**IN THE UNITED STATES COURT OF FEDERAL CLAIMS**

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| COMMUNITY HEALTH CHOICE, INC.<br><br>Plaintiff,<br><br>v.<br><br>THE UNITED STATES,<br><br>Defendant. | ) | No. 1:18-cv-00005-MMS |

**FIRST AMENDED COMPLAINT**

Plaintiff Community Health Choice, Inc. ("Plaintiff" or "CHC"), by and through its undersigned counsel, brings this action against Defendant United States to recover money damages owed by Defendant for (1) violation of the mandatory Risk Corridors payment obligations imposed by Section 1342 of the Patient Protection and Affordable Care Act ("ACA"), and its implementing regulations; (2) breach of implied-in-fact contract between CHC and Defendant for Risk Corridors payment obligations; (3) breach of the covenant of good faith and fair dealing for Risk Corridors payment obligations; (4) violation of the mandatory Cost-Sharing Reduction ("CSR") payment obligations imposed by Section 1402 of the ACA, and its implementing regulations; (5) breach of express contract between CHC and Defendant for CSR payment obligations; and (6) breach of implied-in-fact contract between CHC and Defendant for CSR payment obligations. In support of this action, CHC states and alleges as follows:

## PARTIES

1. Plaintiff Community Health Choice, Inc. is a Texas non-profit organization with a principal place of business at 2636 South Loop West, Suite 125, Houston, TX 77054. CHC is a Qualified Health Plan issuer on the federal health insurance exchange in Texas ("the Texas Health Insurance Exchange").

2. Defendant is the United States, referred to herein as "Defendant" or "the Government." The Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS") are agencies of the Government and are responsible for overseeing federal administration of the Patient Protection and Affordable Care Act ("ACA").

## JURISDICTION AND VENUE

3. This Court has subject matter jurisdiction over this matter and venue is proper in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1), because CHC brings claims for damages over $10,000 against the United States founded upon the Government's violations of money-mandating Acts of Congress, money-mandating regulations of an executive department, and express and implied-in-fact contracts with the United States.

4. The actions or decisions of the Government at issue in this lawsuit were conducted on behalf of the Government within the District of Columbia.

## FACTUAL BACKGROUND

## I. RISK CORRIDORS

### A. THE ACA'S RISK CORRIDORS PROGRAM

5. President Barack Obama signed the ACA into law on March 23, 2010, marking a major reform in the United States health care market. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (March 23, 2010). The ACA expanded access to health care to nearly all Americans and prohibited insurers from denying coverage based on pre-existing conditions. *See* 42 U.S.C. § 300gg-1(a) (stating that an issuer "must accept every employer and individual in the State that applies for such coverage"). As part of the ACA, Congress authorized the creation of various programs to facilitate the formation and operation of health insurance marketplaces for insurers such as CHC. *See* 42 U.S.C. § 18031. These new health insurance marketplaces, or exchanges, offered consumers organized platforms to shop for coverage with specified benefit levels. Health plans offered on the exchanges are known as Qualified Health Plans ("QHPs"). The ACA required that an insurer comply with certain federally-mandated criteria in order to offer plans on the exchanges. Participating insurers are known as "QHP issuers." To become a QHP issuer, for example, an insurer must provide essential health benefits, meet network adequacy standards, and be certified in each marketplace in which it participates. *See* 42 U.S.C. § 18021.

6. Congress recognized that the ACA carried with it tremendous uncertainty for health insurers due to, among other things, the new population of previously uninsured individuals and a new regulatory environment. Because insurers had limited information

on how to set premiums accurately for these new markets, many of them would have been reluctant to participate for fear of incurring large losses. Likewise, participating insurers might have been inclined to charge higher premiums in response to the uncertainty, and the ACA's subsidies program would have required the government to absorb much of those increased costs.

7. To address these concerns, the ACA created three premium stabilization programs: a temporary Reinsurance program; a permanent Risk Adjustment program; and a temporary Risk Corridors program. These programs, commonly referred to as the "Three Rs," were critical to the implementation of the ACA and directly benefitted the Government. They took effect beginning in 2014. *See* 42 U.S.C. §§ 18061-18063.

8. This action involves the Risk Corridors program, which operated only during the first three years of full implementation of the ACA; namely program years 2014, 2015, and 2016. The Risk Corridors program is explicitly "based on" a similar program: Medicare Part D. 42 U.S.C. § 18062(a).

9. Like the Risk Adjustment and Reinsurance programs, the Government created the Risk Corridors program in order to induce QHP issuers to participate in the ACA's exchanges and to offer QHPs at affordable rates, despite the uncertainty summarized above at paragraph 6. Indeed, CMS stated that "[t]he overall goal of these programs is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchange[s] begin in 2014." Centers for Medicare & Medicaid Services, *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (Mar. 2012).

10. Unlike the Risk Adjustment and Reinsurance programs, the Risk Corridors program was designed to share risk not merely among QHP issuers, but rather between QHP issuers and the Government. Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41930-01, 41942 (July 15, 2011) ("Risk corridors create a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers."); Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ,77 Fed. Reg. 17220-01 (Mar. 23, 2012) ("The temporary Federally administered risk corridors program serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government."); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73118 , 73121 (Dec. 7, 2012) ("The temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016."), and 73200 ("The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers."). QHP issuers whose losses exceed a threshold amount would have a portion of those losses reimbursed by the Government, in accordance with a statutory formula. 42 U.S.C. § 18062(b)(1) ("payments out"). QHP issuers whose profits exceed a threshold amount would pay a portion of those profits to the Government, in accordance with another statutory formula. 42 U.S.C. § 18062(b)(2) ("payments in").

