IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MONTANA HEALTH CO-OP, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 18-143C Judge Elaine D. Kaplan

PLAINTIFF'S REPLY IN SUPPORT OF ITS
CROSS-MOTION FOR SUMMARY JUDGMENT

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Plaintiff Montana Health CO-OP ("Montana Health") respectfully submits this Reply in support of its Cross-Motion for Summary Judgment.

I. THE EXISTENCE OF A STATUTORY PAYMENT OBLIGATION UNDER SECTION 1402 IS A SEPARATE QUESTION FROM THE QUESTION OF WHETHER AN APPROPRIATION HAS BEEN MADE.

Section 1402 of the Affordable Care Act (ACA) requires health insurance issuers like Montana Health to make cost-sharing reductions to their insureds. 42 U.S.C. § 18071(a)(2) (issuers "shall reduce the cost-sharing" under the applicable plan). It also mandates that the Government make payments to health insurance issuers for these cost-sharing reductions. 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).

From January 2014 until October 2017—45 consecutive months—the U.S. Department of Health and Human Services (HHS) duly "ma[d]e periodic and timely payments" to issuers, including to Montana Health, "equal to the value of the reductions" that Montana Health provided to its insureds. In October 2017, the Attorney General opined that the general agency funds from which the agency had been making payments for nearly 4 years was not a proper source of funds for these purposes. HHS acquiesced and cut off funds to make the required payments. HHS thus stopped making CSR payments for the remainder of the 2017 benefit year. Montana Health brought this action to obtain the payments required by the statute for the plans that it had already issued and sold for 2017.

The Government argues that this is not simply a case of the Government refusing to pay what it concededly owed. Instead, the Government asserts that notwithstanding the statutory

directive that the Government "shall make" these payments, it has no statutory obligation to pay because the statute did not contain additional language identifying an appropriation from which to pay.[1] The Government's arguments conflate the existence of the statutory obligation with the entirely separate question of whether Congress has appropriated money to pay the obligation.

Even as originally asserted, the Government's position was flatly inconsistent with more than a century of precedent establishing that the absence of an appropriation does not negate the Government's underlying obligation to make payment obligation. *See United States v. Langston*, 118 U.S. 389 (1886); *Collins v. United States*, 15 Ct. Cl. 22, 35 (1879). As explained in *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 Government's arguments were, therefore, untenable when it first filed its motion to dismiss. And they are doubly untenable now in light of *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018). In *Moda*, the Federal Circuit addressed another provision of the ACA that uses nearly identical mandatory payment language. And consistent with historic precedent, the Federal Circuit panel unanimously rejected arguments substantially identical to those that the Government makes here.

The first question posed in *Moda* was whether Section 1342 of the ACA obligated the Government to make certain payments, irrespective of whether Congress appropriated funds for the purpose. The Federal Circuit said "yes," holding that the statutory requirement that "the

[1] In its initial filing, the Government primarily argued that this conclusion followed from the Appropriations Clause of the U.S. Constitution, citing that clause three times. The Government now frames the argument in terms of supposed congressional "intent."

Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount" created an obligation to pay. *Id*. at 1332 (emphasis added). The court held that the "shall pay" language of Section 1342 was "unambiguously mandatory" and imposed a legal obligation on the United States. *Id.* at 1320. In so holding, the court reaffirmed the longstanding rule that the question of whether Congress has appropriated funds enabling the Government's *agents* (here, HHS) to pay an obligation is a question entirely distinct from Congress's creation of a statutory obligation in the first place. *Id.* at 1321 ("it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt"); *id.* at 1322.

The Federal Circuit observed that there was no precedent supporting the Government's contrary position that the absence of an obligation can be inferred from the lack of appropriations or budgetary authority. *Id.* at 1322 ("The government cites no authority for its contention that a statutory obligation cannot exist absent budget authority."). Such a "rule would be inconsistent with *Langston*, where the obligation existed independent of any budget authority and independent of a sufficient appropriation to meet the obligation." *Id.*

Indeed, in *Moda*, the Government argued a variety of theories under which it asked the court to conclude that the failure to establish an appropriation would negate the existence of the obligation created by the plain language of the statute. But in light of the plain language, the Federal Circuit found all of those theories of "no moment" or "immaterial." *Id.* The "plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program." *Id*.

