IN THE UNITED STATES COURT OF FEDERAL CLAIMS

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, d/b/a L.A. CARE HEALTH PLAN, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 17-1542C Judge Wheeler

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT
AND MEMORANDUM OF LAW IN SUPPORT

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Pursuant to Rule 56 of this Court's Rules ("RCFC"), Plaintiff Local Initiative Health Authority for Los Angeles County, d/b/a L.A. Care Health Plan ("L.A. Care"), respectfully moves for summary judgment on Counts I and II of its Amended Complaint (ECF No. 14). Count I challenges the Government's violation of its obligation to make full annual payments to L.A. Care as required under the money-mandating risk corridors provisions of the Patient Protection and Affordable Care Act ("ACA")[1] and its money-mandating implementing federal regulations for Calendar Years ("CY") 2014, 2015 and 2016. Count II challenges the Government's breach of its implied-in-fact contract to make full annual risk corridors payments to L.A. Care for CY 2014, CY 2015 and CY 2016. For the reasons demonstrated below, and articulated by this Court in its recent decisions regarding identical issues in *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (2017) (Wheeler, J.), *appeal pending*, No. 17-1994 (Fed. Cir.), and *Molina Healthcare of California, Inc. v. United States*, 133 Fed. Cl. 14 (2017) (Wheeler, J.), L.A. Care is entitled to summary judgment on Counts I and II as a matter of law.

INTRODUCTION

In 2010, Congress enacted the ACA to help address the country's health-care crisis, stabilize health insurance markets, and expand insurance coverage for tens of millions of previously uninsured Americans. As this Court has recognized, Congress achieved through the ACA "a dramatic overhaul of the nation's healthcare system," which "created a tectonic shift in the nation's health insurance market." *Molina* at 19. Central to the ACA's infrastructure was a network of Health Benefit Exchanges ("Exchanges") created in each state, which depended upon health insurers offering Qualified Health Plans ("QHPs")[2] to eligible purchasers. *See id.*

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[1] Pub. L. 111-148, 124 Stat. 119 (2010).

[2] QHPs are health insurance plans offered by health insurers that agreed to participate and were certified to offer plans on ACA Exchanges after demonstrating their compliance with a host of regulatory requirements. *See, e.g.*, 45 C.F.R. § 156.200 (listing QHP standards); 45 C.F.R. §

To encourage insurers, like L.A. Care, to participate on the Exchanges, Congress established a temporary risk corridors program in § 1342 of the ACA, 42 U.S.C. § 18062. *See Molina* at 17. The risk corridors program was "a way to share the risks between insurers and the Government" in the "new health insurance endeavor." *Id.* at 18 n.1. "By sharing the risks, the Government intended to encourage more insurers to participate" on the Exchanges, and "[t]he Government's *promise* to reimburse certain revenue losses to insurers would allow the insurers to maintain health insurance premiums for consumers at a lower and more reasonable rate." *Id.* (emphasis added).

In reliance on Congress' promises and encouragement in the ACA, and the Government's subsequent reiterations of those promises and encouragement, L.A. Care voluntarily agreed and committed itself to participate on the California Exchange for CYs 2014, 2015, and 2016, furthering Congress' mission through the ACA of expanding affordable health care nationwide. L.A. Care made affordable coverage available for thousands of previously uninsured Americans in Southern California, believing that the Government would mitigate the risk of losses to L.A. Care beyond prescribed amounts during the ACA's three-year risk corridors program, and would share the risk by paying L.A. Care a statutorily fixed percentage of its yearly losses in those years. To L.A. Care's profound detriment, however, the Government reneged on its full risk corridors payment obligation in each year. Like in *Moda* and *Molina*, this Court should find the Government liable for its statutory and contractual violations and award judgment in favor of L.A. Care.

As every court analyzing § 1342 has concluded, the "shall pay" language that Congress

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156.20 (citing ACA § 1302 (42 U.S.C. § 18022)). All duly-certified QHPs "shall participate" in the risk corridors program. 42 U.S.C. § 18062(a). "[I]f an insurer chooses *not* to offer coverage through the Exchanges, then it is *not* subject to the risk corridors program established by section 1342." Comp. Gen. B-325630 at 5-6 (Sept. 30, 2014) (emphasis added).

included in the statute mandates that risk corridors payments be made to QHPs like L.A. Care. *See Molina* at 27 (cataloguing cases). In the years following Congress' enactment of the ACA, the Government repeatedly reiterated its obligation to make full risk corridors payments annually. Congress, meanwhile, repeatedly rejected attempts to amend § 1342 to limit—or even eliminate—the Government's full-payment obligation.

Nevertheless, after L.A. Care had set its premiums and provided the called-for coverage, a later Congress repeatedly used appropriations riders to cut off a few (but, importantly, not *all*) funding sources for making risk corridors payments. The Government then refused to make full risk corridors payments to L.A. Care and other insurers for CY 2014, and has stated that it will not make any risk corridors payments for CYs 2015 or 2016. The Government thus owes insurers approximately $12.28 billion in risk corridors payments for CYs 2014, 2015, and 2016. L.A. Care is owed $25,765,038.33 in total, as stated in the Government's annual risk corridors results, but has only received a small fraction of that amount from the Government.

This Court indisputably has Tucker Act jurisdiction over L.A. Care's claims. On the merits, § 1342's text, structure, purpose, and history make clear that L.A. Care has a statutory right to the full amount of risk corridors payments due and owing. The Government's contrary position—based on § 1342's silence regarding specific appropriations, and the appropriations riders passed years after the ACA's enactment—contravenes controlling case law, proper statutory construction, and fundamental public policies, as this Court already recognized in *Moda* and *Molina*. In those cases, this Court also detailed the controlling case law providing the Government's implied-in-fact contractual responsibility to live up to its end of the bargain and make full risk corridors payments.

The U.S. Supreme Court has observed that "[i]t is very well to say that those who deal with the Government should turn square corners." *United States v. Winstar Corp.*, 518 U.S. 839,

886 n.31 (1996) (plurality op.) (quoting *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 387-388 (1947) (Jackson, J., dissenting)). But as the Court also has admonished, this notion is not "a one-way street." *Id.* Here, this Court should once again compel the Government to turn a square corner, hold it to its full-payment obligation, and grant summary judgment for L.A. Care.

STATEMENT OF THE ISSUES PRESENTED

1. Is the Government liable, under Count I, for its failure to meet its statutory and regulatory obligations to make full annual risk corridors payments to L.A. Care for CY 2014, CY 2015, and CY 2016 under the money-mandating statute and its implementing regulations?

2. Is the Government liable, under Count II, for breach of its implied-in-fact contract with L.A. Care to make full annual risk corridors payments to L.A. Care for CY 2014, CY 2015, and CY 2016?

3. If the Court finds the Government liable under Counts I and/or II, is L.A. Care entitled to recover the $23,512,415.83 in combined unpaid risk corridors payments for CY 2014, CY 2015 and CY 2016 as damages?

STATEMENT OF THE CASE AND UNDISPUTED FACTS

I. CONGRESS ENACTS THE ACA TO EXPAND HEALTH INSURANCE COVERAGE[3]

Congress passed the ACA in 2010, with the goal of creating a series of "interlocking reforms designed to expand" the availability of health insurance nationwide for individuals who previously lacked access to the marketplace. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). To achieve that goal, in the ACA Congress called for the creation of an Exchange in each State where individuals who wanted access to the marketplace could "compare and purchase insurance plans." *Id.* In addition to drastically enlarging the pool of eligible insurance purchasers with the

[3] The record materials cited herein that were not attached as exhibits to L.A. Care's Amended Complaint are attached and indexed in the accompanying Appendix filed herewith.

ACA, Congress expanded Medicaid eligibility and provided subsidies to low-income insurance purchasers. *See* ACA § 2001; ACA §§ 1401, 1402; 42 C.F.R. § 155.305(f), (g). Further, Congress prohibited insurers from denying coverage, or setting increased premiums, based upon a purchaser's medical history. *See* ACA § 1201(2)(A); 42 U.S.C. §§ 300gg–1 to –5 (2012).

Health insurers understandably were circumspect about providing guaranteed coverage because they initially lacked any data on the health of the millions who would be insured on the Exchanges.[4] Given these uncertainties, insurers opting to participate ordinarily would have added "risk premiums" to their rates to account for the Exchange populations being less healthy and more costly to insure, until accurate actuarial data was available.[5] But by Congress' design, the ACA prohibited insurers from managing their risk by traditional methods of underwriting and rate-setting.[6] *See* 42 U.S.C. §§ 300gg, 300gg–1. This threatened to make the Exchanges too expensive, thereby deterring insurer participation.

To encourage insurers to participate in the Exchanges, Congress included three "premium-stabilization" provisions in the ACA—commonly known as the "3Rs"—that reduced insurers' risk: reinsurance, risk corridors, and risk adjustment. *See* ACA §§ 1341–43, *codified at* 42 U.S.C. §§ 18061-18063. The second of these 3Rs, the risk corridors program, is the subject of this lawsuit. It was federally administered by the Centers for Medicare and Medicaid

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[4] One year after the ACA's enactment, HHS acknowledged that "there is significant uncertainty about Exchange enrollment, the overall health of the enrolled population, and the cost of care for new enrollees." 76 FR 41929, 41935 (July 15, 2011).

[5] *See, e.g.*, 77 FR 17219, 17221 (Mar. 23, 2012) ("To protect themselves from adverse selection, issuers may include a margin in their pricing (that is, set premiums higher than necessary) in order to offset the potential expense of high-cost enrollees.").

[6] *See, e.g.*, *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840 (N.D. Ohio 2010) (generally describing underwriting processes in life insurance, auto insurance, and pre-ACA health insurance contexts).

Services ("CMS"), through a formal delegation of authority from the HHS Secretary.[7] As HHS explained, utilization of a risk corridors program in the ACA would "protect QHP issuers … against inaccurate rate setting and will permit issuers to lower rates *by not adding a risk premium* to account for perceived [market] uncertainties[.]" 78 FR 15409, 15413 (Mar. 11, 2013) (emphasis added).

Contemporaneous with § 1342's enactment, Congress appropriated $1 billion "for Federal administrative expenses to carry out" the ACA, without restriction, and placed those funds with HHS in a new Health Insurance Reform Implementation Fund ("Implementation Fund"). 42 U.S.C. § 18121. Funding for risk corridors payments thus became available at the ACA's enactment.

