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

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Plaintiff Maine Community Health Options ("Health Options") respectfully submits this Motion for Summary Judgment and Memorandum of Law in Support. For the reasons stated below, the Court should find Defendant, the United States of America ("Government"), liable under Section 1402 of the Patient Protection and Affordable Care Act ("Section 1402") and related regulations, and grant Health Options' motion for summary judgment.

INTRODUCTION

With its enactment in 2010 of 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"), Congress created a new platform for delivering health insurance: the so-called health insurance "exchange" or "marketplace," an online forum available in each state through which individuals could shop for coverage from participating insurers. The goal was ambitious and intended to be transformative: to make available comprehensive and affordable health care coverage to tens of millions of Americans who otherwise could not afford insurance. Health Options is a health insurance company that was created specifically to help deliver coverage to the new pool of insureds. To achieve that goal, Congress needed health care insurers to participate, so it created a number of financial incentives to entice insurers to join, which many did. Health Options (and many others) honored its end of the bargain; the Government has not. Specifically (and as explained below), the ACA requires the Government to reimburse Health Options for certain cost-sharing reductions that Health Options provided (as the ACA required) to its insureds.

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

The Government's actions are particularly egregious here because Health Options is a non-profit, consumer-sponsored plan, which was specifically created under the ACA to operate on the exchanges to expand coverage for uninsured and under-insured populations. Unlike traditional insurers, Health Options does not have significant business such as large group insurance sold to employers, on which it could have relied to offset the costs of operating in the untested waters of the exchanges. Indeed, the sole reason for Health Options' creation was to operate on the new exchanges.

A. The Statutory Scheme

The ACA required individuals to purchase health insurance coverage if they were not otherwise insured. At the same time, however, the law established subsidies to defray both premium expenses and out-of-pocket costs that otherwise would have been prohibitive to millions of Americans. On the one hand, 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).

On the other hand, and at issue here, Section 1402 of the ACA requires insurers to provide cost-sharing reductions—"CSRs"—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(a)(2) ("the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c)."). "Cost sharing" refers to out-of-pocket payments to health care providers in the form of copayments, coinsurance, and deductibles that individuals typically are 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*. Thus, when an insurer reduces the insured's cost-sharing obligation, what that means is that the insurer ends up covering the difference to the medical provider.

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).[3] These payments are made directly to health insurance issuers. *Id.* § 18082(a)(3).

B. Insurer Implementation

Health plans sold on the exchanges have to meet certain standards established by HHS' Center for Medicare and Medicaid Services ("CMS"), and are referred to as qualified health plans, or QHPs. Health Options is a QHP issuer, *i.e.*, a health insurer that sells QHPs on the exchanges. The health care exchanges began operating in January 2014. From the start, HHS made monthly advance payments to reimburse QHP issuers for their CSRs in accordance with the ACA.[4] HHS continued to make these required monthly payments for nearly four years.

[3] The full text of the section reads: "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." (emphasis added).

[4] *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.

On October 12, 2017, however, HHS Acting Secretary Eric Hargan issued a memorandum to CMS stating that "CSR payments to issuers must stop, effective immediately."[5] According to the memorandum, such payments could not be made because no money had been appropriated to make the payments. CMS ceased making CSR payments as of that date, leaving unpaid millions of dollars of CSR payments already accrued for 2017.

The Government's refusal to pay deprived QHP insurers, including Health Options, of money owed to them on account of their performance on the exchanges for benefit year 2017.