The basic problem with the Government's argument on CSR is that whether one frames the question in terms of what the statute directs, or in terms of congressional intent, the first place to look for the meaning of the statute—and if the statute is unambiguous, the only place to look—is the words of the statute itself. *See Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011); *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). The "shall make" directive of Section 1402 imposes an *unambiguously mandatory* payment obligation on the United States. *See* 42 U.S.C. § 18071; *accord Moda*, 892 F.3d at 1320 (the "shall pay" directive of Section 1342 was "unambiguously mandatory"). There is no material distinction between the words used by Congress in Section 1342 (at issue in *Moda*) and Section 1402, at issue here. The "shall make" language of Section 1402 is as mandatory as the "shall pay" language of Section 1342. Both create an unmistakable obligation to pay. And as in *Moda*, the fact that Congress did not appropriate funds is insufficient to render that obligation ambiguous, or to undermine it in any way.

As explained in Montana Health's cross-motion, these same principles control in this case. The statutory obligation is clearly established by the "shall make" language of the statute, and no negative inference can be drawn from the failure to appropriate funds or establish budgetary authority. They are simply separate issues. Here, Section 1402 plainly created an obligation to pay, and while a lack of appropriation may constrain the "government's own agents" (HHS) from making payments, the underlying statutory payment obligation—and the United States' obligation to make payment—is unaffected.

II. THE GOVERNMENT OFFERS NO VIABLE BASIS TO DISREGARD THE PLAIN LANGUAGE OF SECTION 1402, CREATING AN OBLIGATION, BASED ON CONGRESS'S MERE LACK OF APPROPRIATED FUNDS.

A. Congress Did Not Pass Any CSR Appropriation Riders, so the Government's Reliance on *Moda's* Discussion of Appropriation Riders and Legislative "Intent" Is Misplaced.

The Government's analogy to *Moda* is misplaced because unlike *Moda*, there was ***no subsequent appropriation rider*** that even arguably addressed the Government's CSR obligations. The Government proposes that this Court ignore the first part of *Moda*, which held that equivalent language in Section 1342 of the ACA unambiguously created a payment obligation. Instead, the Government asks this Court to focus on the portion of *Moda* that addressed *subsequent* legislation in the form of appropriations riders, and the legislative history concerning those riders, which the Federal Circuit held had temporarily suspended the obligation to pay Section 1342 funds.[2] Here, the Government's reliance on *Moda*'s discussion of the intent underlying the subsequent "appropriations riders" is misplaced ***because—for CSR—Congress did not affirmatively pass any appropriation riders with which to interpret***.

Moda examined congressional "intent" in a very different context, with very different kinds of evidence of legislative intent before it, to determine whether the "shall pay" obligations stated on the face of the ACA were overridden by subsequent enactments. The Federal Circuit sought to determine whether those *subsequent* enactments revealed Congress's "intent" to limit the amount paid out in the risk corridors program. *Moda*, 892 F.3d at 1322-23. In examining these subsequent appropriation riders, the Federal Circuit noted a line of cases in which courts examined subsequent enactments, and specific legislative history concerning those enactments,

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[2] The portion of the *Moda* opinion addressing the effect of the appropriation riders is now the subject of various petitions for rehearing *en banc*, raising many of the points that Judge Newman made in her dissent from that portion of the decision. *Moda*, 892 F.3d at 1332-37.

to determine whether they abrogated existing statutory obligations. In particular, the Federal Circuit examined the legislative history of those riders, including questions asked by Congress, GAO responses, and a statement by the Chairman of the House Appropriations Committee. *Id.* at 1325.

No similar argument can be made here because: (i) there is no subsequent legislation to construe; and (ii) the Government has proffered no legislative history at all to support its position. Section 1402 means exactly what it says, when it says that the Secretary "*shall make periodic and timely payments to the issuer equal to the value of the reductions*." That obligation stands regardless of whether Congress has made appropriations to allow the agency to fulfill that obligation, and the Government has offered no reasonable basis on which the Court should disregard the clear statutory language at issue.

B. The Government's Various Theories for Equating the Absence of an Appropriation with the Absence of a Payment Obligation Are Without Merit.