II. THE ACA'S RISK CORRIDORS PROVISION REQUIRES THAT PAYMENTS BE MADE ANNUALLY AND IN FULL TO INSURERS

As Congress intended, § 1342 directs the HHS Secretary to "establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016" that "shall be based on" the risk corridors program already used in the Medicare Part D prescription drug program (Part D) to help mitigate similar risks. 42 U.S.C. § 18062(a).

A. Part D's Risk Corridors Program

The Part D risk corridors program "requires the Federal Government to share in sponsors' unexpected profits and losses." Office of Inspector Gen., Dep't of Health & Human Servs., OEI-02-08-00460, *Medicare Part D Reconciliation Payments for 2006-2007* 5 (Sept. 2009), *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf (citing 42 U.S.C. § 1395w-115(e)). Thus, "if a [Part D] plan's allowable costs are at least 2.5 percent above or below the target amount, then a portion of these profits or losses are subject to risk sharing." *Id.*

[7] *See* Comp. Gen. B-325630 at 3 (Sept. 30, 2014), Am. Compl. Ex. 09 (citing 76 FR 53903, 53903-04 (Aug. 30, 2011)); *see also* 42 U.S.C. § 18062(a) ("The Secretary [of HHS] shall establish and administer a program of risk corridors ….").

In implementing Part D, CMS always has made its risk corridors payments annually. *See, e.g.*, 42 U.S.C. § 1395w-115(e)(3)(A). The controlling regulations thus provide that "CMS makes payments after a coverage year" after receipt of all cost data information, and that "CMS at its discretion makes either lump-sum payments or adjusts monthly payments in the following payment year." 42 C.F.R. § 423.336(c). Moreover, Part D's program was neither designed nor implemented as budget neutral. HHS OIG, *Medicare Part D Reconciliation Payments for 2006-2007* 11 tbl. 2 (showing for 2007 that sponsors owed Medicare $795 million while Medicare owed $195 million to sponsors, netting Medicare $600 million); U.S. Gov't Accountability Office Report, *Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk*, GAO-15-447 at 14 (2015), Am. Compl. Ex. 28 ("For the … Medicare Part D risk mitigation programs, the payments that CMS makes to issuers are not limited to issuer contributions.").[8]

B. ACA's Risk Corridors Program

Consistent with Part D, Congress designed the ACA to require *annual* risk corridors payments. Section 1342 thus mandates that "[t]he Secretary shall provide under the" program, "for any plan year," a payment depending on an insurer's profits or losses beyond three percent of a "target amount," defined as total premiums minus administrative costs.[9] *Id.* §§ 18062(b) & (c)(2). The statute also expressly defines the duration of the program as "calendar years 2014, 2015, and 2016[,]" as opposed to a general three-year period. *Id.*[10] In the Government's words,

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[8] *See also* Am. Acad. of Actuaries, Comment to HHS on Proposed Rule, Exchange and Insurance Market Standards for 2015 and Beyond at 2 (Apr. 21, 2014), Am. Compl. Ex. 26 ("The Part D risk corridor program is not budget neutral and has resulted in net payments to [CMS]. Similarly, the design of the ACA risk corridor program does not guarantee budget neutrality.").

[9] *See* Am. Compl. ¶ 48 (approximate illustration of the risk corridors payment methodology).

[10] HHS also must calculate "payments in" and "payments out" of the program on the basis

the risk corridors program was intended to "protect QHP issuers in the individual and small group market against inaccurate rate setting," and to "permit issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." 78 FR 15409, 15413 (Mar. 11, 2013), Am. Compl. Ex. 06; *see also* 77 FR 73118, 73119 (Dec. 7, 2012), Am. Compl. Ex. 03 ("The risk corridors program, which is a Federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.").[11]

As with Part D, Congress likewise intended the annual ACA risk corridors payments to be made *in full*. Nothing in § 1342 states or even suggests that Congress intended the risk corridors program to be administered in a budget-neutral fashion. Rather, the provision specifically states that either "the Secretary shall pay to the plan" a statutorily mandated percentage of its losses ("payments out"), or "the plan shall pay to the Secretary" a like percentage of its profits ("payments in"). *Id.* § 18062(b).

In particular, Congress did not cap "payments out" or "payments in," link the two

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of insurers' costs in "any plan year," not over the life of the program. 42 U.S.C. § 18062(b)(1), (b)(2), (c)(1), (c)(2). In addition, an insurer's risk corridors payment for a plan year is reduced if the insurer receives payments under the risk-adjustment or reinsurance programs for the same year. *See* 42 U.S.C. § 18062(c)(1)(B).

[11] *See also* 76 FR 41929, 41942 (July 15, 2011), Am. Compl. Ex. 02. ("Risk corridors create a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers."); HealthCare.gov, *Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment* (July 11, 2011), Am. Compl. Ex. 16 (same); Presentation, CMS, *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule*, at 11 (Mar. 2012), Am. Compl. Ex. 17 (presentation to health insurers explaining that the risk corridors program "[p]rotects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and qualified health plans to help ensure stable health insurance premiums"); HHS Notice of Benefit and Payment Parameters for 2014, 77 FR 73118, 73121 (Dec. 7, 2012), Am. Compl. Ex. 03 ("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."); Presentation, CMS, *HHS Notice of Benefit and Payment Parameters for 2014*, at 18 & 19 (Mar. 2013), Am. Compl. Ex. 18 (presentation to health insurers explaining that risk corridors program "[p]rotects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and QHP issuers to help stabilize health insurance premiums").

together, or indicate that one was limited by or contingent on the other.[12] Rather, in keeping with its full-payment mandate, Congress eschewed in § 1342 the structure it employed in multiple other ACA provisions, which variously provide that they "shall be implemented in a budget neutral manner[,]" 42 U.S.C. § 1395w-4(p)(4)(C), or that payments to insurers are "subject to the availability of appropriations." *See, e.g.*, 42 U.S.C. § 280k(a); 42 U.S.C. § 300hh-31(a); 42 U.S.C. § 293k(d); 42 U.S.C. § 1397m-1(b)(2)(A).

III. HHS IMPLEMENTS THE RISK CORRIDORS PROGRAM, EXPRESSLY ESTABLISHING RISK CORRIDORS PAYMENTS AS NON-BUDGET NEUTRAL AND ANNUAL, INDUCING L.A. CARE TO PARTICIPATE

To "establish and administer" the risk corridors program in accordance with § 1342, HHS began its rulemaking process.

A. March 2012

In March 2012, after a notice-and-comment period, HHS promulgated regulations implementing the risk corridors program. *See* 45 C.F.R. § 153.510(b); *see also* 76 FR 41929 (July 15, 2011) (proposed rule); 77 FR 17219 (Mar. 23, 2012) (final rule). In line with § 1342(b), the regulations did not make the Government's risk corridors payments contingent on collections from profitable insurers—they were *not* budget neutral. *See id.* Also, as prescribed by § 1342, HHS had no discretion to pay anything less than the full amount. *See id.* HHS thus made it clear that the agency "will pay," and QHPs "will receive," risk corridors payments in "an amount equal to" the risk corridors calculation "[w]hen" it is determined that a QHP qualifies for risk corridors payments—not some fraction of that amount at some indeterminate future date, or perhaps no payment at all. *See id.* In its written interpretation of those final rules, HHS

[12] This stands in stark contrast to ACA § 1341, which immediately precedes § 1342, and which sets forth the ACA's "reinsurance" risk-mitigation program. That provision, unlike § 1342, expressly provides that it is budget neutral, linking "payments out" to "payments in." *See* 42 U.S.C. § 18061(b)(1) ("[T]he applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers.").

confirmed that unprofitable QHPs to whom risk corridors payments are owed "will receive payment from HHS" when their allowable costs for any benefit year exceed the statutory target amounts set forth in § 1342(b)(1). 77 FR 17219, 17251-52 (Mar. 23, 2012), Am. Compl. Ex. 01.

In another rule it released that day, HHS added, "[a] QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters." *Id.* at 17251 (codified at 45 C.F.R. § 153.530(a)).

B. March 2013

A year later, HHS adopted additional regulations, confirming the risk corridors program's annual focus. *See* 77 FR 73118 (Dec. 7, 2012) (proposed rule); 78 FR 15409 (Mar. 11, 2013) (final rule). HHS required QHPs to submit risk corridors data annually (45 C.F.R. § 153.530(d)), and to pay any risk corridors collections owed to the Government within 30 days of receiving annual notice of the charges. *See* 45 C.F.R. § 153.510(d).

Although HHS's regulations forced profitable insurers to promptly remit annual risk corridors collections to the Government, it never formally imposed a prompt "payment out" requirement on itself. But that did not signal a change in the Government's obligation. On the contrary, HHS had previously recognized during rulemaking that "QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers," and the agency stated that "HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer." 77 FR 17219, 17238 (Mar. 23, 2012).

Later, in the March 2013 final rule's preamble, HHS reiterated that "[t]he risk corridors program is ***not statutorily required to be budget neutral***," and that, "[r]egardless of the balance of payments and receipts, HHS will remit payments [to QHPs] as required under section 1342[.]"

78 FR 15409, 15473 (Mar. 11, 2013) (emphasis added). This unequivocal, non-budget-neutral interpretation reaffirmed HHS's repeated prior statements regarding § 1342's purpose and the Government's role in sharing risk under the program. As the Government Accountability Office ("GAO") put it, profitable QHPs who paid into the program were "paying for the certainty that any potential losses related to [their] participation in the Exchanges [were] limited to a certain amount." Comp. Gen. B-325630 at 10 (Sept. 30, 2014).

IV. L.A. CARE OFFERS QHPS AND HHS ANNOUNCES THE TRANSITIONAL POLICY

With this backdrop, in reliance on the Government's statutory, regulatory and contractual obligations and inducements described above, in 2013 L.A. Care developed and established approved ACA plans and premiums, executed QHP Agreements, and made an unalterable commitment to the CY 2014 California ACA Exchange. *See, e.g.*, 45 C.F.R. §§ 147.104, 156.290(a)(2).