11. The Risk Corridors program was established in Section 1342 of the ACA, codified at 42 U.S.C. § 18062 ("Section 18062"), and states in relevant part:

> **(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 [42 U.S.C. 1395w–101 et seq.].
>
> **(b)PAYMENT METHODOLOGY**
> **(1)PAYMENTS OUT** The Secretary shall provide under the program established under subsection (a) that if—
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 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
> (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.
> **(2)PAYMENTS IN** The Secretary shall provide under the program established under subsection (a) that if—
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062 (emphasis added).

12. Nothing in the language or structure of Section 1342 links "payments out" with "payments in." The statutory formulas for calculating "payments out" and "payments in" to individual QHP issuers are independent of each other. Under the terms of the statute, any change in profit-sharing payments received by the Government–either from an

individual QHP issuer or in the aggregate–would have no effect on the amounts of risk-sharing payments the Government "shall pay" to QHP issuers whose losses exceed the statutory threshold. Accordingly, like a QHP issuer's obligation to share profits with the Government if it gains, when a QHP issuer loses more than a threshold amount, the Government's obligation to make Risk Corridors payments is mandatory. Nothing in the statute suggests that the Government can pay anything less than the amount prescribed by the statutory formula.

13. Congress has not amended or repealed Section 1342, 42 U.S.C. §18062.

14. After Congress enacted the ACA, HHS and CMS implemented regulations related to the Risk Corridors program containing the same mandatory language and the same statutory formulas. The Risk Corridors regulation states, in relevant part:

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

45 C.F.R. § 153.510 (emphasis added). This payment methodology is the same as in the statute. Additionally, nothing in 45 C.F.R. Part 153 limits CMS's obligation to pay QHP issuers the full amount of Risk Corridors payments.

### B. CHC'S PARTICIPATION AS A QHP ISSUER IN THE ACA AND ITS RISK CORRIDORS PROGRAM

15. CHC is organized under Texas law as a not-for-profit corporation. CHC was formed in 1997 with a mission to improve the health of underserved children in Harris County by making health insurance more affordable. Today, CHC still serves the same mission, but has expanded its reach to the under-served residents of Southeast Texas. CHC offers plans on the state exchange and has a network of 10,000 doctors and 77 hospitals.

16. The Risk Corridors program was crucial to CHC's decision to become a QHP issuer and to offer and sell QHPs on the Texas Health Insurance Exchange. CHC undertook the obligations and responsibilities of being a QHP issuer with the understanding that the Government would make the Risk Corridors payments prescribed by the statutory formula should CHC experience losses sufficient to qualify for Risk Corridors payments under Section 1342 and 45 C.F.R. § 153.510. CHC also established the pricing of the QHPs it offered based on the understanding that it would receive all Risk Corridors payments for which it qualified under Section 1342 and 45 C.F.R. § 153.510.

17. On September 23, 2013, CHC and CMS entered into a Qualified Health Care Plan Issuer Agreement regarding CHC's provision of insurance in program year 2014 (the "2014 QHP Agreement"). The 2014 QHP Agreement allowed CHC to participate in the Texas Health Insurance Exchange and made CHC eligible without limitation for the Risk Corridors program.

18. CHC offered and sold QHPs to individuals during the "open enrollment" period beginning on October 1, 2013, for health insurance coverage effective January 1, 2014.

19. On October 29, 2014, CHC and CMS entered into a Qualified Health Care Plan Issuer Agreement regarding CHC's provision of insurance in program year 2015 (the "2015 QHP Agreement"). The 2015 QHP Agreement allowed CHC to participate in the Texas Health Insurance Exchange and made CHC eligible without limitation for the Risk Corridors program.

20. CHC offered and sold QHPs to individuals during the "open enrollment" period beginning on November 15, 2014, for health insurance coverage effective January 1, 2015.

21. On October 8, 2015, CHC and CMS entered into a Qualified Health Care Plan Issuer Agreement regarding CHC's provision of insurance in program year 2016 (the "2016 QHP Agreement"). The 2016 QHP Agreement allowed CHC to participate in the Texas Health Insurance Exchange and made CHC eligible without limitation for the Risk Corridors program.

22. CHC offered and sold QHPs to individuals during the "open enrollment" period beginning on November 1, 2015, for health insurance coverage effective January 1, 2016.

23. Over the entire three years of the Risk Corridors program, CHC upheld its obligations as a QHP issuer under all relevant statutes and regulations.

24. For program year 2014, CHC fulfilled its obligation to the Government by making its full and timely payment of $4,628.30 to the Government under the Risk Corridors program.

25. For program years 2015 and/or 2016, CHC is entitled to a payment in the amount of $9,772,520, according to the statutory and regulatory formulas. This amount differs from the amount shown in CMS's annual payment and charge announcements. CHC has notified CMS of the discrepancy and requested correction of CMS's reports.

26. The Government has paid CHC nothing for program years 2015 and 2016.

27. In summary, the Government owes CHC, but has failed to pay, a total of $9,772,520 in Risk Corridors payments for the Risk Corridors program.

### C. HHS HAS RECOGNIZED THE GOVERNMENT'S LEGAL OBLIGATION TO MAKE FULL RISK CORRIDORS PAYMENTS NOTWITHSTANDING ITS THREE-YEAR "BUDGET-NEUTRAL" IMPLEMENTATION

28. Beginning with initial rulemaking and continuing throughout the Risk Corridors program, HHS and CMS have repeatedly recognized through written public statements that the Government has a legal obligation to pay in full the Risk Corridors payments prescribed by Section 1342. HHS and CMS have recognized this legal obligation notwithstanding their so-called "budget-neutral" approach and Congress's annual appropriations riders that have restricted the sources of funds available to the Risk Corridors program. These public statements by HHS and CMS were made by representatives of the Government who had actual authority to bind the United States of America and who made the statements in their official capacity.

29. On March 11, 2013, in implementing final regulations, HHS responded in the Federal Register to a comment "ask[ing] for clarification on HHS's plans for funding risk corridors if payments exceed receipts," stating: "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." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15409, 15473 (Mar. 11, 2013).

