IN THE UNITED STATES COURT OF FEDERAL CLAIMS

COMMON GROUND HEALTHCARE COOPERATIVE, Plaintiff, on behalf of itself and all others similarly situated, vs. THE UNITED STATES OF AMERICA, Defendant.	No. 1:17-cv-00877-MMS (Judge Sweeney)

PLAINTIFF COMMON GROUND HEALTHCARE COOPERATIVE'S REPLY IN FURTHER SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

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Plaintiff Common Ground Healthcare Cooperative ("Common Ground" or "Plaintiff"), on behalf of itself and the CSR Class (the "Class"), respectfully submits this reply in further support of its motion for summary judgment for the Class's claims seeking payment of unreimbursed cost-sharing reduction payments for the 2017 benefit year through the present, and in opposition to Defendant the United States of America's ("Defendant" or the "Government") cross-motion to dismiss (Dkt. 39).

INTRODUCTION

In opposing Plaintiff's motion for summary judgment, the Government argues for a dangerous and cynical precedent. It does not contest—because it cannot, given the Federal Circuit's recent *Moda* opinion—that the plain language of Section 1402 is "unambiguously money-mandating." Instead, the Government argues that the "structure" of the ACA indicates Congress had no intent to create an obligation to make CSR payments, because Congress utilized a permanent appropriation for the premium tax credit in Section 1401, but did not include a similar appropriation for Section 1402's CSR program, which is in the "same subsection" of the ACA. This "structure" supposedly means that, absent a specific appropriation for the CSR program, the Government is not liable for failing to make payments it unequivocally promised to QHP issuers.

The Government's argument fails on multiple levels. Most prominently, it ignores Section 1402's plain language, which, under controlling precedent, is the end of the inquiry because that language is clearly money-mandating. Courts do not look to an act's broader structure for clues as to congressional intent when the statute's plain language renders that intent clear. Section 1402 unequivocally states that the Government "***shall make*** periodic and timely [CSR] payments" to QHP issuers. 42 U.S.C. § 18071(c)(3)(A). This is unambiguous language, unfettered by qualifications or caveats. No reasonable reading of Section 1402 suggests that the

Government intended the CSR program to go unfunded except at Congress's whim. Indeed, this is counter to the Section's purpose—which the Government does not contest—which is to simultaneously incentivize QHP issuers to enter the new ACA exchanges while also helping the nation's lowest-income insureds obtain health coverage. It is not credible for the Government to now argue that Congress intended the current stopgap measures states have allowed—*i.e.*, permitting QHP issuers to temporarily increase silver plan premiums, because they are subject to a reimbursable (and funded) tax credit—as the default way this program would proceed. In essence, the Government asks this Court to assume, in contrast to Section 1402's plain language, that Congress intended the convoluted mess QHP issuers and states now find themselves in, rather than the straightforward reimbursement program Section 1402 explicitly contemplated.

The Government also ignores more than a century of law, the Tucker Act, and the basic principles underlying public-private enterprise when it argues that failing to include a permanent appropriation in a portion of an act somehow indicates that a money-mandating statute is not actually money-mandating. The Government cites no case law actually supporting this proposition and ignores the fact that, if it were correct, Congress could make false promises whenever it wanted just by including a permanent appropriation for one portion of a new law, but not for another. Binding Supreme Court and Federal Circuit precedent, including (among others) the *Langston* and *Slattery* opinions, clearly hold otherwise, as does the *Moda* opinion, which found that the risk corridors program was "unambiguously money-mandating," even though it has no permanent appropriation and was part of the ACA just the same as Sections 1401 and 1402.[1]

[1] Common Ground disagrees with the majority's subsequent holding in *Moda* that subsequent appropriation bills modified the risk corridors program, which is currently subject to

For these reasons, which are discussed at length below, the Court should reject the Government's arguments and enter judgment for Common Ground and the Class, just as another Judge within this Court recently did with respect to virtually identical CSR claims, and in the face of virtually identical arguments from the Government. *See Montana Health CO-OP v. United States*, --- Fed. Cl. ---, 2018 WL 4203938 (Fed. Cl. Sep. 4, 2018) (granting motion for summary judgment to Montana Health for unpaid CSR amounts); *see also Montana Health CO-OP v. United States*, No. 1:18-cv-000143-EDK, Dkt. 17 (Fed. Cl. Aug. 20, 2018) (Montana Health's reply brief in support of its motion for summary judgment, responding to the Government's arguments that the "structure" of the ACA indicates that Congress never intended to create an obligation to pay CSR amounts).

