, the Department and CMS's regulations implementing the ACA, and numerous other written and oral communications by the Government, the Department, and CMS conditioned a variety of benefits – including APTCs, cost-sharing subsidies, risk adjustment and risk corridors payments – on insurers agreeing to participate in the exchanges.

39. EmblemHealth accepted this offer to provide QHPs by participating in exchanges in New York and Connecticut.

40. In particular, EmblemHealth entered into an agreement with the New York Department of Health to offer QHPs on the New York State Health Insurance Exchange (the "New York Exchange") on July 31, 2013. *See* Agreement between Department of Health and Health Insurance Plan of Greater NY (the "NY Agreement") attached as Exhibit 1. The term of the NY Agreement runs from November 1, 2015 (the first day of open enrollment for the 2016 plan year) through December 31, 2020.

41. The NY Agreement required EmblemHealth to offer QHPs for the entire period and to meet all applicable requirements, including those imposed on insurers by the regulations implementing the ACAs cost-sharing reductions. *See generally*, NY Agreement, Appendix C, at § III(B) and (C). The NY Agreement also barred EmblemHealth from making modifications to

the QHP standardized benefits or cost-sharing structures, unless required by state or federal law. *Id.* at § III(C)(3).

42. Moreover, the NY Agreement, consistent with federal regulatory requirements, required that EmblemHealth submit annual premium rate and form filings. *Id*. at § V(A)(2). Importantly, the NY Agreement permitted EmblemHealth to terminate the NY Agreement, and subsequently not offer QHPs, only if EmblemHealth notified "the Exchange of circumstances causing the CONTRACTOR to be ***unable to perform activities and services required under this AGREEMENT.***" *Id.* § X(F) (emphasis added).

43. Similarly, on September 30, 2013, EmblemHealth entered into an agreement with the Connecticut Health Insurance Exchange ("Access Health CT") to offer QHPs in Connecticut. *See* Agreement Between the Connecticut Health Insurance Exchange d/b/a Access Health CT and ConnectiCare Benefits, Inc. (the "CT Agreement") attached as Exhibit 2. The term of the CT Agreement ran from October 1, 2013 through December 31, 2015. The parties agreed to a written amendment of the CT Agreement (the "CT Amendment") effective January 1, 2016 through December 31, 2017. *See* CT Amendment at Preamble, attached as Exhibit 3. The parties subsequently agreed to extend ConnectiCare's partication in Access Health CT through December 31, 2018. *See* Acess Health CT Certification of Issuer's QHPs for Inclusion as Access Health CT Offering for the 2018 Plan Year, attached as Exhibit 4.

44. The CT Agreement required EmblemHealth to offer QHPs in Connecticut for the term of the Agreement and to comply with all "State and Federal laws and regulations applicable to the performance of" EmblemHealth's obligations, which necessarily include the payment of cost-sharing reductions. *See* CT Agreement at Sec. 3.24(A). The CT Agreement also specified that the Exchange, and not EmblemHealth, would "define a cost sharing and benefit design for

each standard plan, which may be amended from time to time as deemed necessary by the Exchange." *See* CT Agreement at Sec. 3.2(B).

45. Consistent with federal regulatory requirements, the CT Agreement required that EmblemHealth submit annual rate filings to the Connecticut Department of Insurance. *Id.* at Sec. 3.1(E)(1).

46. EmblemHealth submitted rates for review by the New York Department of Financial Services and the Connecticut Insurance Department consistent with the ACA's market reforms and the NY and CT Agreements for the 2017 and 2018 plan years.

47. EmblemHealth considered a number of relevant factors in setting rates. Specifically, EmblemHealth considered the costs of medical and pharmaceutical supplies and therapies for the current insured population, morbidity rates for the uninsured population, medical and pharmacy trends, provider network costs, changes in benefit levels, expected risk adjustment payments, expected reinsurance program payment, cost-sharing subsidies, administrative expenses, and taxes and fees.

48. At all relevant times, EmblemHealth has materially complied with applicable laws and regulations governing its participation in the New York and Connecticut Exchanges, and the NY and CT Agreements, respectively.

49. EmblemHealth offered QHPs to individuals throughout the period in question in both New York and Connecticut and has, to the best of its current knowledge and understanding, materially satisfied all the requirements imposed on insurers under both ACA section 1402 of the Affordable Care Act and the regulations implementing that provision, *see* 45 C.F.R. § 156.400, *et. seq.*, as well as the NY and CT Agreements. EmblemHealth has not been advised to the contrary by federal or state regulators.

