IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MAINE COMMUNITY HEALTH OPTIONS Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 17-2057C Judge Margaret M. Sweeney

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

Plaintiff Maine Community Health Options ("Plaintiff" or "Health Options"), respectfully submits this Motion for Summary Judgment and Memorandum of Law in Support of its Complaint for damages against the Defendant, the United States of America ("Government"), acting through the Centers for Medicare & Medicaid Services ("CMS") (and CMS's parent agency, the U.S. Department of Health and Human Services ("HHS")), due to the Government's violations of Section 1402 of the Patient Protection and Affordable Care Act ("Section 1402") and 45 C.F.R. § 156.430 ("Section 156.430").

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules and Regulations

Other Authorities

INTRODUCTION

In March 2010, Congress enacted the Patient Protection and Affordable Care Act[1] and the Health Care and Education Reconciliation Act[2] (collectively, the "Affordable Care Act," "Act," or "ACA"). The Act represented a major shift in health care coverage and regulation in the country, with the principal objective of making comprehensive and affordable health insurance available to tens of millions of then-uninsured Americans. Health Options is a health insurance company that was created specifically to help deliver coverage to the new pool of insureds.

To accomplish its aims, the ACA required individuals to purchase coverage if they are not otherwise insured, but also established an integrated program of subsidies to defray both the premium expenses and out-of-pocket costs of health insurance with two main components: premium tax credits and cost-sharing reductions ("CSR").

First, Section 1401 of the ACA provides premium tax credits for qualified individuals with household income between 100% and 400% of the federal poverty level who purchase health insurance through the exchanges established by the Act. 26 U.S.C. § 36B. The vast majority of individuals who buy insurance on an exchange rely on advance payments of these premium tax credits. *See King v. Burwell*, 135 S. Ct. 2480, 2493 (2015).

Second, and most pertinent here, Section 1402 of the ACA requires insurers to provide "cost-sharing" reductions to individuals who are determined eligible to receive tax credits under Section 1401 and whose household income is below 250% of the federal poverty level. 42 U.S.C. § 18071(c)(2), (f)(2). "Cost sharing" refers to out-of-pocket payments to health care providers in the form of copayments, coinsurance, and deductibles that individuals are typically

[1] Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010).
[2] Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

required to pay under their insurance plan. *See* Congressional Budget Office ("CBO"), *Key Issues in Analyzing Major Health Insurance Proposals* at 15-17 (Dec. 18, 2008), *available at* www.cbo.gov/publication/41746.

Insurers, in turn, are guaranteed by the ACA to be reimbursed by the Government for the cost-sharing reductions they provide to their insureds. Specifically, the ACA requires that the Secretaries of HHS and the Treasury "***shall make periodic and timely payments*** to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added). These payments are made directly to health insurance issuers. *Id.* at § 18082(a)(3).

In January 2014 when the health care exchanges began operating, HHS began making monthly advance payments to reimburse Quality Health Plan ("QHP") issuers for cost-sharing reductions in accordance with the ACA. *See* CMS, Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015 at 27 (Mar. 16, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf. HHS continued to make these required monthly payments for nearly four years.

On October 12, 2017, however, the Government announced that it would no longer fulfill its CSR obligations. HHS Acting Secretary Eric Hargan issued a memorandum to CMS stating that "CSR payments to issuers must stop, effective immediately."[3] According to the memorandum, this instruction was premised upon a legal opinion of the U.S. Attorney General concluding that the CSR program lacked a valid appropriation. CMS ceased making CSR payments as of that date, despite millions of dollars in payments still being due for 2017.

[3] Oct. 12, 2017 Mem. from E. Hargan to S. Verma re: Payments to Issuers for Cost-Sharing Reductions (CSRs), *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

The Government's refusal to pay CSR reimbursements deprives QHP issuers, including Health Options, of money owed to them by statute on account of their performance in the exchanges for benefit year 2017. The Government's abrupt change of policy and refusal to abide by the statutory mandate, in the middle of the benefit year, has caused immediate and significant harm.

The purported basis of the Government's refusal to pay—the claimed lack of an appropriation—does not negate the Government's obligation to pay. Regardless of whether Congress appropriated sufficient funds ***to HHS*** to make the CSR payments, the Government's statutory obligation to make such payments, and Plaintiff's right to those payments, remain. Indeed, in other federal litigation, the Government expressly acknowledged that the ACA "requires the government to pay cost-sharing reductions to issuers" and that "[t]he absence of an appropriation would not prevent the insurers from seeking to enforce that statutory right through litigation." Defs.' Mem. ISO Mot. for Summ. J., *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. No. 55-1 (D.D.C. filed Dec. 2, 2015) at 20. That is exactly what Health Options is doing here. By this lawsuit, Health Options seeks $5,651,672.49[4], the amount of unpaid 2017 CSR payments to which it is entitled under the ACA.