I. ARGUMENT

A. The Government's Statutory Interpretation Arguments Fail as a Matter of Law and Fact

The primary thrust of the Government's opposition argument is that the "structure" of the ACA—not its plain language—somehow indicates that Congress never intended to fund CSR payments. *See* Opp. at 14-19. This argument fails on two levels. First, long-held principles of statutory construction require the Court to *first* look at Section 1402's plain language. Because congressional intent is clear from that language, that is the end of the inquiry. *See Henry v. United States*, 793 F.2d 289, 293 (Fed. Cir. 1986) ("Where the language is plain and admits of no more than one meaning the duty of interpretation does not arise and the rules which are to aid doubtful meanings need no discussion."); *J.M. Huber Corp. v. United States*, 27 Fed. Cl. 659,

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a petition for *en banc* review. However, that holding is irrelevant here, because Congress never once mentioned the CSR program or Section 1402 in any subsequent appropriations bills, which explains why the Government does not (and cannot) attempt to squirm out of their obligations under Section 1402 based on the *Moda* majority's ruling.

664 (1993) ("The Federal Circuit has stated that a court should not look beyond the plain meaning of unambiguous language to divine the real purpose of Congress unless a literal interpretation would lead to an incongruous result."). Second, even if the Court were to delve into the ACA's broader structure, the Government's argument fails because it ignores Section 1402's "overriding purpose," which was to both defray low-income insureds' costs *and* incentivize QHP issuers to enter and continue providing QHPs on the ACA exchanges by promising to pay back the CSRs they advanced on low-income insureds' behalf. Under the Government's made-for-litigation interpretation of Section 1402, Congress never intended to fund these payments at all, which contradicts the plain, unchallenged purpose of the CSR program.

1. Under Well-Accepted Principles Of Statutory Construction, A Statute's Plain Language Controls

As Common Ground noted in its opening brief, when interpreting a statute, a Court must first look to the statute's plain language in order to "inquire whether Congress has clearly spoken on the subject" in dispute. *Bath Iron Works Corp. v. United States*, 27 Fed. Cl. 114, 125 (1992) (citing *Norfolk & W. Ry. Co. v. Am. Train Dispatchers Ass'n*, 499 U.S. 117, 128 (1991)). If the statute is plain on its face, that is the end of the inquiry. *Id.*

Section 1402 could not be more clear. It states that the Government "***shall make*** periodic and timely payments to the [QHP] issuer equal to the value of the [CSR] reductions." 42 U.S.C. 18071(c)(3)(A) (emphasis added). As the *Moda* panel—both the majority and the dissent—observed, this type of language ends the inquiry into whether the original statute is money-mandating. *See Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320-22 (Fed. Cir. 2018) (language that the Government "shall pay" certain amounts is "unambiguously mandatory," and Section 1342 created an obligation to pay full, annual risk corridor amounts);

LCM Energy Sols. v. United States, 107 Fed. Cl. 770, 774 (2012) (noting that a money mandating statute with "a clear standard for the payment of money and states a precise amount of money to be paid" could only be "fairly interpreted" as mandating "the exact amount of the full grant" to which a plaintiff was entitled).

It was only recently that the Government argued Section 1402 was not a self-evident obligation to pay. As Common Ground previously observed, the Government's repeated conduct over the course of years confirms that, prior to this lawsuit, it understood Section 1402 to plainly mandate payment. The Government made monthly reimbursements to QHP issuers from the ACA exchanges' inception until October 2017. It was only when the current administration ceased making CSR payments that the Government argued that such action was required due to lack of appropriations. *See* Mot. at 6-7, 12, 14-16. HHS similarly, repeatedly admitted the same through its words and actions. *Id.* These years-long practices belie the new claim that Section 1402 does not, in fact, on its face constitute a money-mandating statute.