30. One year later, on March 11, 2014, HHS reiterated that "[t]he risk corridors program is a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers," and also stated that it "intends to implement this program in a budget neutral manner." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744, 13829 (Mar. 11, 2014).Simultaneously, HHS also stated, "Our initial modeling suggests that this adjustment for the transitional policy could increase the total risk corridors payment amount made by the Federal government . . . However, we estimate that even with this change, the risk corridors program is likely to be budget neutral or, will result in net revenue to the Federal government." *Id; see also* Bulletin, Center for Medicare & Medicaid Services, "Risk Corridors and Budget Neutrality," (April 11, 2014) ("We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments.")

31. On May 20, 2014, HHS stated in a letter to the U.S. Government Accountability Office ("GAO") that "Section 1342(b)(1) . . . establishes . . . the formula to determine the amounts the Secretary must pay to the QHPs if the Risk Corridors threshold

is met." Letter from William B. Schulz, General Counsel, HHS, to Julia C. Matta, Assistant General Counsel, GAO (May 20, 2014).

32. On May 27, 2014, HHS responded to concerns about its intent to administer the program in a budget neutral way over the three-year life of the program, stating, "As we stated in the bulletin, we anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. . . In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30240, 30260 (May 27, 2014).

33. On June 18, 2014, HHS sent a letter to U.S. Senator Sessions stating that "As established in statute . . . [QHP] plans with allowable costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses." Letter from Sylvia M. Burwell, Secretary, HHS, to U.S. Senator Jeff Sessions (June 18, 2014).

34. On February 27, 2015, in implementing its final rule regarding Notice of Benefit and Payment Parameters for 2016, HHS confirmed that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10779 (Feb. 27, 2015).

35. On July 21, 2015, CMS sent a letter to state insurance commissioners, stating, "As stated in our final payment notice for 2016, 'We anticipate that risk corridors collections will be sufficient to pay for all risk corridors amounts. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.'" Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 21, 2015).

36. In October 2015, when it was first applying its "budget-neutral" approach to the 2014 program year, HHS sent letters to QHP issuers "reiterat[ing] that [HHS] recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid . . . as fiscal year 2015 obligations of the United States Government for which full payment is required." Letter from Kevin Counihan, CEO of Health Insurance Marketplaces, CMS, to QHP Issuers (Oct. 19, 2015).

37. On November 19, 2015, CMS stated in a public bulletin as follows:

> HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation [sic] of the United States Government for which full payment is required.

Bulletin, CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015).

38. On September 9, 2016, when it announced preliminary information about risk corridors for the 2015 program year, CMS stated in a public bulletin:

> 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 of the United States Government for which full payment is required.

Bulletin, CMS, "Risk Corridors Payments for 2015," (September 9, 2016).

39. Even as HHS and CMS pro-rated Risk Corridors payments to limit the total "payments out" to the total "payments in" for the combination of program years 2014, 2015, and 2016, HHS and CMS have never treated the partial payments as discharging the Government's full payment obligations. Each of the annual payment and charge announcements issued by CMS designates the full amount calculated pursuant to the formula specified by Section 1342 as the "HHS Risk Corridors Amount." *See* Bulletin, CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014 (November 19, 2015; Bulletin, CMS, "Risk Corridors Payment and Charge Amounts for 2015 Benefit Year (November 18, 2016); Bulletin, CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (November 15, 2017). And the announcements for program years 2015 and 2016 describe the partial payments being made as "Expected Payment Toward 2014 Amounts." Bulletin, CMS, "Risk Corridors Payment and Charge Amounts for 2015 Benefit Year (November 18, 2016); Bulletin, CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (November 15, 2017). In those same announcements, all payments made under the Risk Corridors program have been designated by CMS and HHS as payments toward 2014 risk corridors payment balances. *Id.* This leaves the remaining balances for 2014 and the full amounts for 2015 and 2016 due, but unpaid. In so doing, HHS and CMS have acknowledged the Government's legal obligation to pay QHP issuers their Risk Corridors amounts in full.

40. HHS's statements and conduct confirm that full Risk Corridors payments are mandatory and remain a legal obligation of the Government.

### D. CONGRESS LIMITED HHS'S FUNDING SOURCES FOR RISK CORRIDORS BUT DID NOT CHANGE THE GOVERNMENT'S LEGAL OBLIGATION TO PAY

41. Congress has considered proposed amendments to, and repeal of, the Risk Corridors program. But Section 1342 has never been amended or repealed. It remains the law of the land.

42. On December 16, 2014, Congress enacted the omnibus appropriations bill for fiscal year 2015, called the "Consolidated and Further Continuing Appropriations Act, 2015" (the "2015 Appropriations Act"). Pub. L. 113-235, 128 Stat. 2130 (Dec. 16. 2014). Section 227 of the 2015 Appropriations Act limited funding sources for Risk Corridors payments as follows:

> 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).

128 Stat. 2491.

43. But the 2015 Appropriations Act did not amend, and therefore had no impact on, the United States' statutory obligation created by Section 1342 to make full and timely Risk Corridors payments to QHP issuers, including CHC. It did not repeal or amend the Risk Corridors payment formula contained in the ACA, nor did it modify the ACA's instruction that the Government "shall pay" the amount specified in the statute.

44. On December 18, 2015, Congress enacted the Omnibus appropriations bill for fiscal year 2016, the "Consolidated Appropriations Act, 2016" (the "2016 Appropriations Act"). Pub. L. 114-113, 129 Stat. 2242 (Dec. 18, 2015). In Section 225 of the 2016 Appropriations Act, Congress again limited funding sources for Risk Corridors payments stating:

> 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).

129 Stat. 2624.

45. But again, the 2016 Appropriations Act did not amend, and therefore had no impact on, the United States' statutory obligation created by Section 1342 to make full Risk Corridors payments to QHP issuers, including CHC. It did not repeal or amend the Risk Corridors payment formula contained in the ACA, nor did it modify the ACA's instruction that the Government "shall pay" the amount specified in the statute.