Shortly after L.A. Care and other insurers began selling QHPs, it became apparent that some consumers' health insurance coverage would be terminated because it did not comply with the ACA. HHS announced a transitional policy in November 2013,[13] under which QHPs in effect on October 1, 2013, "will not be considered to be out of compliance with the [ACA's] market reforms" for the 2014 plan year. Transitional Policy Letter at 1-2. Consumers with non-compliant healthcare plans were no longer required to purchase insurance on the Exchanges from QHPs like L.A. Care. This was a significant change because these consumers tended to be healthier, so the risk pool on the Exchanges was skewed toward a sicker, more expensive group

[13] Letter from Gary Cohen, Dir., CMS Ctr. for Consumer Info. and Ins. Oversight ("CCIIO"), to State Ins. Comm'rs (Nov. 14, 2013), attached hereto at Exhibit 80, ("Transitional Policy Letter").

of potential insurance buyers. *See Molina* at 22.[14] HHS recognized that this transitional policy would change the risk profile of enrollees in QHPs (*i.e.*, increase their average health risk level, and thus increase the QHPs' average costs of providing them health insurance), and that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014." Transitional Policy Letter at 3. However, HHS expressed confidence that "*the risk corridor program* should help ameliorate unanticipated changes in premium revenue." *Id.* (emphasis added). HHS has extended the transitional policy through October 1, 2018.[15]

V. AFTER L.A. CARE PROVIDES COVERAGE, HHS ANNOUNCES THAT THE RISK CORRIDORS PROVISION WILL BE IMPLEMENTED IN A BUDGET-NEUTRAL MANNER, BUT REITERATES THE GOVERNMENT'S FULL-PAYMENT OBLIGATION

After L.A. Care started insuring customers on the CY 2014 Exchange and after HHS cited the risk corridors program as an ameliorating force in the Transitional Policy Letter, however, HHS made a 180-degree reversal from its March 2013 position that the risk corridors program was "not statutorily required to be budget neutral." In the preamble to a final rule issued March 11, 2014, HHS stated it "intends to implement this [risk corridors] program in a budget neutral manner." 79 FR 13743, 13829 (Mar. 11, 2014).[16] This statement was entirely

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[14] *See, e.g.*, HHS 2015 Health Policy Standards Fact Sheet (Mar. 5, 2014), attached hereto at Exhibit 81 ("Because issuers' premium estimates did not take the transitional policy into account, the transitional policy could potentially lead to unanticipated higher average claims costs for issuers of plans that comply with the 2014 market rules.").

[15] *See* Gary Cohen, Dir., CMS CCIIO, *Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016* (Mar. 5, 2014), attached hereto at Exhibit 82; Kevin Counihan, Dir., CMS CCIIO, *Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through Calendar Year 2017* (Feb. 29, 2016), attached hereto at Exhibit 83; Jeff Wu, Acting Dir., CMS CCIIO, *Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through Calendar Year 2018* (Feb. 23, 2017), attached hereto at Exhibit 84.

[16] Along with that March 11, 2014 statement, HHS elaborated:

> Our initial modeling suggests that th[e] adjustment for the transitional policy could increase the total risk corridors payment amount made by the Federal government and decrease risk corridors receipts, resulting in an increase in

absent from the proposed rule of December 2, 2013. *See generally* 78 FR 72322 (Dec. 2, 2013).

In announcing budget neutrality as a goal for the risk corridors program, HHS not only reversed the statement it had made exactly one year earlier. HHS' new interpretation also conflicted with the CBO's assessment of the risk corridors program just issued in February 2014, in which the CBO recognized that the risk corridors program was *not* designed by Congress to be budget neutral:

> By law, risk adjustment payments and reinsurance payments will be offset by collections from health insurance plans of equal magnitudes; those collections will be recorded as revenues. As a result, those payments and collections can have no net effect on the budget deficit. ***In contrast, risk corridor collections (which will be recorded as revenues) will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit.*** CBO projects that the government's risk corridor payments will be $8 billion over three years and that its collections will be $16 billion over that same period....

CBO, *The Budget and Economic Outlook: 2014 to 2024*, at 59 (Feb. 2014), Am. Compl. Ex. 19 (emphasis added). The CBO further explained that:

> In contrast to the risk adjustment and reinsurance programs, ***payments and collections under the risk corridor program will not necessarily equal one another: If insurers' costs exceed their expectations, on average, the risk corridor program will impose costs on the federal budget; if, however, insurers' costs fall below their expectations, on average, the risk corridor program will generate savings for the federal budget.***

Id. at 110 (emphasis added). Thus, while the CBO believed the risk corridors program would result in a net gain of $8 billion for the Government, it specifically noted that the program—unlike the risk adjustment and reinsurance programs—was *not* budget neutral.

In April 2014, CMS issued a question-and-answer bulletin regarding its reversal on budget neutrality. Bulletin, CMS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014), Am.

> payments. However, we estimate that even with this change, the risk corridors program is likely to be budget neutral or, [*sic*] will result in net revenue to the Federal government.

79 FR 13743, 13829 (Mar. 11, 2014), Am. Compl. Ex. 25.

Compl. Ex. 31. There, it indicated that while "[w]e anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments[,]" if payments exceed collections "for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall[,]" and the next year's collections will be used toward the previous year's shortfall. *Id.*

Even after announcing its new budget-neutral position, HHS continued to publicly assure QHPs that the Government would make risk corridors payments in full. A month after CMS's April 2014 bulletin, for example, HHS acknowledged the statutory obligation "to make full payments to issuers." 79 FR 30239, 30260 (May 27, 2014). Other full-payment assurances followed as well, all without equivocation.[17]

In sum, HHS decided in 2014 that it would administer the risk corridors program in a budget neutral manner over the three-year life of the program. It considered a shortfall in "payments in" unlikely, and believed that "payments in" would balance "payments out" of the program. Importantly, HHS recognized that a shortfall in "payments in" would not vitiate the Government's statutory duty to make full "payments out." Given these assurances, and in reliance on the Government's statutory, regulatory and contractual obligations and inducements described above, L.A. Care in 2014 set its CY 2015 premiums, and committed to the CY 2015 California ACA Exchange. L.A. Care then, in 2015, set its CY 2016 premiums and later committed to the CY 2016 California ACA Exchange.

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[17] *See* Letter from William B. Schultz, General Counsel, HHS, to Julia C. Matta, Assistant General Counsel, GAO (May 20, 2014), Am. Compl. Ex. 3 ("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.") (emphasis added); Letter from Sylvia M. Burwell, Secretary, HHS, to U.S. Senator Jeff Sessions (June 18, 2014), Am. Compl. Ex. 35 ("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.").

VI. CONGRESS TAKES STEPS TO LIMIT FUNDING SOURCES FOR RISK CORRIDORS PAYMENTS, BUT LEAVES THE GOVERNMENT'S FULL-PAYMENT OBLIGATION INTACT

In September 2014, the GAO responded to Congressional inquiries about the availability of appropriations for CY 2014 risk corridors payments. *See* Comp. Gen. B-325630 (Sept. 30, 2014). The GAO concluded that fiscal year ("FY") 2014 appropriations *did exist* under the CMS Program Management ("PM") appropriation, but because CY 2014 risk corridors charges and payments would not be made until FY 2015, "the CMS PM appropriation for FY 2015 must include language similar to the language included in the CMS PM appropriation for FY 2014." *Id.* at 7. The GAO also found that "payments in" from profitable insurers under the risk corridors program were "user fees" available to make risk corridors payments. *Id.* at 10.

Then, in the appropriations bill for FY 2015, Congress limited some of the funding sources for—*but did not preclude payment of*—risk corridors payments with a rider stating that:

> 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 [CMS PM] account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Pub. L. 113-235, § 227, 128 Stat. 2491 (Dec. 16, 2014). Congress included the identical rider in the appropriations bills for FY 2016 and FY 2017. *See* Pub. L. 114-113, § 225, 129 Stat. 2624 (Dec. 18, 2015); Pub. L. 115-31, § 223, 131 Stat. 135 (May 5, 2017).[18]

Through all this, despite more than a dozen attempts, Congress never amended or repealed § 1342 or the ACA. *Infra* at 30.

[18] The Appropriations Committee Reports and Explanatory Statements accompanying the appropriations riders recognized that risk corridors payments would still be made. *See* 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014); S. Rep. No. 114-74, at 12 (2015); 163 Cong. Rec. H3954 (daily ed. May 3, 2017).

VII. THE GOVERNMENT ACKNOWLEDGES THAT IT OWES L.A. CARE OVER $25 MILLION IN RISK CORRIDORS PAYMENTS FOR CYS 2014-2016

In July 2015, L.A. Care submitted its CY 2014 risk corridors data to CMS. *See* 45 C.F.R. § 153.530(d). In November 2015—nearly two months *after* L.A. Care already had committed to the ACA Exchanges for CY 2016 (*see* Bulletin, CMS, *Key Dates in 2015* (Apr. 14, 2015), Am. Compl. Ex. 42 (requiring insurers to sign CY 2016 QHP Agreements by "9/25/2015"))—HHS announced each insurer's CY 2014 risk corridors charges and payments. Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015), Am. Compl. Ex. 51. The Government confirmed that it owed L.A. Care $13,561,651.72 in CY 2014 risk corridors payments, but indicated that it would pay only $1,711,191.11—12.6 percent of the amount owed—at some indeterminate future date. *Id.* at Table 5 – California.[19] Nevertheless, the Government acknowledged its obligation to make full payments annually by stating that "HHS recognizes that the [ACA] 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 of the United States Government for which full payment is required." *See id.* at 1.

For CY 2015, although L.A. Care's losses were reduced compared to CY 2014, the news was worse industry-wide. L.A. Care was owed $8,255,198.64 for that year, but the Government refused to pay anything because "all 2015 benefit year collections [would] be used towards remaining 2014 benefit year risk corridors payments[.]" Bulletin, CMS, *Risk Corridors Payment*

[19] In total, the Government owed insurers nearly $2.9 billion for CY 2014, but expected only $362 million in "payments in" for that year. Bulletin, CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), Am. Compl. Ex. 41. Those two numbers produced the Government's 12.6 percent proration rate. *Id.*

and Charge Amounts for the 2015 Benefit Year (Nov. 18, 2016), Am. Compl. Ex. 47.[20] Yet this delay in payment, once again, did not signal a change in the Government's ultimate obligation. HHS continued assuring L.A. Care and other insurers that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." *Id.*

On November 13, 2017, HHS announced the CY 2016 risk corridors results. For all insurers, HHS reported that it expected to collect a mere $27.1 million, while the Government was obligated to make risk corridors "payments out" of $4 billion. Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year* (Nov. 13, 2017), Am. Compl. Ex. 52. This resulted in a total three-year risk corridors payment shortfall of approximately $12.28 billion. Moreover, "[b]ecause 2015 benefit year collections were insufficient to pay 2014 benefit year payment balances in full," HHS announced that the Government would "use 2016 benefit year risk corridors collections to make additional payments toward 2014 benefit year payment balances," and not make any payments toward either CY 2015 or CY 2016 risk corridors amounts owed. *Id.* at 1. HHS stated that the Government owed L.A. Care $3,948,187.97 in risk corridors payments for CY 2016. *Id.* at 3.