The Government violated its CSR payment obligations, money is presently due, and the Government's obligation has not been abrogated. Accordingly, Health Options is entitled to judgment in the amount sought.

STATEMENT OF THE ISSUE

The CSR program was designed to reduce cost sharing—the out-of-pocket costs that insureds would have to pay to their health care providers. Without these subsidies, high cost

[4] $1,912,401.71 for October 2017; $1,890,782.79 for November 2017; and $1,848,487.99 for December 2017.

sharing would deter low-income individuals from seeking health care, directly undermining the ACA's goal of making health insurance affordable for low- and moderate-income Americans. Thus, the CSR program requires the Government to make advance payments to insurers who would then use those subsidies to reduce cost sharing for eligible individuals upon utilization. If an insurer reduced costs for an insured greater than the advanced payment received each month, the Government was obligated to provide additional amounts to meet the full cost-sharing burdens borne by insurers. This is how the law was written, and it is how HHS originally construed, and announced it would administer—and did indeed administer—the program.

The Government's new decision to abandon its cost-sharing obligations violates the very premise of the CSR program. Health Options reduced cost sharing for eligible low- and moderate-income Americans in benefit year 2017, as the ACA required. Therefore, under the CSR program, the Government owes Health Options payment in the amount of $5,651,672.49 for the months that Health Options reduced cost sharing without reimbursement.

STATEMENT OF RELEVANT BACKGROUND

I. THE ACA ESTABLISHED A COST-SHARING REDUCTION PROGRAM WITH ADVANCE PAYMENT OBLIGATIONS.

The Affordable Care Act imposed certain obligations on the federal government to help incentivize the participation of private insurers, stabilize premiums, and induce the uninsured to purchase health insurance coverage. Relevant to this dispute, the ACA established a cost-sharing reduction subsidy, paid preemptively to certain qualified insurers, to facilitate the core statutory mission of providing affordable health care to low- and moderate-income Americans.

Section 1402 of the Affordable Care Act, as codified at 42 U.S.C. § 18071 and implemented in the Code of Federal Regulations at 45 C.F.R. § 156.430, *et seq.*, created the CSR program. In relevant part, Section 156.430 states that "[a] QHP issuer ***will receive periodic***

advance payments based on the advance payment amounts calculated in accordance with § 155.1030(b)(3) of this subchapter." 45 C.F.R. § 156.430(b)(1) (emphasis added). Section 155.1030(b)(3) and other regulations set forth the calculation methodologies applicable to CSR payments.

II. HEALTH OPTIONS IS A QHP ISSUER THAT REDUCED COST SHARING FOR INSUREDS ON THE MAINE EXCHANGE IN RELIANCE ON CSR REIMBURSEMENTS.

Health Options is a member-led non-profit QHP issuer and Maine's only Consumer Operated and Oriented Plan ("CO-OP")[5] insurer. Health Options was created specifically in response to the ACA's call for expanded and affordable health insurance and is required to participate on the exchanges. Its mission is to partner with members, employers, and healthcare providers to create affordable, high-quality benefits that promote health and well-being. Health Options exemplifies the ACA's objectives to bring affordable coverage to more individuals, particularly those individuals who are most in need. It has actively educated the public regarding the availability of coverage under the ACA, how marketplaces work, and Health Options' available benefit plans. But for its existence, there would have been only one carrier on Maine's individual marketplace in 2014, which is also true for 2018.

For Health Options to participate on the marketplaces for the 2017 benefit year, it had to submit its premiums to the Maine Bureau of Insurance by May 9, 2016, and submit a signed Qualified Health Plan Issuer Agreement ("QHPIA") to CMS by the end of September 2016.[6]

[5] Congress created the CO-OP program in ACA Section 1322, which explicitly states that "the purpose of the CO-OP program [is] to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets[.]" 42 U.S.C. § 18042(a)(2).

[6] CMS, Key Dates for Calendar Year 2016: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance (Dec. 23, 2015), *available at*

(Continued...)

Plaintiff timely submitted a signed QHPIA, and by doing so committed itself to offering health insurance coverage on the exchange for benefit year 2017. Because the QHPIA has limited termination rights, and because terminating the QHPIA under any circumstance does not obviate the issuer's obligations under state law to continue coverage for enrollees who purchased the plan, Plaintiff's commitment to the 2017 marketplace was effectively irrevocable as of the end of September 2016.[7]

Plaintiff committed itself to participating in the marketplace in 2017 with the express understanding—based on the plain text of Section 1402 and consistent with the Government's actions in previous benefit years—that, for those plans that required the issuers to reduce cost-sharing obligations of the enrollee, the Government would honor the statutory mandate, *i.e.*, "***the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions***." And in fact, in accordance with that understanding, the Government made monthly CSR payments from January 2017 up and until October 2017, just as it had done for the preceding 36 months.