The Government tries to show that notwithstanding the plain language of Section 1402, Congress impliedly did not intend it to create a payment obligation under Section 1402. As set forth below, those arguments do not lead logically to the conclusion that the Government seeks, namely that the plain language of the statute should be disregarded in favor of the Government's self-serving conception of congressional intent. And all of those arguments ultimately rest on the premise, rejected in *Moda*, that the absence of an appropriation can be equated with the absence of an obligation, when the statute in question unambiguously creates an obligation. *Moda*, 892 F.3d at 1320-22.

1. The comparison between Sections 1401 and 1402 does not address the issues here.

The Government first highlights differences between Sections 1401 and 1402, noting that in Section 1401, Congress identified a source of permanent funding for the tax credit in that provision, but in Section 1402, Congress did not identify a permanent source of funding.

First, the fact that Section 1401 identifies a source of funding for the tax *credit* is wholly unsurprising. Because it was a tax credit, appearing in a health care bill, it seems perfectly logical to call attention to the fact that the funding would be found in the longstanding tax code provision appropriating funds to refund certain tax collections.[3] But it is equally unsurprising that for the Section 1402 CSR payments Congress would create an obligation yet leave the funding of that obligation to future general appropriations to the agency or to specific periodic appropriations to come later. That is the point of *Moda* and the long line of cases it follows: how Congress funds an obligation is distinct from the existence of the obligation itself. *Moda*, 892 F.3d at 1320-22.

Second, and more important, all that the comparison between Section 1401 and Section 1402 shows is that under one of the sections, Congress did designate an appropriation, and under the other, it did not. The difference in language between the sections means no more than what the two provisions say: for Section 1401, Congress established a specific funding mechanism, but for Section 1402, it did not do so.

[3] Section 1401(a) enacted the tax credit provision, codifying it in the Tax Code at 26 U.S.C. § 36B. A different subsection, Section 1401(d), enacted the permanent appropriation for that tax credit, by amending 31 U.S.C. § 1324(b), part of the U.S. Code title that deals with appropriations and other budgetary matters. The cost-sharing reduction requirement of Section 1402, for its part, is codified at 42 U.S.C. § 18071, a title that deals broadly with public health and welfare. Section 1402, as the Government acknowledges, does not concern a tax credit, so there would be no reason for Congress to fund reimbursement payments for cost-sharing reductions as it has funded tax credits for many years, Section 1401 just being the latest.

The Government also asserts that the Court should not "infer that Congress intended to create a statutory entitlement to CSR payments that could only be collected through after-the-fact litigation." Def. Reply at 9. But the Government's premise is flawed. The fact that Congress did not designate an appropriation in 1402 did not mean that an appropriation would not be provided later, as needed, or found in some other appropriation properly available to the agency. Nor is it logical to believe that Congress created this clear statutory obligation, induced insurers to rely on it, but never intended to make good on it at all. The fact that the Government *made* CSR payments for nearly 4 years illustrates how preposterous the Government's current litigating position is. In any event, *Moda* reiterated that the absence of an appropriation mechanism does not relieve the Government of the obligation to make payment. 892 F.3d at 1322.

This Court is positioned to enter judgment based on the existence of a clearly stated statutory obligation; how it is to be paid is ordinarily not the responsibility of the Court. "Whether it is to be paid out of one appropriation or out of another; whether Congress appropriate[ed] 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." *Gibney v. United States*, 114 Ct. Cl. 38, 52 (1949).

2. The Government's "increasing premiums" theory is erroneous.

The Government asserts that since "the structure of the ACA" "allow[s] issuers to recoup their cost-sharing reduction expenses by raising premiums"—at least on a prospective basis—this somehow undermines Section 1402's payment obligation. Def. Reply at 3. For support, the Government cites the fact that a federal district court denied a request for a preliminary injunction directing HHS to resume Section 1402 payments on grounds that states could prospectively authorize insurers to increase premiums ***for 2018***. *Id.* at 10. In other words, that

district court held that the possibility that insurers could increase premiums to offset a prospective loss of CSR payments, and increase their tax credit recovery, affected the equitable balance whether to grant an injunction.