Combined, L.A. Care is undisputedly owed a total of $25,765,038.33 for the CY 2014, CY 2015, and CY 2016 plan years, but to-date, has only received payment of $2,252,622.50 from the United States, leaving $23,512,415.83 in risk corridors payments still due and owing for these three years. *See* Declaration of Marie Montgomery, CFO, L.A. Care ("Decl.") at ¶¶ 7, 10, 12, 14 & 16, attached hereto.

SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate "if the movant shows that there is no genuine dispute

[20] For CY 2015, HHS collected only $95.4 million from profitable insurers, and owed over $5.9 billion to unprofitable insurers.

as to any material fact and the movant is entitled to judgment as a matter of law." RCFC 56(a); *see, e.g.*, *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Santa Fe Pac. R.R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002); *see Moda* at 454 (quoting *Santa Fe*). "Whether a contract exists is a mixed question of law and fact," and "[c]ontract interpretation itself also is a question of law." *Cienega Gardens v. United States*, 194 F.3d 1231, 1239 (Fed. Cir. 1998).

ARGUMENT

I. TUCKER ACT JURISDICTION EXISTS OVER L.A. CARE'S CLAIMS

A. Count I

In Count I, L.A. Care claims that the United States breached a money-mandating statute, § 1342, and its implementing regulations including, *inter alia*, 45 C.F.R. § 153.510. *See* Am. Compl. ¶¶ 288-311. This Court has twice held that it had Tucker Act jurisdiction over identical claims. *See Moda* at 450; *Molina* at 27 & 29 ("[T]he Court's jurisdiction over Molina's claims is not in question."). No risk corridors opinions have found jurisdiction lacking. *See Molina* at 27.

L.A. Care has unquestionably satisfied the two jurisdictional requirements under the Tucker Act. *See Roberts v. United States*, 745 F.3d 1158, 1161 (Fed. Cir. 2014). First, § 1342[21] and its implementing regulations[22] are "clearly money-mandating." *Molina* at 27 (cataloguing cases). Second, as a QHP in the period from CY 2014 through CY 2016, L.A. Care is a member of the class that Congress prescribed to receive risk corridors payments under the statute and regulations.

B. Count II

As previously found in, *inter alia*, *Moda* and *Molina*, the Court unquestionably also has

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21 *See* 42 U.S.C. § 18062(b)(1) ("[T]he Secretary shall pay to the plan.").

22 *See* 45 C.F.R. § 153.510(b) ("HHS will pay the QHP.").

Tucker Act jurisdiction to hear L.A. Care's breach of implied-in-fact contract claim. *See Marchena v. United States*, 128 Fed. Cl. 326, 331 (2016) (Wheeler, J.) (recognizing that a "low threshold requirement" exists to establish jurisdiction over contract claims). A plaintiff claiming the Government has breached an implied-in-fact contract need only make a "non-frivolous *allegation* of a contract with the government." *Mendez v. United States*, 121 Fed. Cl. 370, 378 (2015) (quoting *Engage Learning, Inc. v. Salazar*, 660 F.3d 1346, 1353 (Fed. Cir. 2011)) (emphasis in original). In its Amended Complaint, L.A. Care alleges each of the elements of an implied-in-fact contract. *See, e.g.*, Am. Compl. ¶¶ 312-332. "[T]hese non-frivolous allegations are all that is required. Therefore, the Court also has subject-matter jurisdiction over [L.A. Care's] contract claim." *Moda* at 450 (citing *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 98-99 (2016), *appeal pending*, No. 17-1224 (Fed. Cir.)).

II. L.A. CARE'S CLAIMS ARE RIPE

The "not presently due" ripeness challenge that Defendant repeatedly raised in similar risk corridors cases—and the Court repeatedly rejected[23]—has, with the passage of time, become moot. Defendant acknowledged this in briefs recently filed with the Federal Circuit.[24] Because "HHS … will begin remitting risk corridors payments to issuers in January 2018,"[25] and "[t]he three-year implementation … will end with the payment of 2016 collections,"[26] there is no question that L.A. Care's risk corridors claims are ripe for adjudication.

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[23] *See Molina* at 27 (cataloguing cases showing that "the Court has uniformly rejected the Government's argument that the insurers' claims were not ripe").

[24] *See, e.g.*, Br. for Appellee, *Blue Cross & Blue Shield of N.C. v. United States*, No. 17-2154, at 16 (Fed. Cir. Nov. 1, 2017) (ECF No. 20) ("We recognize … that the practical significance of this timing issue is likely to be overtaken by the passage of time while the litigation is pending. Accordingly, we focus in this brief on the legal issues that will control the disposition of the insurers' claims after this timing issue becomes moot.").

[25] Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year*, at 2 (Nov. 13, 2017), Am. Compl. Ex. 52.

[26] Br. for Appellee, *Me. Cmty. Health Options v. United States*, No. 17-2395, at 16 (Fed. Cir. Dec. 6, 2017) (ECF No. 19).

III. COUNT I: L.A. CARE IS ENTITLED TO SUMMARY JUDGMENT FOR THE GOVERNMENT'S VIOLATION OF ITS STATUTORY AND REGULATORY OBLIGATIONS TO MAKE FULL ANNUAL RISK CORRIDORS PAYMENTS

A. Section 1342 Requires the Government to Make Full Risk Corridors Payments Each Year

This Court made clear in *Moda* and *Molina* that § 1342 on its face requires *annual* risk corridors payments, that HHS clearly interpreted § 1342 as requiring annual payments, and that the statute further requires that *full* risk corridors payments shall be paid *each year*. *See Moda* at 455-57; *Molina* at 30, 32-33 & 35-38. The Court should similarly conclude here that there is no genuine dispute of material fact that § 1342 requires full annual risk corridors payments, and thus L.A. Care is entitled to summary judgment as a matter of law on Count I.

1. Section 1342 and the ACA

Section 1342(b) requires, in mandatory "shall pay" language, the Government to make risk corridors payments pursuant to a specified and fixed statutory formula. *See Molina* at 36 (noting "mountain of controlling case law holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation") (citations omitted). "The mandatory 'shall' … normally creates an obligation impervious to judicial discretion." *Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998).

The mandatory effect of § 1342's "shall pay" language is particularly powerful because Congress used the permissive term "may" elsewhere in the ACA.[27] *See Lopez v. Davis*, 531 U.S. 230, 241 (2001) (noting significance of Congress's "use of the permissive 'may'" in "contrast[] with the legislators' use of a mandatory 'shall' in the very same section" of statute). Thus, § 1342's "shall pay" directive "is unambiguous and overrides any discretion the Secretary

[27] *See, e.g.*, ACA, Pub. L. 111-148, § 1001, 124 Stat. 132, 135 (amending §§ 2713(c) and 2717(a)(2) of the Public Health Service Act), § 1104(h), 124 Stat. 149.

otherwise could have in making 'payments out' under the program." *Moda* at 455. No separate, second promise to appropriate funds—for an obligation Congress already has mandated "shall" be paid—is necessary to create the obligation. *See Molina* at 37 (noting the Federal Circuit's "repeated [] recogni[tion] that the use of the word 'shall' generally makes a statute money-mandating") (citing *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007)).

What Congress omitted from § 1342—in light of the rest of the ACA—is just as significant in supporting a mandatory full-payment construction. Section 1342 nowhere states or suggests that the risk corridors program would be budget neutral, such that "payments out" would be restricted to "payments in" from profitable insurers. *See Molina* at 19 ("The words 'budget neutral' do not appear anywhere in the ACA's Section 1342."); *Moda* at 455 (finding "no language of any kind in Section 1342 that makes 'payments out' of the risk corridors program contingent on 'payments in' to the program").

Nor does § 1342 contain the language Congress typically uses when it intends to condition a "shall pay" statutory command on a specific appropriation of funds. Three years before the ACA's enactment, the Federal Circuit described in detail the type of language Congress could have used in § 1342 to limit payments to appropriations. *See Greenlee Cnty.*, 487 F.3d at 878 (noting that the phrases "subject to the availability of appropriations" and "available only as provided in appropriations laws" are "commonly used to restrict the government's liability to the amounts appropriated by Congress"). "Congress is presumed to know the law, particularly recent precedents that are directly applicable to the issue before it." *Hesse v. Dep't of State*, 217 F.3d 1372, 1380 (Fed. Cir. 2000) (citation omitted). Congress's refusal in 2010 to use the limiting language already mapped out by the Federal Circuit in *Greenlee County* thus speaks volumes.

Moreover, the ACA itself shows that Congress knew how to adopt budget-neutral

provisions when it so intended—as evidenced by the immediately preceding ACA provision governing reinsurance (§ 1341), and numerous other ACA provisions. *Cf. Molina* at 39 ("Congress knew how to supersede the mandate to make full annual risk corridor payments in an appropriation law and chose not to do it."). Courts "do not lightly assume that Congress has omitted from its adopted text requirements that it nonetheless intends to apply, and our reluctance is even greater when Congress has shown elsewhere in the same statute that it knows how to make such a requirement manifest." *EPA v. EME Homer City Generation, L.P.*, 134 S. Ct. 1584, 1601 (2014) (citation omitted). Rather, courts presume "that differences in language like this convey differences in meaning." *Henson v. Santander Consumer USA Inc.*, 137 S. Ct. 1718, 1723 (2017).

Lastly, as discussed above, interpreting § 1342 to require full risk corridors payments is necessary to effectuate the ACA's purpose. The risk corridors program "was designed to protect participating insurers from financial harm and also to guarantee that enough insurers participated in the Exchanges to make the ACA viable." *Molina* at 30; *see also King*, 135 S. Ct. at 2496 (same). Limiting or conditioning "payments out" to "payments in" squarely contravenes the risk corridors program's purpose by transforming it from a program intended for the Government to share in the risks of the new Exchanges with insurers, to one where insurers now exclusively bear those risks themselves. Requiring anything less—and certainly, 96.2% less industry-wide—than full payments would undercut Congress's goal for § 1342 and the ACA, and courts do not "interpret federal statutes to negate their own stated purposes." *N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973); *see also Moda* at 452.