III. THE GOVERNMENT REVERSES COURSE AND REFUSES TO MAKE CSR PAYMENTS.

On October 12, 2017—over a year after Plaintiff had committed itself irrevocably to the 2017 exchange—the Government first announced that it would not make CSR payments for the remainder of the 2017 benefit year. The Government took the new position that 31 U.S.C. § 1324—the appropriation previously used to fund Section 1402—could not be used to fund CSR reimbursements. In an October 11, 2017 memorandum, the Department of Justice concluded that Section 1401 premium tax credits and Section 1402 CSR reimbursements were two distinct

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https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-key-dates-table-April-2016.pdf.

[7] *See* 45 C.F.R. § 147.106(b).

programs, and the permanent appropriation in Section 1324 provided funding only for the Section 1401 premium tax credits. *See* Oct. 11, 2017 Ltr. from Att. Gen. Sessions to Secretary of Treasury and Acting Secretary of HHS, *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf. The next day, HHS announced that it would stop making CSR reimbursements "until a valid appropriation exists." Oct. 12, 2017 Mem. from E. Hargan to S. Verma re: Payments to Issuers for Cost-Sharing Reductions (CSRs), *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. Health Options is a corporation organized under the laws of Maine with its principal place of business in Lewiston, Maine.

2. Health Options applied for federal funding to operate as a CO-OP, and in early 2012, CMS approved Health Options' business plan and application to operate as a QHP issuer, and authorized federal funding to Health Options to operate as a CO-OP as defined in 42 U.S.C. § 18042(a)(1)-(2).

3. Section 1402 of the Affordable Care Act, as codified at 42 U.S.C. § 18071, created the CSR program. In relevant part, that Section states:

> (a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—
>
> > (1) the Secretary shall notify the issuer of the plan of such eligibility; and
> >
> > (2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).
>
> [. . . .]
>
> (c)(3) Methods for reducing cost-sharing
>
> > (A) In general. An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and ***the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.***

42 U.S.C. § 18071(a)(1) and (2), (c)(3)(A) (emphasis added).

4. HHS implemented the CSR program at 45 C.F.R. § 156.430. In relevant part, Section 156.430 states that "[a] QHP issuer ***will receive periodic advance payments*** based on the advance payment amounts calculated in accordance with § 155.1030(b)(3) of this subchapter." 45 C.F.R. § 156.430(b)(1) (emphasis added). Section 155.1030(b)(3) and other regulations set forth the calculation methodologies applicable to CSR payments.

5. Following the ACA's implementation, the Government established a CSR reimbursement schedule under which the Government would provide the required periodic advance payments to QHP issuers. *See* 42 U.S.C. § 18082; 45 C.F.R. § 156.430(b)-(d). The reimbursements are then periodically reconciled to the actual amount of cost-sharing reductions made to enrollees and providers. 45 C.F.R. § 156.430(c).

6. The Government would reimburse the QHP issuer "any amounts necessary to reflect the CSR provided or, as appropriate, the issuer [would] be charged for excess amounts paid to it." *See* CMS, Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015 at 27 (Mar. 16, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf.

7. In January 2014, HHS began making monthly advance payments to reimburse QHP issuers for cost-sharing reductions. *See id.* Section 1324 was the appropriation used to make these payments. *See* Letter from Sylvia M. Burwell, Dir., OMB, to Senators Ted Cruz and Michael S. Lee, at Responses p. 4 (May 21, 2014), *available at* https://www.cruz.senate.gov/files/documents/Letters/20140521_Burwell_Response.pdf.

8. Congress has never repealed or amended the CSR provision, and indeed, in October 2013 appropriations legislation, HHS was required to certify that a program was in place to verify that applicants were eligible for "premium tax credits . . . and reductions in cost-sharing" before "making such credits and reductions available." *See* Continuing Appropriations Act, 2014, Pub. L. No. 113-46, Div. B, § 1001(a), 127 Stat. 558, 566 (Oct. 17, 2013).

9. From 2014 to the present, Health Options provided health insurance in the Maine marketplace, and reduced cost-sharing liability for eligible insureds, as set forth in Section 155.1030(b)(3) and other regulations.

10. For QHP issuers to participate on the marketplaces for the 2017 benefit year, they had to submit their premiums to the appropriate state or federal regulatory authority during May 2016 and submit a signed QHP Issuer Agreement to CMS by the end of September 2016. *See* CMS, Proposed Key Dates for Calendar Year 2016: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance (Dec. 23, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-key-dates-table-12-23-15-FINAL.pdf.

11. Plaintiff's commitment to the 2017 marketplace, and obligation to reduce cost sharing, was irrevocable by the end of September 2016. *See* 45 C.F.R. § 147.106(b).