But the decisive point here in response to the Government's "structural argument" is that there is no indication that Congress ever actually conceived, considered, or "intended" such a possible mechanism to offset prospective losses through premium increases approved by the States, and tax credits when it enacted Section 1402. And the possibility that a cut-off of CSR payments will be reflected in state-approved premiums is far too thin a reed on which to rest a conclusion that in directing that the Secretary "shall make payments," Congress did not mean what it plainly said. Premium setting and approval is assigned to the States, and thus largely outside the scope of the ACA, and there is no indication that it had any role in the design of Section 1402.

The more immediately relevant point is that in presenting its "structural argument," the Government does not make any suggestion of windfall or double recovery in this case that might limit Montana Health's recovery. Indeed, the Government disclaims it. *Id.* at 11.

The recovery sought in this case is solely for the Section 1402 payments that the Government failed to make for the final calendar-year quarter of 2017. Montana Health was not paid what it was owed when the Government ceased Section 1402 payments in October 2017. The Government's decision to halt payment occurred long after Montana Health had committed to provide insurance, under rates that were set, on the understanding that the CSR payments would be made, and which could not be altered. Montana Health was still required by law to provide cost-sharing reductions to eligible insureds, despite not receiving the mandated reimbursement from the Government. Montana Health has no opportunity to recoup those lost

payments since premiums are set (with regulatory approval) prospectively based on anticipated costs for the upcoming plan year. The Government does not contest that Montana Health's 2017 rates could not be changed when the Government stopped making CSR payments in October 2017, or that Montana Health was forced to bear its share of cost-sharing reductions *and* the Government's share.

C. Recovery of Amounts Due From the Government's Failure to Make CSR Payments Are Actionable in the Court of Federal Claims.

The Government effectively asks this Court to ignore the bedrock rule recognizing the right of aggrieved parties to seek damages in the Court of Federal Claims where their entitlement to that relief arises from a money-mandating statute. *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007); *Lummi Tribe of the Lummi Reservation v. United States*, 99 Fed. Cl. 584, 594 (2011); *Wolfchild v. United States*, 96 Fed. Cl. 302, 339 (2010), *rev'd in part* 731 F.3d 1280 (Fed. Cir. 2013). The Government argues that if Congress did not provide a "damages remedy" for insurers in Section 1402, the case cannot proceed. Def. Reply at 8. Of course, if that were true, the *Moda* decision would make no sense. The Federal Circuit could simply have stated that there was no provision creating a cause of action—and stopped there.

The Government's position is fundamentally inconsistent with accepted principles of law. The Tucker Act, 28 U.S.C. 1491(a)(1), waives sovereign immunity for claims predicated on federal statutes, contracts with the Government, and other bases. Where this Court has before it a money-mandating statute, and the claimant seeks payment for damages incurred, that mandate is what gives the plaintiff a right to relief in this Court, if it prevails on its claim. It is the claim for damages under a money-mandating statute that provides the right to recovery. There is no need for an *additional* "express cause of action for damages." Def. Reply at 9. Rather, the right

to relief is implied from the money-mandating statute, and the claim for damages actually incurred.

In *Greenlee County*, for example, the court held that identical language—"the Secretary of the Interior *shall make a payment*" to local governments to compensate them for losses due to the presence of tax-exempt federal land—was money-mandating. 487 F.3d at 876-77 (emphasis added). "We have repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Id.* at 876-77 (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). And since a money-mandating statute "creates the right to money damages," *id.* at 875; *see also Jan's Helicopter Serv., Inc. v. F.A.A.*, 525 F.3d 1299, 1307 (Fed. Cir. 2008) (recognizing the right of a "class of plaintiffs entitled to recover under the money-mandating source"), Montana Health is entitled to pursue its right to recover what it is owed under the money mandating provisions of Section 1402.

The Government's argument is belied by its own citation to *Bowen v. Massachusetts*, 487 U.S. 879, 905 n.42 (1988). There, the Court recognized that "shall" pay statutes generally provide a "self-enforcing" right to recover under the Tucker Act where they "mandate[] compensation by the Federal Government for the damage sustained." *Id.* (*citing Eastport S. S. Corp.* v. *United States,* 372 F. 2d 1002, 1009 (1967) (cited with approval in *United States* v. *Testan,* 424 U. S. 392, 398, 400 (1976)). That is the case here. The money-mandating statute provides reimbursement for the cost-saving reductions that Montana Health was statutorily required to grant to insureds, and which it did grant to its insureds. It thus provides compensation for a past act, which is the "essence of a Tucker Act claim for monetary relief."