2. The ACA's Broader Structure Confirms Section 1402 Is A Money-Mandating Statute

Assuming the Court were to find that Section 1402 is ambiguous in any way, the next step is to look at "other extrinsic aids, such as legislative history." *Id.* (citing *Richards Medical Co. v. United States*, 910 F.2d 828, 830 (Fed. Cir. 1990)). Furthermore, since the Government ignores the basic principles of statutory construction in its brief, it bears repeating that "[w]here a statute's text and legislative history are silent on an issue of statutory construction, the overriding purpose of the provision is highly relevant in resolving the ambiguity." *Augustine v. Dep't of Veterans Affairs*, 429 F.3d 1334, 1342 n.4 (Fed. Cir. 2005). "[T]he court will not look merely to a particular clause . . . , but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and

give it such a construction as will carry into execution the will of the Legislature." *Warner–Lambert Co. v. Apotex Corp.*, 316 F.3d 1348, 1355 (Fed. Cir. 2003) (quoting *Kokoszka v. Belford*, 417 U.S. 642, 650 (1974)); *see also King v. Burwell*, 135 S. Ct. 2480, 2490 (2015) (refusing to read portion of the ACA "out of context" with the broader Act, because it would render other provisions in the Act senseless or contradictory).

In its opposition, the Government concedes that one of the primary purposes of the CSR program was to bring low-income insureds' health care costs down. Opp. at 4-5. The Government also implicitly concedes (through its notable silence) that the CSR reimbursement structure was meant to incentivize QHP issuers to enter the ACA exchanges in the first place, since it was the Government, not the QHP issuers, that ultimately subsidized low-incomed insureds' health care costs. *Compare* Mot. at 1 (noting this was one of the CSR program's purposes); *with generally* Opp. (never rebutting this point). In other words, although QHP issuers were statutorily on the hook to make initial CSR payments, they were able to keep low-income insureds' costs down because the Government would reimburse them for those payments, as it did for years on a monthly basis with an annual reconciliation.

"Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them." *King*, 135 S. Ct. at 2496. It did so in part by adopting reforms at the federal level to help expand coverage in the individual health insurance market. *Id.* at 2485. As the name of the Act explicitly suggests, these reforms were meant to, *inter alia*, make health care more affordable, particularly for low-income insureds. *Id.* at 2486-87.

The opposition focuses its attention on Section 1401, arguing that it is in the "same subpart" of the ACA as Section 1402. That is true. But what the Government ignores is that Sections 1401 and 1402 have different purposes. As the Supreme Court observed, Section 1401

was meant to reduce insureds' insurance premiums through a tax credit. *King*, 135 S. Ct. at 2487. By its plain terms, however, Section 1402 focuses on a different set of costs; *i.e.*, everyday out-of-pocket costs insureds must pay for healthcare, including "deductibles, coinsurance, copayments, or similar charges." 42 U.S.C. § 18022. These latter costs are the sort of routine payment low-income insureds may not have at hand. Accordingly, the CSR program made it so those insureds did not have to pay them; instead, the QHP issuer took on the cost and received reimbursement from the Government for doing so.

The purpose of this dual approach to insurance costs is clear: it reduces both annual ***and*** everyday costs so that low-income insureds can afford and, more importantly, ***make use of*** their health plans. An annual tax credit provides little comfort to an insured if they do not have enough money to satisfy their insurance deductible or make a copayment when they visit the doctor. The CSR program thus addressed very real needs for low-income insureds, but was complementary to, not dependent on, the ACA's premium tax credit.

In its opposition, the Government skips over Section 1402's self-evident purpose, instead focusing on technical arguments about Congress's supposed intent that is contrary to both the plain language of Section 1402 ***and*** the Supreme Court's judicially-recognized purpose for the ACA. Such an interpretation fails as a matter of law. *See Hart v. United States*, 585 F.2d 1025, 1035 (Ct. Cl. 1978) ("[W]e hold that defendant's interpretation of the statute is incorrect, and that the regulation, being contrary to the plain language of the statute, cannot stand"); *Anchor Sav. Bank, FSB v. United States*, 121 Fed. Cl. 296, 312 (2015) ("The language of a particular provision should be read in light of the purpose of the statute as a whole, as evinced by the language of the statute.") (citing *Star–Glo Assoc, LP v. United States*, 414 F.3d 1349, 1357 (Fed. Cir. 2005)). But, even if there were ambiguity in the statutory language, the Government's

argument also fails as a matter of fact because it cannot, in good conscience or in good faith, argue that some clearly-intended statutory purpose is served by refusing to reimburse QHP issuers for payments they mandatorily (but willingly) made on low-income insureds' behalf.