46. On May 5, 2017, Congress enacted the Omnibus appropriations bill for fiscal year 2017, the "Consolidated Appropriations Act, 2017" (the "2017 Appropriations Act"). Pub. L. 115-31, 131 Stat. 135 (May 5, 2017). In Section 223 of the 2017 Appropriations Act, Congress again limited the funding sources for Risk Corridors payments, stating:

> 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).

131 Stat. 543.

47. But again, Congress's 2017 Appropriations Act did not amend, and therefore had no impact on, the United States' statutory obligation created by Section 1342 to make full Risk Corridors payments to QHP issuers, including CHC. It did not repeal or amend the Risk Corridors payment formula contained in the ACA, nor did it modify the ACA's instruction that the Government "shall pay" the amount specified in the statute.

### E. THE GOVERNMENT HAS FAILED TO MAKE RISK CORRIDORS PAYMENTS DUE TO CHC

48. As detailed in Part II above (paragraphs 15 to 27), the Government owes CHC a Risk Corridors payment in the amount of $9,772,520.

49. This payment is presently due.

50. The Government has failed to make this payment despite an express statutory mandate and repeated recognition that full Risk Corridors payments are legal obligations of the Government.

51. Given that 2016 was the final year of the Risk Corridors program, and hence no additional "payments in" to the Risk Corridors program will occur, there is no prospect of future payment to CHC under the Government's "budget-neutral" approach to administering this program.

## II. COST-SHARING REDUCTIONS

### A. THE ACA'S COST-SHARING REDUCTION (CSR) PROGRAM

52. One central purpose of the ACA is to make health insurance affordable and available to low- and middle-income Americans. *See*, *e.g.*, *King v. Burwell*, 135 S. Ct. 2480 (2015). To that end, Section 1402 of the ACA establishes a Cost-Sharing Reduction

("CSR") program, codified at 42 U.S.C. § 18071 ("Section 1402"). The CSR program requires QHP issuers to reduce the out-of-pocket expenses for eligible insureds who enroll in a qualified silver plan and whose household income is not less than 100 percent but does not exceed 250 percent of the poverty line for a family of the size involved. The amount that QHP issuers reduce the cost-sharing is based on the insured's household income level within that range. *See* 42 U.S.C. § 18071(c)(1)-(2). The QHP issuers provide these reductions to eligible insureds so that the insureds do not have to bear the cost up front.

53. The Government is statutorily obligated to fully and timely reimburse the QHP issuers for the reductions they provide on behalf of their eligible insureds. Section 1402 of the ACA states:

> 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). The Secretary of HHS has no discretion to withhold the required CSR payments.

54. Section 1412(a) of the ACA requires HHS to establish a program for advance determination and payment to QHP issuers of CSR payments. 42 U.S.C. § 18082(a). Under this program, HHS must make an advance determination of the CSR and notify the Secretary of the Treasury of that determination. 42 U.S.C. § 18082(a)(1)-(2). The Secretary of the Treasury then "makes advance payments" of CSRs to QHP issuers. 42 U.S.C. § 18082(a)(3). Section 1412(c)(3) further provides that upon notification from HHS the Secretary of the Treasury "shall make" advance CSR payments. 42 U.S.C. §

18082(c)(3). Section 1402 and Section 1412 thus make advance CSR payments to QHP issuers a money-mandating obligation of the United States.

55. Congress has not amended or repealed Sections 1402 or 1412, 42 U.S.C. §§ 18071, 18082.

56. After Congress enacted the ACA, CMS and HHS implemented regulations related to the CSR program in the Code of Federal Regulations. Like the statute, the regulations require that QHP issuers provide the cost-sharing reductions for eligible insureds enrolled in silver plans. *See* 45 C.F.R. § 156.410. Also, like the statute, the regulations use mandatory payment language, stating that "[a] QHP issuer will receive periodic advance payments" for the CSR amounts due. 45 C.F.R. § 156.430(b).

57. HHS and CMS adopted a process of monthly advance CSR payments, together with a reconciliation at the end of the benefit year. In adopting its monthly advance payment approach, CMS and HHS explained, "This approach fulfills the Secretary's obligation to make 'periodic and timely payments equal to the value of the reductions' under section 1402(c)(3) of the Affordable Care Act." 78 FR 15409, 15486 (Mar. 11, 2013).

### B. CHC'S PARTICIPATION IN THE COST-SHARING REDUCTION PROGRAM

58. On September 21, 2016, CHC and CMS entered into a Qualified Health Care Plan Issuer Agreement regarding CHC's provision of QHPs and the payment of various amounts between CHC and CMS in calendar year 2017 (the "2017 QHP Agreement"). CHC has participated in the Texas Health Insurance Exchange as a QHP issuer since the

ACA exchanges were implemented in 2014, and it entered into similar QHP Agreements with CMS for calendar years 2014 through 2016.

59. CHC's President and CEO, Kenneth W. Janda, executed the 2017 QHP Agreement on September 20, 2016. The following day, Kevin J. Counihan and George C. Hoffman, acting in their official capacities as Marketplace CEO and Director and Acting CIO of CMS, respectively, signed the 2017 QHP Agreement on behalf of the Government. The contract confirms that the "undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement."

60. The 2017 QHP Agreement states that "[i]t is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and [CHC]." The 2017 QHP Agreement confirms that CHC "and CMS are entering into this Agreement to memorialize the duties and obligations of the parties." The "CMS Obligations" section of the contract includes CSR payments to CHS as part of a monthly payments and reconciliation process:

> As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [CHC] against amounts owed to CMS by [CHC] in relation to offering of QHPs or any entity operating under the same tax identification number as [CHC] (including overpayments previously made), including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

61. The 2017 QHP Agreement, consistent with language in the QHP Agreements from previous years, sets forth certain requirements that CHC must comply with, including among other things, the laws and regulations applicable to QHP issuers selling plans on the ACA exchanges.