C. The Government's Position

By this lawsuit, Health Options seeks $5,651,672.49, the amount of unpaid 2017 CSR payments to which it is entitled under the ACA. The Government will likely contend, as it has in filings made in other CSR cases before this Court (*e.g.*, *Montana Health CO-OP v. United States*, No. 18-143C (ECF No. 10)), that because Congress did not appropriate funds to cover the CSR payments addressed in Section 1402, the Government has no obligation to pay. That position is untenable and must be rejected for the very reasons the Federal Circuit just explained in *Moda Health Plan, Inc. v. United States*, No. 2017-1994, (Fed. Cir. June 14, 2018). In *Moda*, the Federal Circuit reaffirmed longstanding legal principles and rejected the identical argument in connection with a separate provision of the ACA that uses equivalent terminology, stating that "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt[.]" *Moda*, slip op. at 17. Here, Section 1402 created an obligation to make the CSR payments. The Government's failure to appropriate money to make the payment simply means that the Government has failed to pay its lawful debt—and its obligation to make the

[5] 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.

payment is, of course, enforceable in this Court. Therefore, summary judgment should be granted to Health Options along with an award of damages for the amount sought.

BACKGROUND

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

The Affordable Care Act contained several provisions intended to incentivize private insurers to participate on the exchanges, stabilize annual premiums, and induce millions of uninsured Americans to purchase health insurance coverage. Part and parcel to those objectives, it imposed certain financial obligations on the federal government to offset costs borne by the QHP issuers. Relevant to this dispute, the ACA established a cost-sharing reduction subsidy, pursuant to which the Government is obligated to pay QHP issuers to offset their own costs of extending CSRs to the low- and moderate-income Americans who purchase their QHPs on the exchanges.

Section 1402 of the Affordable Care Act, codified at 42 U.S.C. § 18071, created the CSR program, which states that the Government, acting through the Secretaries of HHS and the Treasury, "***shall make*** periodic and timely payments to the issuer equal to the value of the reductions [that the issuer passes to its insureds]." (emphasis added.) Echoing that command in its implementing regulation, HHS 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 then set forth the calculation methodologies applicable to CSR payments. In other words, by statute, the Government is required to make the CSR payments, and by regulation the Government decided that it would make these payments to insurers in advance (subject to a later true-up).

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")[6] 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.[7] 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

[6] 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).

[7] 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* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-key-dates-table-April-2016.pdf. ("2016 Key Dates").

plan, Plaintiff's commitment to the 2017 marketplace was effectively irrevocable as of the end of September 2016.[8]

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 STOPS MAKING CSR PAYMENTS.

On October 12, 2017—over a year after Plaintiff had committed itself to the 2017 exchange—the Government 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 programs, and the permanent appropriation in Section 1324 provided funding only for the Section 1401 premium tax credits.[9] The next day, HHS announced that it would stop making CSR payments "until a valid appropriation exists."[10]

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[8] *See* 45 C.F.R. § 147.106(b).
[9] *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.
[10] 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 invoked 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 Section 1402.

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* 2016 Key Dates.

11. Health Options' 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.

SUMMARY OF ARGUMENT

The Court should grant summary judgment in favor of Health Options because there is no dispute that the Government has failed to pay Health Options money that it is mandated by the ACA to pay.

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 Section 1402.

2. *Breach of Contract*. In addition, Health Options is entitled to a judgment of liability based on contract law for two reasons.

a. All elements of an implied-in-fact contract are met. 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.

b. Alternatively, the parties entered into a bilateral contract—culminating in the signed QHPIA(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 any conditions precedent to the Government's full payment. The Government is in breach for failing to uphold its side of the bargain.

LEGAL STANDARD

This case presents a 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 only 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 only "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

The facts are not in dispute and Health Options has a clear statutory right to the CSR payments it seeks. As such, summary judgment should be entered for Health Options.

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

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). Section 1402 requires providers to implement such cost-sharing reductions to their insureds. 42 U.S.C. § 18071(a)(2) (issuers "shall reduce the cost-sharing" under the applicable plan). It then mandates that the Government reimburse providers for those cost-sharing reductions that they were required to provide to their insureds. The statute is unambiguous:

> 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 QHP issuer is entitled to CSR payments equal to the value of any cost-sharing reductions it afforded eligible insureds in the 2017 benefit year.[11]

Section 1402 is money-mandating. *See Lexecon v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998) ("the mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion."). For its part, Health Options is an eligible QHP issuer under the ACA and satisfied the requirements for payment from the Government under Section 1402 of the ACA. Accordingly, the Government has a mandatory statutory obligation to pay Health Options the amounts owed to it.