3. Section 1401's Inclusion of a Permanent Appropriation Has No Bearing On Whether Section 1402 Is Money-Mandating

Faced with these multiple reasons to give effect to Section 1402's plain language (and therefore grant summary judgment to Common Ground and the Class), the Government resorts to arguing that, because Section 1401 contains a permanent appropriation, Congress never intended to fund or make CSR payments, because it did not include a similar appropriation in Section 1402. Opp. at 14-19. This argument fails for multiple reasons.

First, whether legislation contains an appropriation or not is completely irrelevant to whether that law requires the Government to make monetary payments; *i.e.*, is money-mandating. *See, e.g.*, *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003) (concluding statute was money-mandating without regard to whether it was supported by a corresponding appropriation); *Montana Health*, 2018 WL 4203938, at *6-*7 (same, with respect to Section 1402). The Government therefore asks the Court to focus on a statutory feature—a permanent appropriation—that has nothing to do with its obligation to pay. Statutes that state the Government "will pay" or "shall pay" certain amounts are money-mandating, period. *Moda*, 892 F.3d at 1320-22 (language that the Government "shall pay" certain amounts is "unambiguously mandatory"); *see also Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) ("*Greenlee II*") (holding that statutory provisions are generally money-mandating if they provide that the Government "shall" pay an amount of money); *Britell v. United States*, 372 F.3d 1370, 1378 (Fed. Cir. 2004) ("[T]his type of mandatory language, e.g., 'will pay' or 'shall pay,' creates the necessary 'money-mandate' for Tucker Act purposes."); *Agwiak*, 347 F.3d at 1380 ("We

have repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating.") (citations omitted).

Second, if the Government were correct that Section 1402's lack of a permanent appropriation—at least relative to Section 1401—meant the Government did not intend to pay CSR amounts, that would negate the plain language of Section 1402. For the reasons discussed above in Section I.A.2, such a result is contrary to law and fact, particularly due to the Government's failure to explain how interpreting Section 1402 in this way would give effect to a clearly-intended purpose from either the Section 1401/1402 "subsection," or the broader ACA.

Third, the Government offers no case law supporting its extraordinary interpretation of the implied interplay between Sections 1401 and 1402. In the opposition, the Government (at 15) cites various cases it contends establish that Congress's omission of a permanent appropriation in Section 1402 means it never intended to create an obligation to pay CSR amounts. These cases, however, are completely inapposite, with none even remotely holding that an appropriation included in one portion of an act negates unambiguously money-mandating language in another portion.

For example, in *Digital Realty Trust, Inc. v. Somers*, 138 S. Ct. 767 (2018), the question was how to define "whistleblower" for purposes of the Dodd-Frank Act's anti-employment retaliation provisions; specifically, whether a "whistleblower" under the statute is someone who has actually reported wrongful conduct to the SEC. *Id.* at 777. Dodd-Frank included a reporting requirement in the initial definition of "whistleblower," but not in the rest of the statute when describing protections for whistleblowers. Noting that courts cannot dispense with conditions placed in explicit portions of a statute, the Supreme Court concluded that there was, in fact, a reporting requirement for whistleblowers before they could enjoy Dodd-Frank's employment

discrimination protections. *Id.* at 777-778. Notably, the Supreme Court confirmed this plain text reading by analyzing it both on the text itself, as well as in connection with "Dodd-Frank's purpose and design," which was "to motivate people who know of securities law violations to *tell the SEC*." *Id.* at 777 (emphasis in original). Although *Digital Realty*'s facts are different than this case, the more appropriate application of that precedent would be to conclude that Section 1401's inclusion of a permanent appropriation demonstrated that Congress clearly intended to fund the programs in that subsection (and, in truth, the entire ACA), especially when considering the ACA's purpose (increasing the number of people with access to health insurance in the United States).