Id. (*citing United States v. Mottaz*, 476 U. S. 834, 850-851 (1986) (suit to require the government to purchase property is not a form of compensation for past acts)).[4]

Indeed, the Department of Justice itself acknowledged the application of this principle to the CSR program in *Burwell*, when it noted the right and ability of insurers to do exactly what Montana Health is doing here. In *Burwell*, the Government acknowledged that the ACA "requires the government to pay cost-sharing reductions to issuers," and 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.*

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

The Government's contention that it has no implied-in-fact contract with Montana Health is also contrary to controlling precedent. Each Government argument reflects a misunderstanding or misapplication of longstanding precedent and improperly ignores the Government's own conduct.

First, the Government's position that the CSR program is simply a "benefits program" cannot be squared with prevailing law or the operative facts, both of which establish that

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[4] The claim at issue in *Bowen* itself did not arise under a statute that was self-enforcing under the Tucker Act because it followed from an administrative review procedure that was more appropriately subject to Administrative Procedure Act review in the district court. *See Bowen,* 487 U.S. at 905 n.42.

statutory schemes that ***are promissory in nature*****—**like the CSR program**—**give rise to contractual obligations to make the requisite payments. As set forth in Montana Health's Cross-Motion for Summary Judgment, the Government's program is precisely the type of *quid pro quo* arrangement found to constitute an implied-in-fact contract in *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). There, the regulation at issue was designed to "induce" certain conduct. *Id*.; *Hanlin v. United States*, 316 F.3d 1325, 1329 (Fed. Cir. 2003) (observing that a statute or regulation could give rise to an implied-in-fact contract based on, among other things, "words of promissory character in the statute or regulation that manifested an undertaking or commitment rather than a mere instruction, prediction or intention"). Here, the Government sought to induce participation in a brand new health insurance marketplace, the costs of which insurers could not reliably predict, and Section 1402 required insurers to provide certain reductions to purchasers, in exchange for receiving the promised payments.

The Government's complaint that the statutory language establishing the CSR program does not "speak in terms of contract," Def. Reply at 13, misses the mark. *Radium Mines* was not based on the regulation's express reference to a possible contract. Rather, as this Court noted, the "key" to *Radium Mines* "is that the regulations at issue were promissory in nature." *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001). The CSR program was promissory in nature because, among other things, it was specifically designed to induce participation in the marketplaces by Montana Health and other insurers. Pl. Cross-Mot. at 18-26. If you do this, we will give you that; if you provide the desired policies and grant the statutorily-required reductions, and make timely submissions, we will timely provide Section 1402 reimbursements. The Government's threadbare invocation of the general presumption against interpreting statutory language as creating contractual rights is unavailing.

Instead of addressing the program's promissory nature, the Government relies heavily on *Moda*, while ignoring a key distinction between the Government's conduct under the risk corridors program and here with the Section 1402 CSR program. Not only did the Government promise to make CSR payments in exchange for Montana Health's acceptance and performance of certain specified duties, but ***the Government in fact fulfilled its promise for 45 months***. The Government cannot escape its own course of conduct confirming the terms of the exchange by the parties. It is, of course, a fundamental principle of contract law that "[w]here an agreement involves repeated occasions for performance by either party with knowledge of the nature of the performance and opportunity for objection to it by the other, *any course of performance accepted or acquiesced in without objection* is given great weight in the interpretation of the agreement." *Metro. Area Transit, Inc. v. Nicholson*, 463 F.3d 1256, 1260 (Fed. Cir. 2006) (emphasis in original) (quoting Restatement (Second) of Contracts § 202(4)). Regardless of the Government's current litigating position, it appears to have agreed with Montana Health that it had made a promise and, until recently, kept that promise to pay.[5]

Second, the Government's argument that the Qualified Health Plan Issuer Agreements ("QHPIA") were "express" contracts that preclude any finding of a bilateral implied-in-fact contract is equally misguided. The Government posits that the QHPIAs were "express" contracts because they "established the relevant contractual parameters of plaintiff's offering of QHPs on an Exchange." Def. Reply at 16.