The fact that Congress did not appropriate funds ***to HHS*** to pay QHP issuers is irrelevant, as the Government's statutory obligation to pay (at issue in this case) and a specific agency's ability to make payments (not at issue here) are unrelated. *See Moda*, slip op. at 16-19. 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 and consequent liability. 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

[11] 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.

> 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).

The Federal Circuit just reiterated this very point in *Moda*. At issue in *Moda* was whether a different provision of the ACA, Section 1342, obligated the Government to make certain payments where certain predicate conditions had been met by QHP issuers. The relevant text stated that, where the predicate conditions had been met, HHS "shall pay to the plan" the amount calculated under the statutory formula. There, the Government argued that the "shall pay" language was meaningless in the absence of an appropriation to HHS to make the payments. The Federal Circuit flatly rejected that argument. Citing a long line of cases that cut against the Government's position,[12] the court of appeals held that the "shall pay" language was "unambiguously mandatory" and imposed a legal obligation on the United States. *See Moda*, slip op. at 19 ("Here, the obligation is created by the statute itself, not the agency. The government cites no authority for its contention that a statutory obligation cannot exist absent budget authority.").

The same reasoning applies here. If Congress chooses not to provide money to fund the CSR obligations—whether through either a permanent appropriation or the traditional annual appropriation process—that is of course its prerogative.[13] But it is also beside the point here

[12] *See Moda*, slip op. at 16-19.

[13] With respect to the risk corridors payments at issue in *Moda*, the Federal Circuit held that, although the statute at issue there (Section 1342) created an express obligation to pay, Congress subsequently capped the amount of payments for that program for each of the three years it was in effect, through the enactment of specific appropriations riders that were intended to suspend the underlying payment obligation. That portion of the court's opinion does not apply in this case (Continued...)

because ***this Court***—as *Moda* and *Collins* and many other decisions make plain—concerns itself with the liability of the United States for obligations the Government fails to honor. How a debt gets paid is not relevant to the question of the debt's existence in the first place. *See Moda*, slip op. at 17. If this Court determines, as it should, that the United States did incur the debt—a conclusion compelled by the Federal Circuit's opinion in *Moda*—then it can enter judgment. The political branches can elect to pay the judgment by authorizing payment through a separate appropriation for this specific judgment, but if they fail to do so, the Judgment Fund is available as a permanent appropriation to pay the judgment.[14] How the judgment is ultimately paid is not a concern of the Court. 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.

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because no appropriations riders address the Government's obligation to make CSR payments, nor place any limitations on appropriations to make such payments.

[14] In a brief filed in *House v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. No. 55-1 (D.D.C. filed Dec. 2, 2015), 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 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.*

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).

Congress has the power to create an obligation "without regard to appropriations," and did so in passing Section 1402. In *Moda*, the Federal Circuit explained that a specific grant of "[b]udget authority is not necessary to create an obligation of the government; it is a means by which an officer is afforded that authority." *Moda*, slip op. at 19 (alteration in original omitted); *see also Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892) ("An appropriation *per se* merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties."). The "shall make" directive of Section 1402 creates an unambiguous obligation to pay here, just as the "shall pay" language created such an obligation in *Moda* (until Congress purportedly took it away by virtue of a subsequent enactment).

Nor does the fact that appropriated funds are available for the tax credits due under Section 1401 change the outcome in this case. The tax credit authorized by Section 1401 fits neatly under a longstanding tax code provision appropriating funds to refund certain tax collections, so Congress amended the tax code provision to add the Section 1401 tax credit to that list. *See* 31 U.S.C. § 1324(b)(2). That separate issue—a matter of longstanding tax policy—sheds no light on the question of what obligation Congress intended to create in Section 1402. For the reasons stated above and in *Moda*, the meaning of Section 1402 is resolved by its terms: "shall make" means, not surprisingly, "shall make."