Next, *Russello v. United States*, 464 U.S. 16 (1983), and *United States v. Wong Kim Bo*, 472 F.2d 720 (5th Cir. 1972), each address situations where the plaintiff argued a ***restriction*** Congress placed into one subsection of a statute could be read into another, related subsection. *Russello*, 464 U.S. at 23 (analyzing whether the restriction to an "enterprise" in one subsection of RICO applied to another subsection that did not mention an "enterprise"); *Wong Kim Bo*, 472 F.2d at 722 (analyzing whether the words "arrest and" should be included as a requirement for violations of 8 U.S.C.A. § 1101(g), because that statute was related to 8 U.S.C.A. § 1326, which included the "arrest and" requirement). Neither case—nor any other Common Ground is aware of—stands for the proposition that including a permanent appropriation for one program implies an intention to never provide one for a different program in the same legislation. There are any number of reasons why Congress might choose not to include a permanent appropriation for a money-mandating program, which is why the Supreme Court and Federal Circuit have been clear for more than a century that a failure to appropriate funds has no impact on a statute's money-mandating nature. *See Moda*, 892 F.3d at 1322 (observing "[t]he government cites no authority

for its contention that a statutory obligation cannot exist absent budget authority," and further noting "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."); *see also Agwiak*, 347 F.3d at 1380 (concluding statute was money-mandating without regard to whether it was supported by a corresponding appropriation).[2]

B. Whether Congress Appropriated Funds To Make CSR Payments Is Legally Irrelevant For This Tucker Act Claim

Time and again, courts from the Supreme Court down have noted that Congress's failure to appropriate funds for a self-imposed monetary obligation has no bearing on whether that obligation exists and whether a plaintiff may sue to collect on that obligation. *See, e.g.*, *United States v. Langston*, 118 U.S. 389 (1886) (holding that Congress owed Haitian ambassador $2,500 where statute mandated that he be paid $7,500 annually and Congress only appropriated $5,000 for that purpose); *Moda*, 892 F.3d at 1320-22 (rejecting Government's argument "that a statutory obligation cannot exist absent budget authority"); *Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) (*en banc*) (failure to appropriate funds did not absolve the Government of its obligation to pay amounts owed); *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (Congress's failure to appropriate funds does not "defeat a Government obligation

[2] For this reason, the Government's attempts to distinguish *Langston* are meritless. The Government attempts to argue that this case is ***not*** like *Langston* because Section 1401 contains a permanent appropriation, showing that this is not just a "failure to appropriate." *See* Opp. at 17-18. But that logic assumes the failure to include an appropriation in organic legislation establishing a federal program is somehow relevant to whether Congress establishes a self-imposed obligation to pay. As discussed in Sections I.A.2 and I.A.3 above, the case law is crystal clear that a failure to appropriate in organic legislation has no bearing on whether a statute is money-mandating. And, here, the Government already demonstrated its understanding that it had created such a self-imposed obligation by paying CSR amounts for nearly four years, until the current administration ceased payments abruptly at the end of 2017.

created by statute"); *Montana Health*, 2018 WL 4203938, at *6-*7 (rejecting the Government's arguments that it had no obligation to pay CSR amounts absent an appropriation).[3]

Despite this clear and more-than-century-old line of cases, the Government argues that the majority's opinion in *Moda* somehow stands for the proposition that, any time Congress appropriates funds for only a portion of an act's provisions, parties owed money under the remainder of that act have no recourse in this Court under the Tucker Act. *See* Opp. at 20-23. Such an argument is a complete misreading of *Moda*, and it is contrary to well-accepted law.

In *Moda*, both the majority and the dissent concluded that the ACA unquestionably established a money-mandating obligation for the risk corridors program, and, thus, a basis to seek payment for risk corridor amounts under the Tucker Act. *Moda*, 892 F.3d at 1320 n.2, 1322 (majority), 1331-33 (dissent). The key question in *Moda* was whether subsequent appropriations bills modified the original money-mandating obligation by "clear implication." *Id.* at 892 F.3d at 1322 ("The government next argues the riders in the appropriations bills for FY 2015 and FY 2016 repealed or suspended its obligation to make payments out in an aggregate amount exceeding payments in. We agree."). Critical to that inquiry was whether Congress made any statements in subsequent bills that, by "clear implication," modified the "unambiguously money-mandating" language found in Section 1342 of the ACA. *Id.* at 1333.

The Government does not argue here that Congress took any subsequent steps to modify or obviate a money-mandating obligation. Instead, the Government argues that, ***in the very same***

[3] *See also District of Columbia v. United States*, 67 Fed. Cl. 292, 340 (2005) (holding that government had a statutory obligation to pay the plaintiff; statute did not expressly specify that payments made pursuant to it were an "obligation" of the Government); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949) (requiring payment of overtime wages to government workers where such overtime was mandated by statute, but Congress forbade the employing agency from using appropriated funds for that purpose)

statute passing into law "unambiguously money-mandating" language, Congress nevertheless negated that language because it included a permanent appropriation for Section 1401's premium tax credit, but did not include an appropriation for Section 1402's CSR program. The Government further argues that Congress provided no avenue for QHP issuers to seek repayment if it failed to appropriate funds for the CSR program, and thus that Common Ground and the Class supposedly have no ability to seek damages under the Tucker Act. *See* Opp. at 20-24.