12. On October 12, 2017, HHS announced that it would stop making CSR reimbursements "until a valid appropriation exists." Oct. 12, 2017 Mem. from E. Hargan to S. Verma re: Payments to Issuers for Cost-Sharing Reductions (CSRs), *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

13. HHS has not made any CSR payments due to issuers since the October 12, 2017 announcement.

JURISDICTION

This Court has Tucker Act jurisdiction over Plaintiff's claim because the ACA's CSR program is an act of Congress that (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]" and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." 28 U.S.C. § 1491(a)(1); *see United States v. White Mountain Apache Tribe*, 537 U.S. 465, 466 (2003); *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (en banc in relevant part) (citations omitted).

Tucker Act jurisdiction is also "limited to actual, presently due money damages from the United States." *See Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (citations and internal quotations omitted). Health Options is entitled to presently due money damages because it has fulfilled all statutory requirements for payment. *See Doe v. United States*, 100 F.3d 1576, 1580, 1582-84 (Fed. Cir. 1996) (jurisdiction existed where plaintiff had fulfilled all statutory conditions for payment). Health Options has submitted all required information to HHS demonstrating its entitlement to payment in specific amounts under Section 1402 of the ACA, amounting to $5,651,672.49 for unpaid obligations in benefit year 2017.

Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded[.]" *Fisher*, 402 F.3d at 1173. Health Options has pled that the ACA is money-mandating, requires full and timely payment, sets forth statutory requirements for receipt of payment that Health Options fulfilled, and requires payment the Defendant has not made. *See,*

e.g., Compl. ¶¶ 12-17, 29-32, 45-49, 57-59. Accordingly, this Court's jurisdiction is beyond dispute. *Me. Cmty. Health Options v. United States*, No. 16-967C, ECF Dkt. No. 30 (Order) at 1-2 (Fed. Cl. filed Mar. 9, 2017); *Moda Health Plan, Inc., v. United States*, 130 Fed. Cl. 436, 449-51 (2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 776 (2017).

In the alternative, the Contract Disputes Act, 41 U.S.C. § 7101, *et seq*., a money-mandating statute, provides Plaintiff a cause of action that gives rise to this Court's jurisdiction pursuant to the Tucker Act.

SUMMARY OF ARGUMENT

Judgment in Health Options' favor is appropriate because the Government has refused to pay Health Options money that is mandated by the ACA.

1. *Statutory Mandate to Pay.* A QHP issuer is required to offer certain plans with varying levels of cost sharing. 42 U.S.C. § 18021(a)(1)(C)(ii). Under the ACA, an insurer must reduce cost sharing for eligible individuals enrolled in one of these mandated plans. *Id*. § 18071(c)(2). In turn, the Government is obligated to reimburse insurers for these cost-sharing reductions. *Id*. § 18071. The Government's failure to reimburse Health Options these amounts for benefit year 2017 is a violation of the ACA and its implementing regulations.

2. *Breach of Implied-in-Fact Contract.* Judgment in Health Options' favor is also appropriate because the Government breached its unilateral or bilateral implied-in-fact contract with Health Options. There is no doubt as to the existence of an implied-in-fact contract, as all elements of an implied-in-fact contract are met in either scenario.

Empowered by the ACA's authorization to contract with QHP issuers, the Government held out a unilateral offer of CSR reimbursements to induce Health Options and other QHP issuers to begin performance, and Health Options accepted such offer by beginning performance.

Consideration flowed both ways, where the Government benefited from Health Options' reductions in cost sharing to eligible insureds, and Health Options benefited from the Government's promise of payment under the statute.

Alternatively, the parties entered into a bilateral contract—culminating in the signed QHP Issuer Agreement(s)—in which the parties agreed that Health Options would be bound to reduce cost-sharing amounts for eligible individuals in exchange for CSR payments.

In either scenario, Health Options has fulfilled its contractual duty and condition precedent to the Government's full payment. The Government is in breach for failing to uphold its side of the bargain.

SUMMARY JUDGMENT STANDARD

This case presents a clear question of statutory interpretation appropriate for summary disposition, as all material facts are undisputed. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." RCFC 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-16 (2008). A fact is material if it "might affect the outcome of the suit under the governing law[,]" *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986), and a dispute of material fact is genuine "if the evidence is such that a reasonable finder of fact could return a verdict for the nonmoving party[,]" *Johnson*, 80 Fed. Cl. at 116 (citing *Liberty Lobby, Inc.*, 477 U.S. at 248).

"Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Johnson*, 80 Fed. Cl. at 116 (quoting *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002)). The existence of a contract is a mixed question of

law and fact, and the court may grant summary judgment when there is no genuine issue for trial. *See La Van v. United States*, 53 Fed. Cl. 290 (2002), *aff'd*, 382 F.3d 1340 (Fed. Cir. 2004).