62. CHC set rates for the calendar-year 2017 plans in 2016, as required by the 2017 QHP Agreement and related regulations. The Government's obligation to make CSR payments affected CHC's decisions in setting its rates for the calendar-year 2017 plans. CHC set its rates for 2017 and undertook the obligations and responsibilities of being a QHP issuer with the understanding that the Government would make the CSR payments as required by Section 1402, its implementing regulations, and the 2017 QHP Agreement. CHC could not change its rates for the calendar-year 2017 plans after they were offered and sold.

63. CHC offered and sold ACA-qualified health insurance plans to individuals during the "open enrollment" period beginning on October 1, 2016, for health insurance coverage effective January 1, 2017.

64. In 2017, approximately 58% of CHC's insureds were enrolled in a silver plan and were eligible for CSRs. CHC had over 80,000 eligible insureds that qualified for CSRs and has paid the reductions for these insureds. CHC has spent millions of dollars a month covering the reductions for these insureds.

65. CHC has upheld all of its obligations as a QHP issuer under all relevant statutes and regulations and has fulfilled the terms of its 2017 QHP Agreement.

66. On October 2, 2017, CHC and CMS entered into a Qualified Health Care Plan Issuer agreement regarding CHC's provision of QHPs and the payment of various amounts between CHC and CMS for calendar year 2018 (the "2018 QHP Agreement"). The 2018 QHP Agreement was substantially similar to the 2017 QHP Agreement and

continued to include CSR payments as a part of a monthly payments and reconciliation process.

67. CHC offered and sold ACA-qualified health insurance plans to individuals during the "open enrollment" period beginning on November 1, 2017, for health insurance coverage effective January 1, 2018.

68. CHC has continued to cover the CSRs for eligible insureds who qualify for them.

69. CHC has continued to uphold all of its obligations as a QHP issuer under all relevant statutes and regulations and has fulfilled the terms of its 2018 QHP Agreement.

**C. THE GOVERNMENT'S FAILURE TO MAKE CSR PAYMENTS TO CHC**

70. The Government fulfilled its statutory obligation to make timely CSR payments to issuers, including CHC, from January 2014 until October 2017. The Government made monthly payments estimated to be "equal to the value of the reductions" directly to participating insurers on or about the 20th of each month, until October 2017. Accordingly, through September 2017, the Government had been making its required "periodic and timely payments to the issuer equal to the value of the reductions," by making a monthly payment on or about the 20th of each month, until failing to do so on or around October 20, 2017.

71. On October 12, 2017, the White House released a statement from the Press Secretary stating, in its entirety:

> Based on guidance from the Department of Justice, the Department of Health and Human Services has concluded that there is no appropriation for cost-sharing reduction payments to insurance companies under

> Obamacare. In light of this analysis, the Government cannot lawfully make the cost-sharing reduction payments. The United States House of Representatives sued the previous administration in Federal court for making these payments without such an appropriation, and the court agreed that the payments were not lawful. The bailout of insurance companies through these unlawful payments is yet another example of how the previous administration abused taxpayer dollars and skirted the law to prop up a broken system. Congress needs to repeal and replace the disastrous Obamacare law and provide real relief to the American people.

72. On October 13, 2017, in a docket entry in the appeal of the district court's decision in *House v. Burwell*, the Executive Branch stated that "[HHS] has directed that [CSR] payments be stopped because it has determined that those payments are not funded by the permanent appropriation for 'refunding internal revenue collections,' 31 U.S.C. § 1324, or by any other appropriation. The upcoming October 18 payment thus will not occur." Litigation Notice at 1, *United States House of Representatives v. Hargan*, No. 16-5202 (D.C. Cir. Oct. 13, 2017).

73. Also on October 13, 2017, CMS sent a letter to issuers stating that "[CMS] will discontinue payments of [CSR] to issuers effective in October. As a result, there will be a minor delay in the October payment cycle." Letter from Financial Management Coordination Center, CMS to Issuers (Oct. 13, 2017). The letter further stated that "CMS will withhold advance CSR payments for the current month of coverage and will not make any adjustment to CSR payment amounts related to retroactive enrollment data changes for prior months of 2017. Issuers will therefore receive no net payment of 2017 advance CSR in the October and future payment cycles." *Id.* Moreover, "CSR reconciliation payments for the 2016 benefit year, including any payments owed as the result of reported discrepancies, will not be made." *Id.*

74. As noted, the Government had been making periodic and timely CSR payments to issuers in accordance with its statutory, regulatory, and contractual obligations since the beginning of the CSR program, until October 2017. Before the October 2017 announcement, the Secretary of HHS had taken the view that funding for CSR payments was within the scope of the permanent appropriation of 31 U.S.C. § 1324, and had made CSR payments as part of an integrated monthly payment and reconciliation process together with premium tax credits. On this basis, CSR payments continued throughout the pendency of the lawsuit initiated by the House of Representatives challenging the existence of an appropriation for such payments, until October 2017.

75. Sections 1402 and 1412, as money-mandating statutes, create a legal obligation on the part of the Government to make CSR payments to QHP issuers regardless of whether Congress has made a specific appropriation for CSR payments.

76. Since September 2017, the Government has not made its required CSR payments to CHC. The Government has further indicated that it will not make any future CSR payments that will be due and required by Sections 1402 and 1412.

77. CHC has been damaged by the Government's breach of its mandatory obligation to make CSR payments as required by Sections 1402 and 1412. Pursuant to Section 1402, CHC has continued to provide the CSRs for its eligible insureds, yet it has not been reimbursed for these costs. For 2017, the Government has failed to pay CHC CSR payments in an amount estimated to be $23,788,966, consisting of estimated CSR payments of $8,447,084 for October 2017; $7,612,725 for November 2017; and $7,729,157 for December 2017.