This facially strained position finds no support in the ACA, *Moda*, or in Tucker Act jurisprudence. As an initial matter (and as discussed above), any interpretation of a statute that negates its plain language, contradicts the statute's overall purpose, or both, is incorrect as a matter of law. *See Hart*, 585 F.2d at 1035 ("[W]e hold that defendant's interpretation of the statute is incorrect, and that the regulation, being contrary to the plain language of the statute, cannot stand"); *Anchor Sav. Bank*, 121 Fed. Cl. at 312 ("The language of a particular provision should be read in light of the purpose of the statute as a whole, as evinced by the language of the statute."). Moreover, if a statute's plain language suggests it is money-mandating, that is sufficient for Tucker Act jurisdiction in this Court. *See Moda*, 892 F.3d at 1320 n.2 (noting "a statute is money-mandating for jurisdictional purposes if it 'can fairly be interpreted' to require payment of damages, or if it is 'reasonably amenable' to such a reading, which does not require the plaintiff to have a successful claim on the merits") (citing *Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007)). Even if the Government ultimately prevails in arguing that it owes no money in a particular instance—whether due to statutory interpretation or application—that does not remove a plaintiff's ability to have this Court decide the issue. *See generally, e.g.*, *id.*

As the Federal Circuit previously held, a plaintiff may pursue a Tucker Act claim when they identify a money-mandating statutory obligation, regardless of whether Congress appropriated funds to satisfy that obligation. *See Slattery*, 635 F.3d at 1321. The Government's argument to the contrary is thus baffling, because it clearly asks this Court to violate binding, *en banc* precedent. Furthermore, *Moda* said nothing in contradiction to *Slattery* and, in fact, was fully in line with that precedent insofar as *Moda* decided the plaintiff's Tucker Act claim on the merits notwithstanding that the majority's ultimate opinion was that the Government did not owe Moda (or any other QHP issuer) additional risk corridor amounts.

C. Current Stopgap Measures Have No Bearing On The Class's CSR Reimbursement Claims

At various points in its opposition, the Government argues that many CSR Class members have not suffered any harm because various states permitted them to raise premiums on silver plans, thereby shifting cost increases from the Government's failure to pay CSR reimbursements back to the federal government via the ACA's tax subsidy program. Opp. at 9-11, 18. The intent behind these arguments is clear: the Government wishes to essentially argue "no harm, no foul," because states have identified emergency ways to prevent the utter chaos that might have resulted from the Government's failure to make CSR payments. This Court, however, has already noted that the Government did not previously "identify any statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligations (even if insurers intentionally increased premiums to obtain larger premium tax credit payments to make up for lost cost-sharing reduction payments)." Dkt. 30 at 10. It is telling that the Government has not done so.

The law—based on acts the Government itself passed and jurisprudence that has long been in effect—is that, absent a specific statutory provision, the Government's obligation to

make payments according to a money-mandating statute is absolute. It is no defense for the Government to argue that the current administration's efforts to sow chaos in the health insurance markets failed, thereby giving the Government a free pass on its self-imposed legal and monetary obligations.

CONCLUSION

For the foregoing reasons, Common Ground respectfully reiterates it request that the Court grant summary judgment in the CSR Class's favor.

Dated: October 12, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on October 12, 2018, a copy of the attached Plaintiff Common Ground Healthcare Cooperative's Reply in Further Support of its Motion for Summary Judgment and Memorandum of Law in Support was served via the Court's CM/ECF system on Defendant's counsel Marcus S. Sacks.