2. HHS' Interpretation of § 1342

HHS's own interpretation of § 1342—as evident from its implementing regulations—further confirms that full risk corridors payments are required by the Government to QHPs.

To begin with, the regulations specify that QHPs "will receive payment from HHS" pursuant to the formula set forth in § 1342, and "HHS will pay" those amounts. 45 C.F.R. § 153.510(b). This language parallels the mandatory "shall pay" provisions in § 1342 and, like § 1342, contains no qualifications or conditions limiting the Government's "payments out" by "payments in" or making payments subject to a Congressional appropriation.

At the same time, HHS's implementing regulations for the ACA's other two 3Rs risk-mitigation programs explicitly provide that those programs ***are*** budget neutral. *See* 45 C.F.R. § 153.230(d) (reinsurance); 77 FR 73118, 73139 (Dec. 7, 2012) (risk adjustment); 78 FR 15409, 15441 (Mar. 11, 2013) (risk adjustment). As with statutes, where an agency uses limiting language in certain regulations, but omits that language in closely related regulations (*e.g.*, § 153.510(b), the risk corridors regulation), courts presume that the agency did so intentionally and to convey a different meaning. *See Henson*, 137 S. Ct. at 1723 (courts presume "that differences in language like this convey differences in meaning"); *Smith v. Brown*, 35 F.3d 1516, 1523 (Fed. Cir. 1994) ("The canons of construction of course apply equally to any legal text and not merely to statutes.") (citation omitted), *superseded on other grounds by* 38 U.S.C. § 7111.

Further, HHS repeatedly stated that the risk corridors program is ***not*** budget neutral, and that full payments ***are*** required by the Government. *See Moda* at 457 (finding that HHS "has consistently recognized that Section 1342 is not budget neutral" and that HHS "has never conflated its inability to pay with the lack of an obligation to pay"); *Molina* at 24 & 26 (same).

B. <u>There Are No Statutory Limits on the Government's Obligation to Make Full Risk Corridors Payments</u>

In other risk corridors cases, Defendant has contended that the risk corridors program is budget neutral because: (i) Congress did not expressly authorize in § 1342 the appropriation of funds specifically to pay for risk corridors "payments out"; and (ii) Congress's appropriations

riders limited "payments out" to "user fees" collected from "payments in." *See, e.g.*, Br. for Appellant, *Moda Health Plan, Inc. v. United States*, No. 17-1994, at 17-26 (Fed. Cir. July 10, 2017) (ECF No. 18); Br. for Appellee, *Land of Lincoln Mut. Health Ins. Co. v. United States*, No. 17-1224, at 18-27 (Fed. Cir. Apr. 24, 2017) (ECF No. 107). Neither prong of this argument withstands analysis.

1. Section 1342 Does Not Limit the Government's Full-Payment Obligation

Most fundamentally, Defendant erroneously conflates a legally enforceable Government payment obligation with an appropriation of funds to pay for that obligation.

In Tucker Act cases, a threshold jurisdictional consideration is whether the statute giving rise to the claim for relief is "money-mandating"—that is, can the statute or regulation "fairly be interpreted as mandating compensation by the Federal Government for the damages sustained." *Roberts*, 745 F.3d at 1162 (citation omitted). Statutes, like § 1342, providing that the Government "shall" make payment are money-mandating and impose on the Government a legal obligation to pay. *See Greenlee Cnty.*, 487 F.3d at 877; *see also Molina* at 27 (noting all cases addressing issue have found § 1342 is money-mandating). Because § 1342 contains no express limitation regarding appropriations,[28] Congress intended in § 1342 to "impose[] a statutory obligation to pay the full amounts according to the statutory formulas *regardless of appropriations*[.]" *Prairie Cnty., Mont. v. United States*, 782 F.3d 685, 690 (Fed. Cir.), *cert. denied*, 136 S. Ct. 319 (2015) (emphasis added).

The mere fact that Congress has not specifically appropriated funds to pay for the legally enforceable obligation under a money-mandating statute, such as § 1342, does not alter the existence of the obligation or prevent this Court from enforcing it. *See Slattery v. United States*,

[28] Such as "subject to the availability of appropriations." *Greenlee Cnty.*, 487 F.3d at 878.

635 F.3d 1298, 1321 (Fed. Cir. 2011) (*en banc*) ("[T]he jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid.").

Thus, as the Federal Circuit recently reiterated (and Defendant itself has acknowledged),[29] it "has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." *Prairie Cnty.*, 782 F.3d at 689 (citation omitted). Indeed, requiring a money-mandating statute to also appropriate funds in order to create a Government payment obligation would, in effect, engraft the very sort of "second [sovereign immunity] waiver" requirement on Tucker Act jurisdiction that the Federal Circuit—sitting *en banc* and following Supreme Court precedent—rightly rejected in *Slattery*. *See Slattery*, 635 F.3d at 1316 (citing *Mitchell v. United States*, 463 U.S. 206, 218 (1983)). Such a statutory revision is a job for Congress, not the courts.

As a result, rather than leaving L.A. Care without remedy or recourse, "[t]he failure to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims." *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966);[30] *see also Collins v. United States*, 15 Ct. Cl. 22, 34-35 (1879) ("Congress, the legislative branch of the government, may by law create [a money-mandating] liability," which "exists independently of the appropriation, and may be enforced by proceedings in this court"); *Molina* at 37 (holding that

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[29] *See* Def.'s Mem. in Supp. of Mot. for Sum. J. at 20, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, Doc. 55-1 (Dec. 2, 2015 D.D.C.) (asserting that "the absence of an appropriation would not prevent the insurers from seeking to enforce [their ACA] statutory right through litigation").

[30] Court of Claims decisions "are binding precedent" in this Court. *Delmarva Power & Light Co. v. United States*, 542 F.3d 889, 893 (Fed. Cir. 2008) (citation omitted).

under controlling precedent, "the Government's obligation to make payments [does not] depend[] on a reference to a specific appropriation" in a money-mandating statute).

To reinforce this point, Congress uses very specific language when it intends to limit a substantive statutory obligation it previously has created. For example, in *Prairie County*, the Federal Circuit held that in the Payment in Lieu of Taxes Act ("PILT")—a money-mandating statute providing local governments payments for "tax-immune" federal lands in their jurisdictions—Congress limited the Government's statutory "shall pay" obligation to available appropriations because the statute expressly stated that "[a]mounts are available only as provided in appropriation laws." 782 F.3d at 690 (citation omitted). The Court found, unsurprisingly, that using "only" "reflect[ed] congressional intent to limit the government's liability" for PILT's money-mandating payments. *Id.*; *see also Greenlee Cnty.*, 487 F.3d at 878 ("[I]n some instances the statute creating the right to compensation … may restrict the government's liability … to the amount appropriated by Congress…. [T]he language 'subject to the availability of appropriations' is commonly used[.]").

Unlike in the PILT, however, § 1342's money-mandating "shall pay" language is unqualified and has never been altered. Its lack of any "subject to the availability of appropriations" language that is "commonly used to restrict the government's liability to the amounts appropriated by Congress[,]" *Greenlee Cnty.*, 487 F.3d at 878, is particularly significant because Congress used that same limiting language elsewhere in the ACA.[31] *See Henson*, 137 S. Ct. at 1723 (courts presume "that differences in language like this convey differences in meaning"). Thus, § 1342 is a "prime example" of a statute that "authorize[s] and mandate[s] payments without making an appropriation[.]" *Molina* at 36 n.15 (citation omitted).

[31] *See, e.g.*, 42 U.S.C. § 280k(a); 42 U.S.C. § 300hh-31(a); 42 U.S.C. § 293k(d); 42 U.S.C. § 1397m-1(b)(2)(A).

Further confirmation of this construction comes from Congress's own treatment of the provision. Far from deeming § 1342 to be budget neutral, in early 2014, Congress appropriated over $3.6 billion for CMS's "other responsibilities" without any reference to, or restriction related to, the risk corridors program. Pub. L. 113-76, 128 Stat. 374 (Jan. 17, 2014). The GAO later concluded that such "other responsibilities" "include[d] the risk corridors program," and thus that these appropriated funds "would have been available for making" risk corridors payments. Comp. Gen. B-325630 (Sept. 30, 2014).

Defendant has insisted in other cases that because—unlike the Part D risk corridors program's statute, 42 U.S.C. § 1395w-115(e)(3), and other ACA provisions—§ 1342 does not itself authorize appropriations, no Government payment obligation has been created. *See, e.g.*, Br. for Appellant, *Moda*, at 18-19; Br. for Appellee, *Lincoln*, at 19-20. But again, the Federal Circuit's money-mandating test does not contain an appropriations requirement, *see Roberts*, 745 F.3d at 1162, and 140 years of precedent hold that "[t]his court … does not deal with questions of appropriations, but with the legal liabilities incurred by the United States under[, *inter alia*,] the laws of Congress," which "liabilities may be created where there is no appropriation of money to meet them." *Collins*, 15 Ct. Cl. at 35. Accordingly, "the lack of language specifying that Section 1342 could impact the national budget is not evidence of the lack of Congress's intent to impact the national budget." *Molina* at 32.

In fact, Part D's risk corridors program provides further ***support*** for L.A. Care's position. Congress required that § 1342 "shall be based on" § 1395w-115(e)(3). As Defendant acknowledges, § 1395w-115(e)(3) made Part D's risk corridors payments a Government obligation. And those Part D "payments out" were not limited to collections received. U.S. Gov't Accountability Office Report, *Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk*, GAO-

15-447 at 14 (2015), Am. Compl. Ex. 28. Under Defendant's reading, however, § 1342 and § 1395w-115(e)(3) would have directly contrary meanings—the ACA provision not imposing a Government obligation at all; the Part D provision imposing a Government obligation to make full payments. That would improperly delete § 1342's "shall be based on" mandate from the statute. *See Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1659 (2017) (courts "give effect, if possible, to every clause and word of a statute") (citation omitted). This Court therefore should reject Defendant's interpretation here, as it has done before. *See Moda* at 455; *Molina* at 32.