78. Based on the Government's announced payment practices, the Government will also not pay CHC any CSR payments in 2018. Additional and further damages will continue to accrue as a consequence.

79. It is imperative as a matter of law that CHC be compensated in money damages for the Government's failure to comply with Sections 1402's and 1412's unambiguous mandate that it reimburse CHC for the CSRs that CHC has, pursuant to Section 1402, provided to eligible insureds. A failure to do so would not only result in the manifest injustice of uncompensated losses to CHC, but would also undermine private parties' trust and confidence in the Government as a reliable partner in future endeavors.

**COUNT I**
**VIOLATION OF MONEY-MANDATING STATUTE (RISK CORRIDORS)**

80. CHC hereby repeats and incorporates herein each and every allegation in paragraphs 1-79.

81. Section 1342(b)(1) of the ACA mandates compensation, expressly stating that the Secretary of HHS "shall pay" Risk Corridors payments to QHP issuers in accordance with the payment formula set forth in the statute.

82. HHS's and CMS's implementing regulation at 45 C.F.R. § 153.510(b) also mandates compensation, expressly stating that HHS "will pay" Risk Corridors payments to QHP issuers in accordance with the payment methodology set forth in the regulation, which is identical to the methodology in Section 1342(b)(1).

83. CHC was a QHP issuer in program years 2014, 2015, and 2016.

84. CHC satisfied all statutory and regulatory requirements for participation in and payments under the Risk Corridors Program in program years 2014, 2015, and 2016.

85. CHC fulfilled its obligation by paying the Government $4,628.30 for program year 2014 of the Risk Corridors Program.

86. CHC is entitled under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b) to recover full Risk Corridors payments from the Government.

87. The Government has failed to make full Risk Corridors payments to CHC, despite the Government repeatedly confirming that Section 1342 mandates that the Government make Risk Corridors payments, and that the Government owes CHC the full amount of its Risk Corridors payments.

88. Congress's attempts to limit funding sources for Risk Corridors payments due for program years 2014, 2015, or 2016, without modifying or repealing Section 1342 of the ACA, did not and could not defeat or otherwise abrogate the Government's statutory obligation created by Section 1342 to make full and timely Risk Corridors payments to QHP issuers, including CHC.

89. The Government's failure to make full and timely Risk Corridors payments to CHC constitutes a violation and breach of the Government's mandatory payment obligations under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b).

90. As a result of the Government's violation of Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b), CHC has been damaged in the full amount it is still owed under the Risk Corridors program, together with interest, costs of this action, and such other relief as this Court deems just and proper.

**COUNT II**
**BREACH OF IMPLIED-IN-FACT CONTRACT (RISK CORRIDORS)**

91. CHC hereby repeats and incorporates herein each and every allegation in paragraphs 1-90.

92. CHC entered into a valid implied-in-fact contract with the Government regarding the Government's obligation to make full and timely Risk Corridors payments to CHC in exchange for CHC's agreement to become a QHP issuer, offer and sell ACA-qualified plans on the Texas Health Insurance Exchange, forfeit a portion of profits in accordance with the "payments in" provision of the Risk Corridors program, and follow the relevant statutes and regulations.

93. Section 1342 of the ACA, HHS's implementing regulations (45 C.F.R. § 153.510), and HHS's and CMS's admissions regarding their obligation to make Risk Corridors payments made by representatives of the Government who had actual authority to bind the United States, constituted a clear and unambiguous offer by the Government to make full Risk Corridors payments to QHP issuers, including CHC, that agreed to participate and/or did participate as a QHP issuer and that suffered qualifying losses.

94. Section 1342 specifically directs the Secretary of HHS to make Risk Corridors payments in specific sums, and HHS has no discretion to pay more or less than those sums.

95. CHC accepted the Government's offer by agreeing to become a QHP issuer and thereafter by participating in the Texas Health Insurance Exchange, under which it offered and sold QHPs, agreed to forfeit a portion of profits in accordance with the

"payments in" provision of the Risk Corridors program, complied with all relevant statutes and regulations, and accepted the otherwise uncertain risks imposed by the ACA.

96. CHC satisfied and complied with its obligations or conditions which existed under the implied-in-fact contract, which extends to and covers all of program years 2014, 2015, and 2016, during all of which CHC participated as a QHP issuer selling QHPs in the Texas Health Insurance Exchange.

97. The Government's agreement to make full and timely Risk Corridors payments was a substantial factor material to CHC's agreement to enter into its QHP Agreements and to its decision to participate in the ACA and its Risk Corridors program. Participation in the Risk Corridors program was mandatory for insurers who chose to become QHP issuers. *See* 42 U.S.C. § 18062(a) ("a qualified health plan…shall participate").

98. The parties' agreement is further confirmed by the parties' conduct, performance, and statements following CHC's acceptance of the Government's offer, the execution by the parties of the QHP Agreements expressly incorporating "the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies;" and the Government's repeated assurances that full and timely Risk Corridors payments would be made. *See, e.g.*, 78 Fed. Reg. 15409, 15473.

99. The implied-in-fact contract was authorized by representatives of the Government who had actual authority to bind the United States and was entered into with mutual assent and consideration by both parties.

100. The Risk Corridors program's protection from uncertain risk and new market instability was a real benefit that significantly influenced CHC's decision to agree to become a QHP issuer and to follow the applicable statutes and regulations for participation.

101. CHC, in turn, provided a real benefit to the Government by agreeing to become a QHP issuer and participate in the ACA, despite the otherwise uncertain financial risk.

102. Adequate insurer participation was crucial to the Government's achieving the overarching goal of the ACA: to make affordable health insurance available to individuals who previously did not have access to affordable coverage, and to help to ensure that every American has access to high-quality, affordable health care by protecting consumers from increases in premiums due to uncertainty in the new markets.

103. The Government induced CHC to participate in the ACA by including the Risk Corridors program in Section 1342 of the ACA and its implementing regulations, by which Congress, HHS, and CMS committed to help protect health insurers financially against risk selection and market uncertainty.