ARGUMENT

I. THE GOVERNMENT IS LIABLE FOR ITS FAILURE TO MAKE CSR PAYMENTS UNDER A MONEY-MANDATING STATUTE.

Health Options is entitled to summary judgment because, based on the undisputed facts and as a matter of law, the Government owes Health Options CSR payments for benefit year 2017. This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and internal quotations omitted). The plain text of Section 1402 mandates that the Government reimburse providers for cost-sharing reductions that they were required to provide to their insureds. The statutory text leaves no ambiguity:

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

42 U.S.C. § 18071(c)(3)(A) (emphasis added). Thus, a health insurance issuer is entitled to CSR payments if it provided cost-sharing reductions to eligible insureds in the 2017 benefit year.[8]

There is no question that Health Options satisfies the statutory criteria for payment. Plaintiff is an eligible QHP issuer under the ACA and satisfied the requirements for payment from the Government under Section 1402 of the ACA and Section 156.430. The Government's refusal to pay Health Options the amounts owed under the CSR program is in direct contravention of Section 1402 of the ACA and its implementing regulations.

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

The Government's recently conceived position that CSR payments cannot be made because Congress has not appropriated funds ***to HHS*** to pay them does not get the Government off the hook. Regardless of whether funds have been appropriated to HHS to make payment, the Government is bound by the unambiguous command of Section 1402 to make CSR payments to eligible issuers. The function of the Court of Federal Claims is to render judgment on the liability of the United States for an unmet obligation—the existence of a specific appropriation is irrelevant to the question of the Government's obligation. Longstanding precedent makes this clear:

> This court, established for the sole purpose of investigating claims against the government, does not deal with questions of appropriations, but with the legal liabilities incurred by the United States under contracts, express or implied, the laws of Congress, or the regulations of the executive departments. (Rev. Stat., § 1059.) That such liabilities may be created where there is no appropriation of money to meet them is recognized in section 3732 of the Revised Statutes.

Collins v. United States, 15 Ct. Cl. 22, 35 (1879).[9]

In a brief filed in federal district court in litigation ***relating to the CSR program***, the Government acknowledged the right and ability of insurers to do exactly what Health Options is doing now. Conceding that the ACA "requires the government to pay cost-sharing reductions to

[9] *See also United States v. Langston*, 118 U.S. 389, 392-94 (1886) (finding the Government liable for statutory promise of payment in absence of a specific appropriation); *Gibney v. United States*, 114 Ct. Cl. 38, 52 (1949) ("Whether . . . Congress appropriate an insufficient amount . . . or nothing at all, are questions . . . which do not enter into the consideration of a case in the courts."); *Strong v. United States*, 60 Ct. Cl. 627, 630 (1925) (awarding statutorily mandated military pay despite lack of an appropriation); *Parsons v. United States*, 15 Ct. Cl. 246, 246-47 (1879) (awarding statutorily mandated payment despite lack of an appropriation, noting that "*the absence of an appropriation constitutes no bar to the recovery of a judgment in cases where the liability of the government has been established.*") (emphasis added); *see also Graham v. United States*, 1 Ct. Cl. 380, 382 (1865) (entering judgment for difference where congressional appropriation fell short of statutorily obligated amount); *Miller v. United States*, 86 Ct. Cl. 609, 610-13 (1938) (same); *Danford v. United States*, 62 Ct. Cl. 285, 287-88 (1926) (entering judgment for statutorily promised payment amount where no congressional appropriation was made, noting that "[t]he fact that Congress made no appropriation for the two years for which [Plaintiff] was not paid does not preclude the plaintiff from obtaining relief in this court.").

issuers," the Government explained to the district court that "[t]he absence of an appropriation would not prevent the insurers from seeking to enforce that statutory right through litigation." Defs.' Mem. ISO Mot. for Summ. J., *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. No. 55-1 (D.D.C. filed Dec. 2, 2015) at 20. The Government further acknowledged that prevailing insurers "can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund. . . . The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund." *Id*.

For the very reasons pointed out by the Government in *House v. Burwell*, it does not matter whether Congress appropriated funds in the ACA (31 U.S.C. § 1324) ***for HHS*** to make CSR payments. What matters is that, in Section 1402, Congress obligated the Government to make those payments. If Congress chooses not to fund its CSR obligations either permanently in a separate provision of the ACA or through the more traditional annual appropriation process, that is of course its prerogative. But it is also beside the point here because ***this Court***—as *Collins* and many other decisions make plain—concerns itself with the liability of the United States for obligations the Government fails to honor. It is then left to the political officers to decide how to pay any judgment rendered.

The Judgment Fund is a permanent appropriation against which Health Options can seek to exercise its judgment, so there is no question that an appropriation exists for the Government to make good on a judgment in Health Options' favor— the very point the Government made in *House v. Burwell*. As the Court of Claims said in *Gibney*:

> The judgment of a court has nothing to do with the means—with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them. Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether it is to be paid out of one appropriation or out of another; whether Congress appropriate[s] an insufficient amount, or a sufficient amount, or nothing

> at all, are questions which are vital for the accounting officers, but which do not enter into the consideration of a case in the courts.