50. Federal regulations, and many state laws, require advance filing of premium rates and prohibit mid-year rating changes to account for changes in expected costs, which prohibited EmblemHealth from taking any action to mitigate the harm that the Department's non-payment of CSRs created.

EmblemHealth's CSR-Eligible Enrollment

51. Consistent with its historical role as a health plan that has served the New York City area and surrounding communities for more than 75 years, and mindful of the Government's promises to make ATPC and CSR payments, EmblemHealth committed to seek QHP certification to sell coverage through exchanges in all states in which it, or its affiliates, are domiciled.

52. Average monthly membership in the individual market since the exchanges became operative in New York, through HIP, was as follows:

Year	Total Individual Exchange Enrollment	CSR-Eligible Enrollment
2014	26,187	14,170
2015	21,157	10,420
2016	9,300	1,578
2017	12,086	2,529
2018	17,990	3,101

53. Average monthly membership in the individual market since the exchanges became operative in Connecticut, through ConnectiCare, was as follows:

Year	Total Individual Echange Enrollment	CSR-Eligible Enrollment
2014	25,172	14,476

2015	36,582	16,053
2016	50,810	24,339
2017	63,623	28,979
2018	73,471	29,716

54. For the 2014 plan year, EmblemHealth paid and received $5,824,015 on behalf of CSR-Eligible Enrollees in New York. For the 2014 plan year, ConnectiCare paid and received $12,636,542 on behalf of CSR-Eligible Enrollees in Connecticut.

55. For the 2015 plan year, EmblemHealth paid and received $5,372,714 on behalf of CSR-Eligible Enrollees in New York. For the 2015 plan year, ConnectiCare paid and received $11,244,294 on behalf of CSR-Eligible Enrollees in Connecticut.

56. For the 2016 plan year, EmblemHealth paid and received $226,317 on behalf of CSR-Eligible Enrollees in New York. For the 2016 plan year, ConnectiCare paid and received $12,673,925 on behalf of CSR-Eligible Enrollees in Connecticut.

57. For the 2017 plan year, EmblemHealth paid $313,208 on behalf of CSR-Eligible Enrollees in New York, and received $313,208 in payment from the Department. For the 2017 plan year, ConnectiCare paid $20,461,070 on behalf of CSR-Eligible Enrollees in Connecticut, and received $20,461,070 in payment from the Department. Full payment of the amounts for 2017 was due to the fact that CRS reimbursements paid to EmblemHealth by CMS through October 2017 equalled or exceeded actual CSR reimbursements made by EmblemHealth through all of 2017.

58. For the 2018 plan year, EmblemHealth paid an estimated (with the precise amount to proven in this case) $573,289[1] on behalf of CSR-Eligible Enrollees in New York, but received no payment from the Department. For the 2018 plan year, ConnectiCare paid $30,949,718 on behalf of CSR-Eligible Enrollees in Connecticut, but received no payment from the Department.

59. By failing to make payments to EmblemHealth for the 2018 plan year, Defendant has breached both its statutory duty to EmblemHealth to make CSR payments to insurers, and its contractual obligation to EmblemHealth to provide certain payments in exchange for EmblemHealth participating in the ACAs exchanges by offering QHPs. This failure deprives EmblemHealth of approximately $31.5 million owed for plans offered in the New York and Connecticut markets, under the terms of the ACA, its implementing regulations, and the implied contract between EmblemHealth and the Government to offer QHPs in satisfaction of the Government's statutory requirement to do so.

COUNT I

Violations of Statutory and Regulatory Mandates to Make Payments

60. EmblemHealth re-alleges and incorporates by reference the allegations set forth in the above paragraphs, as if fully rewritten herein.

61. ACA §§ 1402, 1412 and 45 C.F.R. § 156.430 expressly obligate the Government to make "timely payments" to reimburse QHP issuers for the cost-sharing reductions paid by the QHP to providers on behalf of CSR-eligible enrollees. These provisions remain effective.

[1] For 2018, the final actual payment amount for CSR-eligible enrollees has not been reconciled for HIP-enrolled individuals. The estimated $573,289 amount reflects a total possible amount of CSR payments of $714,487, adjusted for expected utilization. In other words, not all CSR-eligible enrollees are expected to utilize the full amount of CSRs under their plans, so the $573,289 amount represents a projection of the actual CSR payments based on utilization trends.