104. The Government repeatedly acknowledged its statutory and regulatory obligations to make full and timely Risk Corridors payments to qualifying QHP issuers

through its conduct and statements to the public and to CHC, made by representatives of the Government who had actual authority to bind the United States.

105. CHC fulfilled its obligation under the implied-in-fact contract for program year 2014 by paying $4,628.30 in Risk Corridors payments to the Government.

106. Under its implied-in-fact contract with the Government, CHC is entitled to recover full Risk Corridors payments from the Government.

107. Congress's attempts to limit funding sources for Risk Corridors payments due for program years 2014, 2015, and 2016, did not and could not defeat or otherwise abrogate the United States' implied-in-fact contractual obligation to make full and timely Risk Corridors payments to CHC.

108. The Government's failure to make full and timely Risk Corridors payments to CHC is a material breach of the implied-in-fact contract.

109. As a direct and proximate result of the Government's breach of the implied contract, CHC has been damaged in the full amount it is still owed under the Risk Corridors program, together with interest, costs of this action, and such other relief as this Court deems just and proper.

**COUNT III**
**BREACH OF IMPLIED COVENANT OF**
**GOOD FAITH AND FAIR DEALING (RISK CORRIDORS)**

110. CHC hereby repeats and incorporates herein each and every allegation in paragraphs 1-109.

111. A covenant of good faith and fair dealing is implied in every contract, including those with the Government, and imposes obligations on both contracting parties

that include the duty to refrain from doing anything that will destroy or injure the reasonable expectations of the other party's right to receive the benefits of the contract.

112. The implied-in-fact contract entered into between the Government and CHC regarding its participation as a QHP issuer under the ACA during program years 2014, 2015, and 2016 created the reasonable expectation for CHC that the Government would make full and timely Risk Corridors payments, which CHC relied on as an important part of the contract consideration, just as the Government expected that QHP issuers would fully and timely make (and did fully and timely make) the "payments in" to the Government under the Risk Corridors program.

113. CHC fully and timely paid in its 2014 Risk Corridors payments owed to the Government in the amount of $4,628.30.

114. By failing to make full and timely Risk Corridors payments owed to CHC, the Government has destroyed or injured CHC's right to receive the benefits of the implied-in-fact contract, as it reasonably expected to receive, in breach of the implied covenant of good faith and fair dealing.

115. The Government breached the implied covenant of good faith and fair dealing by, at least: (1) promising through statute and regulation to make the Risk Corridors payments in the amounts specified, but subsequently failing to do so and instead making only partial, pro-rated payments to QHP issuers; (2) passing appropriations language in the 2015, 2016, and 2017 Appropriations Acts that targeted QHP issuers' rights to Risk Corridors payments by limiting funding sources to make payments, after CHC had undertaken significant expense and substantially performed its obligations under

the contract; and (3) publicly making statements that the Government would make full Risk Corridors payments to QHP issuers, which CHC relied on in agreeing to become a QHP issuer and in participating in the Exchange, but then failing to make full Risk Corridors payments after CHC had relied on the statements and performed the QHP contracts.

116. Under the implied covenant of good faith and fair dealing, CHC is entitled to recover full Risk Corridors payments from the Government.

117. As a direct and proximate result of the aforementioned breaches of the covenant of good faith and fair dealing, CHC has been damaged in the full amount it is still owed under the Risk Corridors program, together with interest, costs of this action, and such other relief as this Court deems just and proper.

**COUNT IV**
**VIOLATION OF MONEY-MANDATING STATUTE (CSR)**

118. CHC hereby repeats and incorporates herein each and every allegation in paragraphs 1-117.

119. Pursuant to Section 1402 of the ACA and its implementing regulations at 45 C.F.R., § 156.430(b), the Government is required to "make periodic and timely payments to the issuer" for cost-sharing reductions provided by the QHP issuer to eligible insureds. Likewise, Section 1412 mandates that HHS notify the Secretary of the Treasury of eligible CSRs and that the Treasury "shall make such advance payment" to QHP issuers as HHS directs.

120. CHC is a qualified QHP issuer and, pursuant to its legal obligations, CHC provided CSRs to eligible insureds and provided notification of CSR amounts to CMS.

121. CHC has satisfied all statutory and regulatory requirements for participating in and receiving payments under the CSR program and is eligible and entitled to receive CSR payments from the Government under Section 1402 and its implementing regulations.

122. The Government has failed to make full and timely CSR payments to CHC, and has failed and refused to make any CSR payments to CHC since October 2017.

123. A failure, if any, by Congress to appropriate funds for CSR payments due, absent an amendment or repeal of Sections 1402 and 1412 of the ACA, could not defeat or otherwise abrogate the Government's statutory obligation created by Sections 1402 and 1412 to make full and timely CSR payments to QHP issuers, including CHC.

124. The Government's failure to make full and timely CSR payments to CHC since October 2017 constitutes a violation and breach of the Government's mandatory payment obligations under Sections 1402 and 1412 of the ACA and 45 C.F.R. § 156.430(b).

125. As a result of the Government's violation of Sections 1402 and 1412 of the ACA and 45 C.F.R. § 156.430(b), CHC has been damaged in the full amount it is owed under the CSR program, together with interest, costs of this action, and such other relief as this Court deems just and proper.

**COUNT V**
**BREACH OF EXPRESS CONTRACT (CSR)**

126. CHC hereby repeats and incorporates herein each and every allegation in paragraphs 1-125.

127. CHC and the Government, through its authorized agents, entered into QHP Agreements for 2017 and 2018.

128. The QHP Agreements "anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and [CHC]."

129. The QHP Agreements included "CMS Obligations," providing as follows:

> As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [CHC] against amounts owed to CMS by [CHC] in relation to offering of QHPs or any entity operating under the same tax identification number as [CHC] (including overpayments previously made), including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally facilitated Exchange user fees.