114 Ct. Cl. at 52. *See also id.* (stressing that an appropriation "limitation upon the power of the Secretary does not extend to the court; the real question before the court is that of the claimant's legal right to receive the pay" to which the controlling statute entitled him). *Accord N.Y. Airways, Inc. v. United States*, 177 Ct. Cl. 800, 811 (1966) ("The 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.") (citations omitted).

For the reasons stated, Health Options is entitled to receive, and the Government is obligated to pay, $5,651,672.49 in CSR payments. The Court should hold the Government liable for the full amount for failing to abide by its statutory obligation.

II. THE GOVERNMENT IS LIABLE FOR BREACH OF IMPLIED-IN-FACT CONTRACT.

This Court has jurisdiction over implied contract claims, 28 U.S.C. § 1491(a)(1), and the Judgment Fund is available to pay judgments. *Slattery v. United States*, 635 F.3d 1298,1303, 1317-21 (Fed. Cir. 2011), *cert. denied sub nom. McCarron v. United States*, 134 S. Ct. 1276 (2014). Implied contracts require (1) mutuality of intent, (2) unambiguous offer and acceptance, (3) consideration, and (4) actual authority of the Government contracting representative or ratification. *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995).

Here, all elements of an implied contract are met, and Health Options is entitled to the contractually obligated amounts. The Government held out a unilateral offer of CSR payments to Health Options and other QHP issuers to begin performance by reducing cost-sharing amounts for eligible insureds on the exchanges. The issuers accepted by beginning performance, rendering the offer irrevocable. Alternatively, the parties entered into a ***bilateral*** contract—culminating in the signed QHP Issuer Agreement(s)—in which the parties agreed that Health

Options would be bound to provide cost-sharing reductions to eligible individuals through its participation in the Maine marketplace. In either scenario, HHS's failure to uphold its side of the bargain constitutes a textbook contractual breach.

A. The Government Breached an Implied-in-Fact, Unilateral Contract with Health Options.

1. *There Was Mutuality of Intent to Contract.*

The Government contracts when its conduct or language "allows a reasonable inference" that it intended to do so. *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011). The surrounding circumstances include the statutory purpose, context, legislative history, or any other objective indicia of actual intent.[10] Health Options' well-pled facts show that the combination of Section 1402, HHS's implementing regulations, and the Government's conduct support that the "conduct of the parties show[s], in the light of the surrounding circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996) (citations omitted); *see also, e.g.*, Compl. ¶¶ 4-17, 27-32, 50-59.

This longstanding test is best illustrated in *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957), where the court found that a regulation establishing a guaranteed minimum Government purchase price for uranium was not "a mere invitation to the industry to

[10] *See, e.g.*, *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 468 (1985); *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 17-18 (1977) (although the statute did not expressly state an intent to contract, it was "properly characterized as a contractual obligation" when considering the purpose of the agreement and the fact that the Government "received the benefit they bargained for"); *Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986) (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"); *Nat'l Educ. Ass'n-R.I. v. Ret. Bd. of R.I. Emps.' Ret. Sys.*, 890 F. Supp. 1143, 1152-53 (D.R.I. 1995) (quoting *U.S. Trust Co.*, 431 U.S. at 17 n.14) ("[T]his Court is not limited to an examination of statutory language when it determines whether a statute amounts to a contract[,]" but also should evaluate "the circumstances").

make offers to the Government," and was an intent to contract, because the regulation's purpose was to "induce persons to find and mine uranium." *Id.* at 405-06. In other words, the case focused on the regulations' "promissory" nature in finding an implied-in-fact contract.[11] The Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes.[12] *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

Applying this precedent, it is clear that the purpose of the CSR program was to mitigate risks for insurers and thereby ***induce*** them to offer insurance coverage in the individual market. The CSR program's promissory nature evidences the Government's intent to enter into a binding contract to make full CSR payments—payments which CMS itself admitted it owed—to plans that performed in accordance with the ACA's requirements.

The fact that the CSR program contained numerous requirements that issuers had to fulfill in order to receive payment further helps establish that the Government was required to make payment once those requirements were met. In *New York Airways*, this Court described the mandatory statutory payment in that case as creating an implied contract once the plaintiff had satisfied the requirements for payment. *N.Y. Airways, Inc.*, 177 Ct. Cl. at 816 (holding that the actions of the parties support the existence of a contract at least implied in fact where the

[11] *See also Wells Fargo Bank, N.A. v. United States*, 26 Cl. Ct. 805, 810 (1992), *aff'd*, 88 F.3d 1012 (Fed. Cir. 1996) ("'There is ample case law holding that a contractual relationship arises between the government and a private party if promissory words of the former induce significant action by the latter in reliance thereon.' Thus, where a unilateral contract is at issue, the fact that only one party has made a promise does not imply that a contract does not exist. A contract comes into existence as soon as the other party commences performance.") (quoting *Nat'l Rural Utils. Coop. Fin. Corp. v. United States*, 14 Cl. Ct. 130, 137 (1988) (internal citations omitted)).