2. The Appropriations Riders Do Not Limit the Government's Full-Payment Obligation.

Congress's later appropriations riders likewise do not repeal or supersede the Government's mandatory full-payment obligation under § 1342—either expressly or impliedly. The riders merely limit some, but not all, appropriated funds from being used to pay that obligation. This Court properly recognized the controlling law and applied the facts in *Moda* and *Molina*. *See Moda* at 458-62; *Molina* at 33-34 & 38-41. Defendant's stated position is that *Maine II* (should be followed, but this Court highlighted that opinion's flaws in *Molina*. *See Molina* at 41.

a. The riders' text does not expressly alter the Government's full-payment obligation.

It is "strongly presumed that Congress will specifically address language on the statute books that it wishes to change." *Hymas v. United States*, 810 F.3d 1312, 1320 (Fed. Cir. 2016) (citation omitted). To repeal or supersede an existing statute, Congress must do so "expressly or by clear implication[,]" *Prairie Cnty.*, 782 F.3d at 689, and "the only permissible justification for a repeal by implication is when the earlier and later statutes are irreconcilable." *J.E.M. Ag Supply, Inc. v. Pioneer Hi-Bred Int'l, Inc.*, 534 U.S. 124, 141-42 (2001) (citation omitted).

The already-strong presumption against implied repeals "applies with especial force when[,]" as here, "the provision advanced as the repealing measure was enacted in an appropriations bill[,]" *United States v. Will*, 449 U.S. 200, 221-22 (1980), which has "the limited and specific purpose of providing funds for authorized programs." *TVA v. Hill*, 437 U.S. 153, 190 (1978) (recognizing strong "presum[ption]" that appropriations bills do not change substantive legislation); *see also N.Y. Airways*, 369 F.2d at 749 ("The intent of Congress to effect a change in the substantive law via provision in an appropriation act must be clearly manifest."). Indeed, "[r]epealing an obligation of the United States is a serious matter," and permitting Congress to alter substantive law by "burying a repeal in a standard appropriations bill would provide clever legislators with an end-run around the substantive debates that a repeal might precipitate." *Moda* at 458 (citing *Gibney v. United States*, 114 Ct. Cl. 38, 51 (1949)). Simply put, "[t]here can be no room for inference when dealing with whether the Government will honor its statutory commitments." *Molina* at 41.

These precedents make clear why nothing in the text of the relevant riders *expressly* repeals the Government's legally enforceable obligation under § 1342 to make full risk corridors payments. The riders only precluded the use of certain funding sources for those payments:

> 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 [CMS PM] account*, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Pub. L. 113-235, § 227, 128 Stat. 2491 (Dec. 16, 2014) (emphasis added); Pub. L. 114-113, § 225, 129 Stat. 2624 (Dec. 18, 2015) (same); Pub. L. 115-31, § 223, 131 Stat. 135 (May 5, 2017) (same). Notably, the riders do not prohibit drawing on funds provided from other possible appropriations sources, such as the Implementation Fund or the CMS PM account's "user fees" appropriation identified by the GAO. *See Molina* at 24-25.

Context reinforces the riders' limited reach and shows that Congress did not believe that they operated to expressly repeal the Government's full-payment obligation. On more than a ***dozen occasions***—before the FY 2015 rider, between the FY 2015 and FY 2016 riders, and after the FY 2016 rider—members of Congress attempted, but failed, to amend § 1342 to make it budget neutral or even eliminate the Government's risk corridors payment obligations entirely.[32] Of course, if the riders had accomplished these objectives, there would be no need for either an amendment or a repeal. Congress knew better; the riders did ***not*** limit the Government's § 1342 payment obligations, and it would be "improper for [this Court] to give a reading to the [riders] that Congress" itself did not give them. *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 220 (1983); *see also ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 22 n.6 (2011) (finding statute money-mandating where Congress unsuccessfully tried to make it discretionary).

In any event, Congress cannot do indirectly what it is required to do directly. The step that Congress did not take—the passage of legislation clearly and expressly vitiating the underlying payment obligation—is the one the law requires. Because "Section 1342 clearly requires the Government to make full annual risk corridor payments," "Congress cannot"—and did not—"repeal this commitment" simply by blocking some—but not all—funding sources. *Molina* at 41; *Moda* at 462 (same).

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[32] *See* S. 1726, 113th Cong. (2013) (would eliminate § 1342); H.R. 3541, 113th Cong. (2013) (same); H.R. 3812, 113th Cong. (2014) (same); H.R. 3851, 113th Cong. (2014) (same); H.R. 5175, 113th Cong. (2014) (same); S. 123, 114th Cong. (2015) (same); H.R. 221, 114th Cong. (2015) (same); H.R. 3985, 113th Cong. (2014) (seeking to eliminate § 1342 after 2014); 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015) (noting consideration and rejection of amendment providing that "Secretary shall not collect fees and shall not make payments under" risk corridors program); S. 2214, 113th Cong. (2014) (would amend § 1342 to "ensur[e] budget neutrality"); H.R. 4354, 113th Cong. (2014) (same); H.R. 4406, 113th Cong. (2014) (would limit payments out to the amount of payments in); S. 359, 114th Cong. (2015) (same); H.R. 724, 114th Cong. (2015) (same).

b. The riders do not impliedly repeal or supersede the Government's full-payment obligation.

With no express legislative repeal, Defendant is left to argue that the riders *impliedly* repeal § 1342's mandate. But controlling precedents confirm that the appropriations riders lack the clear congressional intent required to implicitly repeal the Government's full-payment obligation under § 1342. While the Court in *Maine II* found these controlling precedents "difficult to harmonize," *Maine II* at 12, this Court has had no trouble reconciling the contours of the implied-repeal doctrine. *See Moda* at 457-62; *Molina* at 33-34 & 38-41.[33]

(1) *Gibney*

The Court of Claims' ruling in *Gibney*, 114 Ct. Cl. 38, forecloses any implied-repeal attack on § 1342. In *Gibney*, the Court of Claims held that an appropriations bill prohibiting INS from using appropriations for overtime pay, "other than as provided in the Federal Employees Pay Act of 1945," did not suspend the overtime payment obligation. 114 Ct. Cl. at 48-49. According to the Court, "a simple limitation on an appropriation bill of the use of funds" has never "been held to suspend a statutory obligation." *Gibney*, 114 Ct. Cl. at 53. As noted, the riders here likewise merely limit some funding for the Government's payment obligation, but do not suspend the obligation to pay.

(2) *Langston*

The Supreme Court's decision in *United States v. Langston*, 118 U.S. 389 (1886), leads to the same no-implied-repeal conclusion. There, a later appropriations act provided $5,000 for the U.S. minister to Haiti's annual salary, statutorily set at $7,500. *See Langston*, 118 U.S. at

[33] Defendant appears to have conceded that *Star-Glo Associates, LP v. United States*, 414 F.3d 1349 (Fed. Cir. 2005), undermines its case, because Defendant has not raised the opinion in its latest briefs filed with the Federal Circuit. *See generally* Br. for Appellee, *Me. Cmty. Health Options v. United States*, No. 17-2395 (Fed. Cir. Dec. 6, 2017) (ECF No. 19); Br. for Appellee, *Blue Cross & Blue Shield of N.C. v. United States*, No. 17-2154 (Fed. Cir. Nov. 1, 2017) (ECF No. 20); *see also Molina* at 36-37 (discussing *Star-Glo*).

390-91. The Supreme Court found that there was no "positive repugnancy between the old and the new statutes." *Id.* at 393 (emphasis added). It observed that none of the appropriations acts "contains any language to the effect that such sum shall be 'in full compensation' for those years." *Id.* Nor "was there in either of them an appropriation of money 'for additional pay,' from which it might be inferred that Congress intended to repeal the act" setting the minister's salary at $7,500. *Id.* The Court thus held that a money-mandating statute "should not be deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount … for particular fiscal years, and which contained no words that expressly or by clear implication modified or repealed the previous law." *Id.* at 394.

Here, as in *Langston*, Congress kept the underlying obligation alive, and "merely appropriated a less amount" by limiting certain—but not all—funding sources to make § 1342 payments. *Langston* thus controls.

(3) *Mitchell*

The stark contrast between the riders' language at issue here and the appropriations bill found to repeal an earlier statute in *United States v. Mitchell*, 109 U.S. 146 (1883), demonstrates the proper outcome here. In *Mitchell*, a statute set the annual salary of Indian interpreters at $400, which "shall be in full of all emoluments and allowances whatsoever." 109 U.S. at 147. Later appropriations acts cut the base pay to $300, but also appropriated $6,000 "[f]or additional pay … to be distributed in the discretion of the Secretary of the Interior." *Id.* at 149. So, interpreters lost some salary, but could now earn a bonus. The Supreme Court held that the change in compensation structures—from a base salary with no bonus, to a lower base with a bonus—"distinctly reveals a change in the policy of Congress on this subject" that was "irreconcilable" with the 1851 statute, rendering it "suspended." *Id.* at 149-50. By contrast, the riders here clearly do not "reveal[] a change in the policy of Congress" regarding the

Government's full risk corridors payment obligation that was "irreconcilable" with § 1342's "shall pay" mandate. *Id.* This case is much more like *Langston* than *Mitchell*.

(4) *Dickerson* and *Will*

Defendant's reliance on *United States v. Dickerson*, 310 U.S. 554 (1940), and *Will*, 449 U.S. 200, does not change the implied-repeal analysis. Neither case is apposite on the critical construction issue. In *Dickerson*, the Supreme Court held that a prior statute for military re-enlistment bonuses was incompatible with a later appropriations bill expressly revoking those bonuses "notwithstanding" the prior statute. As *Gibney* correctly found, the "notwithstanding" clause in *Dickerson*'s appropriation—a term that is absent from the riders here—"carried a temporary *suspension* of the legislative authorization." 114 Ct. Cl. at 53.

Will is inapplicable as well. There, the Supreme Court considered the effect of an appropriations bill prohibiting "funds available for payment to executive employees" from being "used to pay any such employee or elected or appointed official any sum in excess of 5.5 percent increase in existing pay and such sum if accepted shall be in lieu of the 12.9 percent due for such fiscal year." 449 U.S. at 208. Because the prior cost-of-living-increase statute could not coexist with an appropriation blocking the use of ***any*** pay-related funds for cost-of-living increases beyond a certain percentage, which Congress expressly made "in lieu" of the full amount due under the prior cost-of-living statute, the Court found an implied repeal. *Id.* at 223-24 ("Congress intended to ***rescind*** these raises entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The ***clear intent*** of Congress in each year ***was to stop*** for that year the application of the Adjustment Act.") (emphasis added).