62. For all relevant times, EmblemHealth has been and is a QHP issuer that provided the mandatory cost-sharing reductions on behalf of CSR-eligible enrollees, has satisfied all requirements under ACA § 1402, and met all statutory and regulatory conditions for reimbursement of the cost-sharing reductions it provided for the 2018 plan year.

63. Despite doing so, payments by Defendant to EmblemHealth for cost-sharing reductions ceased effective November 2017, and it is clear that, under the existing legal and regulatory framework, the payments to which EmblemHealth is entitled will not be made.

64. The Government has failed to make the statutorily-mandated reimbursements since November 2017, violating the ACA and its implementing regulations.

65. As a result of the Government's failure, EmblemHealth has been damaged and is entitled to full payments for the 2018 plan year.

COUNT II

Breach of Implied-in-Fact Contract

66. EmblemHealth re-alleges and incorporates by reference the allegations set forth in the above paragraphs, as if fully rewritten herein.

67. EmblemHealth entered into a valid implied-in-fact contract with the Government, under which EmblemHealth was required to make cost-sharing reductions on behalf of CSR-eligible enrollees and was entitled to payment from Defendant for the payments EmblemHealth made on behalf of CSR-eligible enrollees.

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

69. The Government's offer to make "timely payments" of CSR reimbursements was material to EmblemHealth's decision to offer QHP plans through exchanges.

70. EmblemHealth's compliance with its obligations under ACA § 1402, and other relevant statutory and regulatory provisions, constituted acceptance of the Government's offer.

71. Both EmblemHealth and the Government's actions evinced an intent to be bound by the terms of this implied-in-fact contract, including the payment of CSRs to EmblemHealth from January 2014 through October 2017.

72. Consideration for the implied-in-fact contract included, with respect to the Government, compliance with the ACA's statutory and regulatory requirements, as well as reimbursement of CSRs provided by QHP issuers on behalf of eligible enrollees. With respect to EmblemHealth, consideration included EmblemHealth's compliance with the ACA's statutory and regulatory requirements for QHPs, including the development of new, compliant plans, and the benefit provided to the Government of participating in exchanges, as only exchange coverage would allow eligible individuals to receive APTCs and CSRs.

73. EmblemHealth satisfied and complied with its obligations under the implied-in-fact contract.

74. The Government's failure to make required cost-sharing reduction payments constitutes a material breach of this implied-in-fact contract.

75. The Government's announced policy with respect to the non-payment of cost-sharing reductions further constitutes an anticipatory breach of this implied-in-fact contract.

76. EmblemHealth has been damaged by the Government's breach, and accordingly, full payments to EmblemHealth are required for the 2018 plan year.

COUNT III

Taking Without Just Compensation

77. EmblemHealth re-alleges and incorporates by reference the allegations set forth the above paragraphs, as if fully rewritten herein.

78. EmblemHealth has a vested property interest in the approximately $31.5 owed to it by the Government.

79. The Government's actions, as set forth in this Complaint and related official pronouncements, constitute an unjustified deprivation and taking of EmblemHealth's property for public use without just compensation, in violation of the Fifth Amendment of the United States Constitution.

80. Accordingly, EmblemHealth is entitled to just compensation for the Government's taking of approximately $31.5 for the 2018 plan year.

PRAYER FOR RELIEF

WHEREFORE, EmblemHealth requests this Court to enter judgment in its favor and against the Government with respect to Counts I, II and/or III, and order the following relief:

A. Award EmblemHealth money damages it is or will be entitled to under the cost-sharing reduction program, which EmblemHealth estimates to be approximately $31.5 million;

B. Award EmblemHealth such additional damages and other relief (including declaratory relief) available under applicable law;

C. Award EmblemHealth pre- and/or post-judgment interest to the greatest extent permitted by law;

D. Award EmblemHealth costs and attorneys' fees to the greatest extent permitted by law; and

E. Award EmblemHealth any and all further relief that this Court may deem just and proper.

Dated: August 12, 2019

Respectfully submitted,

GROOM LAW GROUP, CHARTERED

By: s/ Edward J. Meehan
Edward J. Meehan, Esq.
Tamara S. Killion, Esq.
Ryan C. Temme, Esq.
1701 Pennsylvania Ave., N.W.
Washington, DC 20006
P: (202) 857-0620
F: (202) 659-4503
E: emeehan@groom.com
E: tkillion@groom.com
E: rtemme@groom.com

Counsel for Plaintiffs EmblemHealth, Inc., Health Insurance Plan of Greater New York, Inc., and ConnectiCare Benefits, Inc.