[12] The fact that *Radium Mines* involved a purchase contract for uranium that met the regulatory qualifications is irrelevant, as the crux of *Radium Mines* is that "the regulations at issue were promissory in nature." *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001) (citations omitted).

agency's order was "in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer").

Similarly, when the Government includes "numerous requirements . . . to receive the payments" those payments are "compensatory in nature," and one can accept such offer for payment through satisfaction of the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F. 2d 518, 521 (5th Cir. 1948). Here, the ACA required QHP issuers to reduce cost sharing for eligible insureds, and when the QHP issuers met this requirement, the mutuality of intent formed an implied-in-fact contract, obligating the Government to pay QHP issuers.

2. *Health Options Accepted the Government's Offer, and the Condition Precedent to Payment Was Satisfied.*

The Government ***offered*** advance payments to insurers that reduced cost sharing through the language of Section 1402 of the ACA, HHS's implementing regulations, the Government's actions in making CSR payments for benefit years 2014, 2015, 2016, and nine months of 2017, and the actions of agency officials with authority to bind the Government regarding their obligation to make CSR payments. This constitutes a clear and unambiguous offer by the Government to make advance CSR payments to health insurers, including Plaintiff, that agreed to reduce cost sharing for eligible individuals on the ACA exchanges. Such an offer evidences a clear intent by the Government to contract with Plaintiff.

Insurers then ***accepted*** this offer by beginning performance and providing cost-sharing reductions to eligible individuals on the exchanges, thus executing an enforceable unilateral contract.[13] Specifically, Health Options accepted the Government's offer by complying with the

[13] In a unilateral contract, the offeree may only accept the offer by performing its contractual obligations. *See Contract*, Black's Law Dictionary (10th ed. 2014) (defining "unilateral (Continued...)

numerous QHP administrative requirements, providing health insurance coverage, and reducing cost-sharing amounts for certain individuals, as defined by Section 1402 and its implementing regulations. Courts have found such an exchange to constitute an unambiguous offer and acceptance without any explicit reference to an offer or contract.[14] As such, the Government's offer became irrevocable at the point of acceptance—when Health Options began performance.

3. *There Was Consideration.*

Consideration at the time of contract formation flowed both ways. QHP issuers are the backbone of the Government's effort to provide insurance coverage through the exchanges and, ***but for*** the Government's promise to help mitigate certain risk by reimbursing cost-sharing reductions for low- and moderate-income individuals, issuers would not have entered the marketplace. When Health Options agreed to offer QHPs and reduce cost sharing, the Government and Health Options committed to an intricate set of specific, reciprocal obligations. The Government benefitted from Health Options' participation in the marketplace in compliance with the Government's extensive QHP standards, including the requirement to reduce cost sharing for certain insureds. In exchange, Health Options received consideration because HHS committed that ***only*** issuers that actually reduced cost sharing would receive CSR payments, and that HHS would make advance CSR payments. *Ace-Fed. Reporters, Inc. v. Barram*, 226 F.3d

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contract" as "[a] contract in which only one party makes a promise or undertakes a performance."); *Lucas v. United States*, 25 Cl. Ct. 298, 304 (1992) (explaining that a prize competition is a unilateral contract because it requires participants to submit entries in return for a promise to consider those entries and award a prize).

[14] *Radium Mines*, 153 F. Supp. at 405-06 (risk stabilization and minimum prices constituted offer which "induced" companies to accept through performance); *N.Y. Airways*, 177 Ct. Cl. at 816-17(finding published "board rate" for aviation transportation services constituted an offer that plaintiff accepted through performance).

1329, 1332 (Fed. Cir. 2000) (Government buying from "between two and five authorized sources," to the exclusion of others, was "consideration" with "substantial business value.").

4. *The Secretary of HHS Had Actual Authority to Contract.*

Actual authority can be express or implied—either is sufficient to bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). Agency heads have contract-making authority "by virtue of their position." FAR 1.601(a) (contractual authority in each agency flows ***from*** the Agency Head to delegated officials).[15]

Moreover, Section 1402's instruction that the Secretary "shall establish" the CSR program and "shall pay" CSR payments, along with the Secretary's broad obligation to administer and implement the ACA,[16] gives the Secretary the express (or at least implied) authority to enter into binding QHP Issuer Agreements to implement the ACA. *See Winstar Corp.*, 518 U.S. at 890 n.36; *H. Landau*, 886 F.2d at 324. Coverage through the exchanges, and the obligation to reduce cost sharing, is carried out exclusively through private insurers' QHPs, and the ability to contract with them is "integral" to the Secretary's ability to effectuate his statutory duty to implement the CSR program. *See id*. Indeed, where contracts have been inferred from statutes promising payment, the Government's authority to contract is clear. *See, e.g.*, *Radium Mines*, 153 F. Supp. at 405-06; *N.Y. Airways*, 177 Ct. Cl. at 816-17.