130. CHC satisfied and complied with its obligations under the QHP Agreements, during which CHC participated as a QHP issuer selling QHPs to eligible insureds on the Texas Health Insurance Exchange.

131. The Government has failed to make full and timely CSR payments to CHC since October 2017, constituting a material breach of the QHP Agreements.

132. Specifically, the Government breached at least the contract provision that "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [CHC] against amounts owed to CMS by [CHC] in relation to offering of QHPs . . . including . . . advance payments of CSRs."

133. As a direct and proximate result of the Government's breach of the QHP Agreements, CHC has been damaged in the full amount it is owed under the CSR program.

134. The Government has not indicated that it will resume CSR payments, constituting an ongoing breach of contract as a result of which CHC will continue to suffer further damages. CHC is entitled to compensation for all damages, together with interest, costs of this action, and such other relief as this Court deems just and proper.

**COUNT VI**
**BREACH OF IMPLIED-IN-FACT CONTRACT (CSR)**

135. CHC hereby repeats and incorporates herein each and every allegation in paragraphs 1-134.

136. CHC entered into a valid implied-in-fact contract with the Government regarding the Government's obligation to make full and timely CSR payments to CHC in exchange for CHC's agreement to become a QHP issuer, sell QHPs on the Texas Health Insurance Exchange, and follow the relevant statutes and regulations.

137. Sections 1402 and 1412 of the ACA, HHS's implementing regulations (45 C.F.R. § 156.430), and the CSR program as administered by HHS and CMS, through authorized representatives of the Government who had actual authority to bind the United States, constituted a clear and unambiguous offer by the Government to make full CSR payments to health insurers, including CHC, that agreed to participate and/or did participate as a QHP issuer in the CSR Program.

138. Sections 1402 and 1412 specifically direct the Secretaries of HHS and Treasury to make CSR payments in specific sums, and neither HHS nor Treasury has discretion to pay more or less than those sums.

139. CHC accepted the Government's offer by agreeing to become a QHP issuer and by participating in the Texas Health Insurance Exchange, selling ACA-qualified plans to insureds eligible for cost-sharing reductions, and complying with all relevant statutes and regulations.

140. CHC satisfied and complied with its obligations under the implied-in-fact contract.

141. Given CHC's focus on lower income Americans who would otherwise be uninsured, the Government's agreement to make full and timely CSR payments was a significant factor material to CHC's agreement to enter into the implied-in-fact contract and to participate in the CSR Program under the ACA.

142. The parties' agreement is further confirmed by the parties' conduct, performance, and statements following CHC's acceptance of the Government's offer, the execution by the parties of QHP issuer agreements expressly incorporating "the laws and common law of the United State of America," and the Government's consistent performance of its obligation to make full and timely CSR payments until October 2017.

143. The implied-in-fact contract was authorized by representatives of the Government who had actual authority to bind the United States and was entered into with mutual assent and consideration by both parties.

144. The CSR Program's reimbursement to QHP issuers who covered low-income Americans under plans allowing for CSRs was a real benefit that significantly influenced CHC's decision to agree to become a QHP issuer and participate in the CSR Program.

145. CHC, in turn, provided a real benefit to the Government by agreeing to become a QHP issuer and participate in the CSR program, and to insure low-income Americans who otherwise could not afford coverage. QHP issuer participation in the CSR program benefited the Government in at least two ways. First, it helped the Government meet the statutory objective of expanding coverage by allowing QHP issuers to offer lower, government-subsidized premiums to eligible insureds. Second, it provided the Government an efficient mechanism to provide the benefit to eligible insureds on a monthly basis, instead of requiring insureds to incur higher costs up front and obtain the benefit in the form of a tax refund the following year.

146. CHC provides millions of dollars a month in CSRs for its insureds enrolled in silver plans who are eligible for the CSR program, thereby giving coverage to low- and middle-income Americans who otherwise could not afford coverage.

147. The Government's failure and refusal to make full and timely CSR payments to CHC is a material breach of the implied-in-fact contract.

148. As a direct and proximate result of the Government's breach of the implied-in-fact contract, CHC has been damaged in the full amount it is owed under the CSR program.

149. The Government has not indicated that it will resume CSR payments, constituting an ongoing breach of the implied-in-fact contract as a result of which CHC will continue to suffer further damages. CHC is entitled to compensation for all damages, together with interest, costs of this action, and such other relief as this Court deems just and proper.

**PRAYER FOR RELIEF**

Wherefore, Plaintiff demands judgment against the Defendant, the United States, as follows:

1. For the First Cause of Action, awarding CHC damages in the amount of $9,772,520, together with any other losses sustained as a result of the Government's violation of Section 1342(b)(1) of the ACA and of 45 C.F.R. § 153.510(b) regarding CHC's Risk Corridors payment;

2 For the Second Cause of Action, awarding CHC damages in the amount of $9,772,520, together with any other losses sustained as a result of the Government's breach of its implied-in-fact contract with CHC regarding CHC's Risk Corridors payment;

3. For the Third Cause of Action, awarding CHC damages in the amount of $9,772,520, together with any other losses actually sustained as a result of the Government's breach of its implied covenant of good faith and fair dealing with CHC regarding CHC's Risk Corridors payment;

4. For the Fourth Cause of Action, awarding damages sustained by CHC in an amount to be determined as a result of the Defendant's violation of Section 1402 of the ACA and of 45 C.F.R. § 156.430(a) regarding CSR payments;

5. For the Fifth Cause of Action, awarding damages sustained by CHC in an amount to be determined;

6. For the Sixth Cause of Action, awarding damages sustained by CHC, in an amount to be determined;

7. Awarding CHC all available interest, including, but not limited to, pre- and post-judgment interest;

8. Awarding CHC all available attorneys' fees and costs; and

9. Awarding CHC such other and further relief to as the Court deems just and proper.

Dated: February 27, 2018

*s/ William L. Roberts*

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