But here, Congress did not analogously prohibit the entire universe of "funds available for risk corridors payments" from being "used to pay any risk corridors payments," nor did Congress state that "pro-rated risk corridors user fees if accepted shall be in lieu of the full risk

corridors payment due for such calendar year." And, § 1342's money-mandating "shall pay" obligation plainly is not irreconcilable with the limitation of ***some***—but not ***all***—funding sources for those payments. This case is much more like *Gibney* than *Dickerson* or *Will*.

(5) *Highland Falls*

Finally, Defendant elsewhere has placed particular reliance on the Federal Circuit's decision in *Highland Falls-Fort Montgomery Central School District v. United States*, 48 F.3d 1166 (Fed. Cir. 1995), but once again context demonstrates its inapplicability. In *Highland Falls*, ***earmarks for specific dollar amounts*** in appropriations acts were held to suspend ***discretionary payments*** to school districts that had been determined by the Secretary of Education. Referring to those earmarks, the Federal Circuit found "great difficulty imagining a more direct statement of congressional intent than the instructions in the appropriations statutes at issue here." *Id.* at 1170 (noting that an appropriation specifically earmarked "$15,000,000"). In this case, by comparison, Defendant does not—*because it cannot*—point to any similar earmarks in the risk corridors riders. They do not exist.

Further, the Government has no discretion under § 1342's "shall pay" mandate to pay less than the statutorily-prescribed sums, while the underlying statute in *Highland Falls* was not money-mandating—as Defendant itself argued in that case. *See Highland Falls*, 48 F.3d at 1167 (noting trial court's finding "that Highland Falls's entitlement to funds under the [Impact Aid] Act was not mandatory and that [Highland Falls] therefore did not have a monetary claim against the government"); Br. of U.S., *Highland Falls*, No. 94-5087, 1994 WL 16182294, at *7 (Fed. Cir. June 7, 1994) (arguing that the Government's motion to dismiss had "demonstrated that the Impact Aid program is not a mandatory spending program"). The *Highland Falls* statute also allowed for the possibility that Congress might underfund the program—no similar provision exists in § 1342. Thus, *Highland Falls*—like Defendant's other cited authorities—does not

support Defendant's position. *See Molina* at 39 (concluding that the "reasoning in *Highland Falls* simply does not apply because the appropriation laws at issue are quite different").

c. Construing the riders to repeal the Government's full-payment obligation raises serious constitutional issues.

Defendant's reliance on the riders should be rejected for an additional reason: It raises serious constitutional concerns because reading the riders to work an implied repeal of the Government's full-payment obligation would retroactively abrogate L.A. Care's vested rights and upset its legitimate, investment-backed reliance interests protected by the Due Process Clause. *See Landgraf v. USI Film Prods.*, 511 U.S. 244, 266 (1994) (noting that the Due Process Clause "protects the interests in fair notice and repose that may be compromised by retroactive legislation").

Here, by the time Congress enacted the initial FY 2015 rider (in December 2014), L.A. Care had signed on as a QHP, developed and offered ACA plans, and nearly completed its QHP performance for CY 2014; its right to risk corridors payments for CY 2014 had almost fully vested; and it already had committed to performing in CY 2015. Thus, construing the riders to vitiate the Government's obligation to pay impermissibly "would impair rights" L.A. Care "possessed when" it performed in CY 2014. *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (citation omitted); *see also Landgraf*, 511 U.S. at 266 (same).

Such a severe retroactive effect on L.A. Care likewise raises constitutional due process concerns that should be avoided under any circumstances. *See Landgraf*, 511 U.S. at 266; *Clark v. Martinez*, 543 U.S. 371, 379 (2005) ("[S]tatutes should be interpreted to avoid constitutional doubts."). And that is especially true here given the strong presumption against "an ***implied repeal*** [that] might raise constitutional questions." *St. Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772, 788 (1981) (citation omitted; emphasis added).

As the Supreme Court has made clear, the law must, and does, "safeguard[] both the expectations of Government contractors and the long-term fiscal interests of the United States." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191 (2012). Requiring the Government to "honor its statutory commitments" and rejecting the riders as a proper means of "back[ing] out" would do just that. *Molina* at 41. If, however, the riders are deemed to impliedly repeal the Government's full-payment obligation, that would cast aside the settled expectations of L.A. Care and the other insurers. It would also turn common sense on its head, because it would be nothing short of "madness" for L.A. Care "to have engaged in these transactions with no more protection than" pro-rata payments limited to unpredictable collections from profitable insurers. *Winstar*, 518 U.S. at 910 (plurality op.) (citation omitted); *Molina* at 45 (same).

At the same time, the Government has its "own long-run interest as a reliable contracting partner in the myriad workaday transaction of its agencies." *Winstar*, 518 U.S. at 883. But if Congress can eliminate an "unequivocal obligation" of the Government (*Molina* at 41) by slipping a spending limitation into an appropriations bill, and then later asserting in litigation that the limitation substantively revised an earlier-enacted statute, nobody dealing with the Government—in any industry—could confidently rely upon even an explicit statutory promise. "After all, 'to say to [L.A. Care], "The joke is on you. You shouldn't have trusted us," is hardly worthy of our great government.'" *Moda* at 466 (quoting *Brandt v. Hickel*, 427 F.2d 53, 57 (9th Cir. 1970)).

This Court accordingly should hold the Government to its clear statutory obligation and require it to make the full risk corridors payments it owes to L.A. Care.

IV. COUNT II: THE GOVERNMENT BREACHED AN IMPLIED-IN-FACT CONTRACT WITH L.A. CARE BY REFUSING TO MAKE FULL ANNUAL RISK CORRIDORS PAYMENTS

Additionally, this Court should recognize—as it did in *Moda* and *Molina*—that "the

undisputed facts show the Government entered into an implied-in-fact contract with [L.A. Care] and subsequently breached the contract when it failed to make full risk corridor payments." *Molina* at 41 (citing *Moda*). The Court should make this finding "*regardless* of the Government's appropriation law defenses," because "later appropriation restrictions cannot erase a previously created contractual obligation." *Id.* (emphasis in original). Accordingly, the Court should find in the alternative that L.A. Care is entitled to summary judgment on Count II for the Government's breach of an implied-in-fact contract.

To assert the existence of an implied-in-fact contract with the Government, a plaintiff must demonstrate: (1) mutuality of intent, (2) consideration, (3) offer and acceptance, and (4) actual authority to contractually bind the Government.[34] *See Forest Glen Props., LLC v. United States*, 79 Fed. Cl. 669, 683 (2007); *Molina* at 41. An implied-in-fact contract "is not created or evidenced by explicit agreement of the parties, but is inferred as a matter of reason or justice from the acts or conduct of the parties." *Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986). L.A. Care satisfies all of these elements, like the insurers did in *Moda* and *Molina*.

A. There Was Mutuality of Intent to Contract

In *Molina*, this Court considered, and roundly rejected, Defendant's renewed effort to assert that mutuality of intent is lacking in the risk corridors cases. *See Molina* at 43-45; *see also id.* at 41-42 (describing Court's mutuality-of-intent analysis in *Moda*). To establish the mutual intent element, L.A. Care need only demonstrate "language … or conduct on the part of the government that allows a reasonable inference that the government intended to enter into a contract." *ARRA Energy*, 97 Fed. Cl. at 27. Such intent can be inferred from the "conduct of the

[34] The final three "elements of an implied-in-fact contract were easily met in *Moda Health Plan*, as they [were] in [*Molina*,]" and as they are here. *Molina* at 42.

parties showing, in the light of the surrounding circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996).

Here, § 1342 and HHS's implementing regulations established "a program that offers specified incentives in return for voluntary performance of private parties" in the "form of an actual undertaking," and that was "promissory" in nature because it gave HHS "no discretion to decide whether or not to award incentives to parties who perform." *Moda* at 463-64 (relying on *N.Y. Airways*, 369 F.2d 743 (Ct. Cl. 1966) and *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957)); *see also Molina* at 43-45 (rejecting Government's challenge to *Moda*'s reasoning and to that decision's reliance on *N.Y. Airways* and *Radium Mines*). Under this controlling authority, these features of the risk corridors program confirm the Government's intent to contract.

Moreover, as L.A. Care has demonstrated, in and after 2011, the Government repeatedly manifested its intent to share the risk with insurers by making annual risk corridors payments designed to encourage L.A. Care's participation on the ACA Exchange. *See, e.g.*, Am. Compl. ¶¶ 95-113; 77 FR 73118, 73119 (Dec. 7, 2012) (§ 1342 was intended to "protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains"); 78 FR 72322,72379 (Dec. 2, 2013) (same); 79 FR 13743, 13829 (Mar. 11, 2014) (same); *Molina* at 45 (noting that "[t]hese statements, made before Molina and similar insurers agreed to offer plans on the Exchanges, were designed to instill confidence in the Government's promise to actually share the risks of the ACA and actually protect against potential losses").

L.A. Care also has demonstrated that the Government accepted L.A. Care's services in performance of the contract requirements, knowing that L.A. Care had expended resources to become a QHP per the Government's requirements. *See, e.g.*, Am. Compl. ¶¶ 17-19, 86, 162, 168-170, 179, 181, 188. The Government's collection of CY 2014, CY 2015, and CY 2016 risk

corridors charges from certain profitable QHPs, and its partial CY 2014 risk corridors payments to other QHPs, including L.A. Care, further confirm the parties' meeting of the minds. *See*, *e.g.*, Am. Compl. ¶¶ 164, 182, 189, 198; *see Vargas v. United States*, 114 Fed. Cl. 226, 233 (2014) (finding that, among other facts, government's partial payment of amount owed under written agreement could support implied-in-fact contract).

Controlling law refutes Defendant's narrow focus on only circumstances surrounding enactment of the ACA. The Supreme Court itself has made clear that courts should consider the conduct and "legitimate expectations" of the parties both before ***and*** after the relevant legislation was passed, and determine whether "Congress would have struck" the bargain under such circumstances. *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 468-69(1985); *see also Hercules*, 516 U.S. at 424 (same); *N.Y. Airways*, 369 F.2d at 751 (relying upon statements of "key congressmen" "throughout the years in question").