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[5] The Government's argument that HHS lacked contracting authority ignores the fact that, as set forth in Montana Health's Cross-Motion, actual authority can be express ***or implied***. Pl. Cross-Mot. at 23-24. For the reasons set forth therein, the Secretary had both express and implied authority to enter into contracts. The Government confuses "actual authority" of the HHS Secretary (to enter contracts) with whether entering into QHPIA contracts was potentially unauthorized under the Anti-deficiency Act; "actual authority" exists as a function of position. 48 C.F.R. § 1.601(a).

But the Government's premise is flawed, and the argument collapses, because the QHPIA agreements were not express contracts of the kind that would preclude a finding of implied contract that goes far beyond the terms of whatever was in the QHPIA. The QHPIA: (1) memorializes that the insurer is properly licensed and certified to sell health plans on the Exchange, and (2) sets forth standard rules for insurers to maintain data security and private patient information. QHPIAs do not contain any essential contract terms regarding payment, delivery, quantity, or performance. While they purport to be agreements, they do not contain any indicia of the Government's reciprocal obligations or consideration. Nothing within the four-corners of the QHPIA purports to be a "contract" with the U.S. Government. As the Government acknowledged, the QHPIAs contained some of "the relevant contractual parameters of plaintiff's offering of QHPs on an Exchange," Def. Reply at 16, but what the Government overlooks is that those nebulous "parameters" do not contain the essential terms of an *express* contract. Mere agreements or MOUs with the Government may evidence implied-in-fact contracts, but they are not "express" contracts. *See, e.g.*, *Cal. Fed. Bank, FSB v. United States*, 245 F.3d 1342, 1346-47 (Fed. Cir. 2001) (although forbearance letters do not constitute an express contract with the government, they constitute contemporaneous document evidencing the necessary elements of an implied-in-fact contract). Moreover, in *Molina Healthcare*, the Court of Federal Claims specifically examined whether QHPIAs were "express contracts" and held that they were not. *Molina Healthcare of Cal., Inc. v. United States*, 133 Fed. Cl. 14, 46 (2017) (holding instead that there *was* an implied-in-fact contract).

Rather, as explained by Montana Health, the full gamut of essential terms constituting the parties' implied-in-fact contractual bargain were specified and set forth in various statutory and regulatory provisions that preceded the QHPIA and, collectively, formed the parties' implied-in-

fact contract. Specifically, the QHPIAs contain some of the insurers' compliance obligations (a portion of the quid) that the insurers complied with in exchange for the statutory payment terms set forth elsewhere (the quo). While the QHPIAs were not express contracts, they *were components* of the parties' implied-in-fact unilateral or, alternatively, bilateral, contract.

As such, the Government's assertion that Montana Health's implied contract with the Government is "precluded" by the QHPIAs is untenable. In each cited case the plaintiffs had ***already signed express contracts*** (and were simply trying to evade those plain terms by alleging implied side-agreements). *See, e.g.*, *Durant v. United States*, 16 Cl. Ct. 447, 451-52 (1988) (because an "***express*** contract, Form ASCS–477, ***existed*** between the parties," plaintiffs could not allege overlapping implied contract (emphases added)); *Schism v. United States*, 316 F.3d 1259, 1278 (Fed. Cir. 2002) (en banc) (because plaintiffs had already "agreed in ***an express, written contract*** to be bound[,]" their allegations of implied agreements was "foreclosed" (emphasis added)). Those cases have no relationship to the situation where a where the parties had never signed "express" contracts setting forth the basic terms of the *quid pro quo*.

CONCLUSION

For the reasons stated, Montana Health is entitled to receive, and the Government is obligated to pay, $5,286,097 in CSR payments. The Government's motion to dismiss should therefore be denied, and the Court should grant summary judgment for Montana Health on its statutory claim or, alternatively, on its breach of an implied-in-fact contract claim.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on August 20, 2018, a copy of the forgoing Plaintiff's Reply in Support of Its Cross-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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