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 grant summary judgment for Health Options on its statutory claim.

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

The Judgment Fund is available to pay judgments based on implied-in-fact contracts. *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). The promise of CSR payments induced Health Options into the new marketplaces. The United States received the benefits of Health Options' expanded coverage of previously uninsured Americans at lower premiums than it would have offered absent the CSR program. The United States has failed to uphold its side of the bargain, and the obligated CSR payments are still owed.

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-in-fact 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 to begin performance by reducing cost-sharing amounts for eligible insureds on the exchanges. Health Options accepted by beginning performance, rendering the offer irrevocable. Alternatively, the parties entered into a ***bilateral*** contract—culminating in the signed QHPIA(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' failure to uphold its side of the bargain constitutes a textbook contractual breach.

A. The Government Breached an Implied-in-Fact 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.[15] Health Options' well-pled facts show that the combination of Section 1402, HHS' 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. ¶¶ 4-15, 29-34, 52-61.

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 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

[15] *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").

focused on the regulations' "promissory" nature in finding an implied-in-fact contract.[16] The Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes.[17] *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.[18] The CSR program's promissory nature evidences the Government's intent to enter into a binding contract to make full CSR payments—payments which HHS 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

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[16] *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)).

[17] 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).

[18] In *Moda*, the Federal Circuit held that "the circumstances of this legislation and subsequent regulation did not create a contract promising the full amount of risk corridors payments." *Moda*, slip op. at 35. Whatever the merits of that portion of the *Moda* decision, the CSR payments at issue here are precisely the type of "traditional quid pro quo contemplated in *Radium Mines.*" *Id.* at 34.

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 satisfied that 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' 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 Health Options, who 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 QHP issuers.

Health Options then accepted the offer by beginning performance and providing cost-sharing reductions to eligible individuals on the exchanges, thus executing an enforceable unilateral contract.[19] Specifically, Health Options accepted the Government's offer by complying

[19] 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 contract" (Continued...)

with the 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. This exchange constituted an unambiguous offer and acceptance regardless of any explicit reference to an offer or contract. 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 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").

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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).

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).[20]

Moreover, Section 1402's instruction that the Secretary "shall establish" the CSR program and "shall make" CSR payments, along with the Secretary's broad obligation to administer and implement the ACA,[21] gives the Secretary the express (or at least implied) authority to enter into binding QHPIAs 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 H. Landau*, 886 F.2d at 324. 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.

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 QHPIAs. All elements of an implied-in-fact contract were met.

[20] *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).
[21] *See* ACA §§ 1001, 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d).

First, the parties' offer and acceptance were unambiguously evidenced by entering into the QHPIAs, 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 above in part 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 QHPIAs had express actual authority to contract. FAR 1.601(a). The QHPIAs expressly memorialized their authority, stating, "[t]he undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement."[22] 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 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

[22] *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.

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 QHPIA, 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.[23] 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 QHPIAs for Health Options' participation in the Maine marketplace for each benefit year. The QHP certification process, along with the ultimate QHPIA, 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.

* * * * *

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. The Government has received the benefit promised by QHP issuers like Health Options (health coverage for millions of Americans, at prices that do not include premium increases to offset the CSR) without adhering to its side of the bargain (making CSR payments)

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

even though the promise of such payments was essential to inducing health insurers into the new marketplaces in the first place.

Health Options sold QHPs on the exchanges as a QHP issuer and reduced cost sharing for eligible individuals. The Government is in breach of its reciprocal contractual duty to make full CSR payments. 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

For the reasons given, summary judgment should be entered in favor of Health Options on its statutory claim or, alternatively, on its breach of an implied-in-fact contract claim. Health Options should be awarded 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: July 16, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on July 16, 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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