L.A. Care has not only identified "circumstances surrounding the enactment of the ACA"—it has gone further, pointing to the core features of § 1342 and HHS's implementing regulations themselves, which plainly were promissory in nature and imposed enforceable obligations on the Government. *See N.Y. Airways*, 369 F.2d at 751-52 (finding implied-in-fact contract arising out of statutory language, based on parties' conduct indicating an intent to contract); *Radium Mines*, 153 F. Supp. at 405-06 (finding implied offer in regulation designed to induce plaintiffs to purchase uranium); *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982) (citing *Radium Mines* as example of cases "where contracts were inferred from regulations promising payment"); *Moda* at 463-64.

B. <u>There Was Consideration</u>

L.A. Care sufficiently asserts consideration. Am. Compl. ¶¶ 316-326. Defendant cannot credibly challenge that it "offered consideration in the form of risk corridors payments under

Section 1342." *Molina* at 42 (quoting *Moda* at 465). Nor can Defendant contest that "[i]n return," L.A. Care "provid[ed] QHPs to consumers on the … Exchange[]" in California. *Id.*

C. L.A. Care Accepted the Government's Offer, and the Condition Precedent to Payment was Satisfied

On the element of offer and acceptance, L.A. Care has demonstrated a Government offer to make full and timely risk corridors payments for CYs 2014, 2015 and 2016, which L.A. Care accepted by becoming a QHP and performing. An offer must be manifested by conduct that indicates assent to the proposed bargain. *See Grav v. United States*, 14 Cl. Ct. 390, 393 (1988) (holding Government's offer in statute was accepted, forming implied-in-fact contract). Offer and acceptance can be found in the "conduct of the parties." *Forest Glen*, 79 Fed. Cl. at 684; *see also N.Y. Airways*, 369 F.2d at 751-52 (finding implied-in-fact-contract formed through acceptance of Government's offer arising in statute).

The Government's offer was made in the text of § 1342, the provision's implementing regulations, and the Government's subsequent statements surrounding the implementation of the risk corridors program. *See Molina* at 42, 45; *Moda* at 464. Those statements incentivized L.A. Care to participate on the ACA Exchange. Becoming a QHP was volitional for L.A. Care, and was subject to the Government's discretion in whether to certify L.A. Care as a QHP. Only after it was awarded QHP status, and accepted the Government's offer to participate on the ACA Exchange, did L.A. Care become obligated to remit risk corridors charges or entitled to receive risk corridors payments. *See, e.g.*, Am. Compl. ¶¶ 19, 27-28; 42 U.S.C. § 18062(a).

The Government's repeated, undisputed statements before L.A. Care accepted the offer assured L.A. Care of the Government's intent to make each year's risk corridors payments by the end of the following calendar year. *See, e.g.*, Am. Compl. ¶¶ 58, 82, 95-113, 315. This constituted an offer. And L.A. Care, by engaging in preparations and incurring significant

expenses to become a QHP, and then selling QHPs on the California Exchange, accepted the offer and performed. *See, e.g.*, Am. Compl. ¶¶ 28-31, 317, 323; *Molina* at 42, 45; *Moda* at 464.

Further, the condition precedent for the Government's payment obligation to mature was met: L.A. Care suffered annual losses in excess of the statutory threshold. *See Molina* at 42 (citing *Moda* at 464).

D. The HHS Secretary Had Actual Authority to Contract on the Government's Behalf

To satisfy the "actual authority" element, L.A. Care must show that "the officer whose conduct is relied upon had actual authority to bind the government in contract." *Lublin Corp. v. United States*, 98 Fed. Cl. 53, 56 (2011). "Authority to bind the government is generally implied when [it] is considered to be an integral part of the duties assigned to a government employee." *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989) (alterations omitted). Here, L.A. Care has demonstrated that an authorized Government agent entered into or ratified an implied-in-fact contract relating to the risk corridors payments.

The HHS Secretary "had actual authority to contract on the Government's behalf" regarding the risk corridors program that the Secretary must "establish and administer." *Moda* at 465; 42 U.S.C. § 18062(a). L.A. Care has demonstrated that the implied-in-fact contracts were authorized or approved by Government representatives who had actual authority to bind the Government in contract as part of their employment duties. *See, e.g.*, Am. Compl. ¶¶ 66, 97-98, 161, 168-169, 325-326. L.A. Care also has demonstrated that HHS and CMS officials with authority repeatedly made statements regarding the Government's obligation to make full and timely risk corridors payments. *See, e.g., id.*

Furthermore, L.A. Care has demonstrated that Kevin Counihan, CMS's CEO of the ACA Marketplace at all relevant times, ratified the terms of the contract through his acceptance of the

benefits provided by L.A. Care and his statements confirming the Government's obligations. *See, e.g.*, *id*.; *see also Silverman v. United States*, 679 F.2d 865, 870 (Ct. Cl. 1982) (finding Government bound if it ratifies contract even if Government official lacked authorization to enter into it). Mr. Counihan's job included overseeing the ACA Marketplace, and entering into agreements with QHPs was integral to his duties. *See* Am. Compl. ¶ 97; *Telenor Satellite Servs. Inc. v. United States*, 71 Fed. Cl. 114, 120 (2006) (agent had implied actual authority where authority was "an integral part of the duties"). Accordingly, L.A. Care has satisfied the authority element.

E. The Government Breached its Implied-In-Fact Contractual Obligations and L.A. Care is Entitled to Judgment

Finally, L.A. Care has demonstrated that the Government breached its implied-in-fact contractual obligations by failing to pay the full amount of risk corridors payments owed for losses L.A. Care sustained for CY 2014, CY 2015 and CY 2016. *See, e.g.*, Am. Compl. ¶¶ 218; Decl. ¶¶ 16. Accordingly, the Court should find as a matter of law, as it found in *Moda* and *Molina*, that no genuine dispute of material fact exists over L.A. Care's satisfaction of all the elements to establish that the Government had and breached an implied-in-fact contract with L.A. Care regarding risk corridors payments, for which the Government is liable to L.A. Care, and that L.A. Care is entitled to summary judgment in its favor on Count II.

V. L.A. CARE IS ENTITLED TO SUMMARY JUDGMENT ON DAMAGES

There is no genuine dispute regarding the amount of L.A. Care's damages under Counts I and II: $23,512,415.83. Decl. ¶¶ 16.

A. Total Payments Owed

1. CY 2014

On November 19, 2015, CMS announced the risk corridors payments the Government owes to each QHP, including L.A. Care, for CY 2014, and the amounts those issuers would

receive from CY 2014 risk corridors collections, assuming full risk corridors charge collections were received by the Government from profitable QHPs. *See* Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015), Am. Compl. Ex. 51 ("CY 2014 Risk Corridors Report").

CMS announced that the Government is required to pay L.A. Care risk corridors payments for CY 2014 of $13,561,651.72, but the Government declared that it would only make prorated payments to L.A. Care equal to 12.6% of the amounts owed, $1,711,191.11 for CY 2014. *See id.* at Table 5 – California; Decl. ¶¶ 7-9.

2. CY 2015

On November 18, 2016, CMS announced the risk corridors payments the Government owes to each QHP, including L.A. Care, for CY 2015. *See* Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year* (Nov. 18, 2016), Am. Compl. Ex. 47 ("CY 2015 Risk Corridors Report"). CMS stated that the Government's risk corridors charge collections from profitable QHPs for CY 2015 would be used toward the CY 2014 risk corridors balances still owed, and that CY 2016 risk corridors collections would be used first to pay remaining CY 2014 risk corridors balances owed, and then, if funds are available, to pay risk corridors balances owed for the CY 2015 benefit year. *See id.* at 1.

L.A. Care's losses in the ACA California Individual Market for CY 2015 resulted in the Government acknowledging that it owes L.A. Care a risk corridors payment of $8,255,198.64 for CY 2015. *See id*. at 3; Decl. ¶ 10.

3. CY 2016

On November 13, 2017, CMS announced the risk corridors payments the Government owes to each QHP, including L.A. Care, for CY 2016. *See* Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year* (Nov. 13, 2017), Am. Compl. Ex. 52

("CY 2016 Risk Corridors Report"). CMS stated that the Government's risk corridors charge collections from profitable QHPs for CY 2016 would be used entirely toward some—but not nearly all of—the remaining CY 2014 risk corridors balances owed, confirming that the Government would make no risk corridors payments for CY 2015 or CY 2016, and only partial payments for CY 2014. *See id.* at 1.

L.A. Care's losses in the ACA California Individual Market for CY 2016 resulted in the Government acknowledging that it owes L.A. Care a risk corridors payment of $3,948,187.97 for CY 2016. *See id*. at 3; Decl. ¶ 12.

B. CY 2014 Partial Payments Received

To-date, the Government has made partial payments to L.A. Care totaling only $2,252,622.50, which the Government has treated as payment toward the CY 2014 risk corridors amounts owed. *See* Decl. ¶ 14.

C. Damages Amount

Subtracting the Government's CY 2014 partial payments made from the total amounts owed, to-date, the following risk corridors payments to L.A. Care remain unpaid by the Government: $11,309,029.22 for CY 2014, $8,255,198.64 for CY 2015, and $3,948,187.97 for CY 2016, for a total of $23,512,415.83. Decl. ¶ 16. This is the undisputed amount of L.A. Care's damages caused by the Government's breach of its statutory and contractual obligations.

L.A. Care therefore requests that the Court instruct the Clerk to enter final judgment for L.A. Care in the amount of $23,512,415.83, plus reasonable costs under RCFC 54(d).

CONCLUSION

L.A. Care respectfully requests that this Court grant its Motion for Partial Summary Judgment as to Counts I and II, and enter judgment for L.A. Care on those Counts in the amount of $23,512,415.83, plus reasonable costs under RCFC 54(d), for the Government's failure to

comply with its statutory/regulatory (Count I) and implied-in-fact contractual (Count II) obligations to make full annual risk corridors payments to L.A. Care for CY 2014, CY 2015, and CY 2016.

Dated: February 8, 2018

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on February 8, 2018, a copy of the foregoing Plaintiff's Motion for Partial Summary Judgment and accompanying Declaration and Appendix were filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing with be sent to all parties by operation of the Court's ECF system.

s/ Lawrence S. Sher
Lawrence S. Sher
Counsel for Plaintiff