B. The Government Breached an Implied-in-Fact Bilateral Contract with Health Options.

[15] *Accord United States v. Winstar Corp.*, 518 U.S. 839, 890 n.36 (1996) ("The authority of the executive to use contracts in carrying out authorized programs is . . . generally assumed in the absence of express statutory prohibitions or limitations.") (quoting 1 R. Nash & J. Cibinic, Federal Procurement Law 5 (3d ed. 1977); *H. Landau*, 886 F.2d at 324 (authority to bind the Government "is generally implied" where such authority is integral to execute program duties).

[16] *See* ACA §§ 1001, 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d).

Alternatively, the Government entered into an implied-in-fact bilateral contract with Health Options, as evidenced by the Government's certification of Health Options, culminating with the mutually signed QHP Issuer Agreements. All elements of an implied-in-fact contract were met.

First, the parties' offer and acceptance was unambiguously evidenced by entering into the QHP Issuer Agreements, which included the cost-sharing requirement. The agreements were signed by officials of CMS who are authorized to represent CMS. The agreements formally offered Health Options participation as a QHP issuer on the exchanges. Health Options accepted this offer through its signature on the agreements, agreeing to offer plans as a QHP issuer on the exchanges, and obligating itself to reduce cost sharing for eligible insureds.

Second, as discussed *supra* II.A.3, consideration flowed both ways, where the Government benefited from Health Options' performance and actual reductions in cost sharing, and Health Options benefited from the Government's promise of reimbursement for these amounts.

Third, Kevin Counihan and other directors of CMS who signed the QHP Issuer Agreements had express actual authority to contract. FAR 1.601(a). The QHP Issuer Agreements expressly memorialized their authority, stating, "[t]he undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement."[17] At a minimum, Mr. Counihan and the other directors had implied actual authority by nature of their positions. *See H. Landau*, 886 F.2d at 324 ("Authority to bind the Government is generally implied when such authority is considered to be an integral part of the duties assigned to a Government

[17] *See e.g.*, CMS, "Agreement Between Qualified Health Plan Issuer and Centers for Medicare and Medicaid Services," *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/qhp-issuer-agreement.pdf.

employee.") (quoting Ralph C. Nash & John Cibinic, *Formation of Government Contracts*, 43 (1982)). Even if, *arguendo*, Mr. Counihan and the other directors lacked actual authority to bind the Government, the Government continued to accept and benefit from Health Options' performance as a QHP issuer on the exchanges, with the knowledge of—and lack of repudiation by—the HHS Secretary, thereby effecting an institutional ratification. *See Silverman v. United States*, 230 Ct. Cl. 701, 710 (1982) (finding institutional ratification where, although an official did not have contracting authority, the agency accepted "the benefits flowing from" the official's "promise of payment"). HHS recognized its obligation to reimburse cost-sharing reductions and promised the same.

Fourth, mutual intent to contract can be inferred from the parties' conduct and surrounding circumstances. A QHP Issuer Agreement, which included cost-sharing obligations, was the culmination of the QHP certification process, where issuers such as Health Options apply to become a QHP issuer, and then CMS—as administrator of federally facilitated marketplaces—reviews the application and certifies the issuer as a QHP.[18] QHP certification is a prerequisite for issuers to participate in the exchanges under the ACA. Health Options and CMS engaged in this QHP certification process and entered into the QHP Issuer Agreements for Health Options' participation in the Maine marketplace for each benefit year. The QHP certification process, along with the ultimate QHP Issuer Agreement, evidences the mutual intent of Health Options and CMS to enter into a bilateral implied-in-fact agreement, where the parties would perform their respective obligations pursuant to Section 1402 of the ACA.

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[18] In state-based Marketplaces, the states themselves perform this function.

In sum, the ACA created an implied-in-fact contract with insurers like Health Options, under which the Government owed Health Options CSR payments if Health Options sold QHPs on the exchanges pursuant to QHP issuer standards and reduced cost sharing for eligible individuals. Health Options sold QHPs on the exchanges as a QHP issuer and reduced cost sharing for eligible individuals. The Government breached its reciprocal contractual duty by failing to make full CSR payments as promised. Therefore, there is no genuine dispute that the Government is liable to Health Options under the implied-in-fact contract, and Health Options is entitled to summary judgment on that basis.

CONCLUSION

Health Options respectfully requests that its motion for summary judgment be granted because, based on the undisputed facts, the Government owes Health Options complete CSR payments as a matter of law. Specifically, Health Options requests monetary relief in the amounts to which Plaintiff is entitled under Section 1402 of the Affordable Care Act and 45 C.F.R. §156.430, *i.e.*, $5,651,672.49. Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

Dated: January 12, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on January 12, 2018, a copy of the forgoing motion for summary judgment was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

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