/s/ Stephen Swedlow
Stephen Swedlow

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United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter III. Available Coverage Choices for All Americans
Part A. Establishment of Qualified Health Plans

42 U.S.C.A. § 18022

§ 18022. Essential health benefits requirements

Currentness

(a) Essential health benefits package

In this title, the term "essential health benefits package" means, with respect to any health plan, coverage that--

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential health benefits

(1) In general

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) Limitation

(A) In general

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) Notice and hearing

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for consideration

In defining the essential health benefits under paragraph (1), the Secretary shall--

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection,[1] so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that--

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 18031(b)(2)(B)(ii) [2] of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and [3]

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains--

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) Rule of construction

Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) Requirements relating to cost-sharing

(1) Annual limitation on cost-sharing

(A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of Title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 and later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) Repealed. Pub.L. 113-93, Title II, § 213(a)(1), Apr. 1, 2014, 128 Stat. 1047

(3) Cost-sharing

In this title--

(A) In general

The term "cost-sharing" includes--

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of Title 26) with respect to essential health benefits covered under the plan.

(B) Exceptions

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage

For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of coverage

(1) Levels of coverage defined

The levels of coverage described in this subsection are as follows:

(A) Bronze level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value

(A) In general

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of Title 26) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application

In determining under this title, the Public Health Service Act [42 U.S.C. 201 et seq.], or Title 26 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) Plan reference

In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic plan

(1) In general

A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if--

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides--

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollment

An individual is described in this paragraph for any plan year if the individual--

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of Title 26 by reason of--

(i) section 5000A(e)(1) of such title (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such title (relating to individuals with hardships).

(3) Restriction to individual market

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only plans

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) Payments to Federally-qualified health centers

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(l)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title for such item or service.

CREDIT(S)

(Pub.L. 111-148, Title I, § 1302, Title X, § 10104(b), Mar. 23, 2010, 124 Stat. 163, 896; Pub.L. 113-93, Title II, § 213(a), Apr. 1, 2014, 128 Stat. 1047.)

Footnotes

1 So in original. Probably should be “paragraph,”.

2 So in original. Probably should be “18031(d)(2)(B)(ii)”.

3 So in original. The word “and” probably should not appear.

42 U.S.C.A. § 18022, 42 USCA § 18022

Current through P.L. 115-231. Also includes P.L. 115-233 to 115-243, 115-247, 115-249, and 115-250. Title 26 current through P.L. 115-253.

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KeyCite Yellow Flag - Negative Treatment
Unconstitutional or PreemptedNegative Treatment Reconsidered by Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services, 11th Cir.(Fla.), Aug. 12, 2011

KeyCite Yellow Flag - Negative TreatmentProposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 157. Quality Affordable Health Care for All Americans
Subchapter IV. Affordable Coverage Choices for All Americans
Part A. Cost-Sharing Reductions

42 U.S.C.A. § 18071

§ 18071. Reduced cost-sharing for individuals enrolling in qualified health plans

Effective: March 30, 2010
Currentness

(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).

(b) Eligible insured

In this section, the term "eligible insured" means an individual--

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of Title 26, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) Determination of reduction in cost-sharing

(1) Reduction in out-of-pocket limit

(A) In general

The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket [1] limit under section 18022(c)(1) of this title in the case of--

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) Coordination with actuarial value limits

(i) In general

The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above--

(I) 94 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 87 percent in the case of an eligible insured described in paragraph (2)(B);

(III) 73 percent in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved; and

(IV) 70 percent in the case of an eligible insured whose household income is more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

(ii) Adjustment

The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) Additional reduction for lower income insureds

The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to--

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 94 percent of such costs;

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 87 percent of such costs; and

(C) in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 73 percent of such costs.

(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.

(B) Capitated payments

The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) Additional benefits

If a qualified health plan under section 18022(b)(5) of this title offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 18031(d)(3)(B) of this title to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) Special rule for pediatric dental plans

If an individual enrolls in both a qualified health plan and a plan described in section 18031(d)(2)(B)(ii)(I)[2] of this title for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 18022(b)(1)(J) of this title.

(d) Special rules for Indians

(1) Indians under 300 percent of poverty

If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 5304(d) of Title 25) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section--

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) Items or services furnished through Indian health providers

If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services--

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) Payment

The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) Rules for individuals not lawfully present

(1) In general

If an individual who is an eligible insured is not lawfully present--

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which--

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction--

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present

For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority

The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Definitions and special rules

In this section:

(1) In general

Any term used in this section which is also used in section 36B of Title 26 shall have the meaning given such term by such section.

(2) Limitations on reduction

No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such title.

(3) Data used for eligibility

Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 18082 of this title and not the taxable year for which the credit under section 36B of Title 26 is allowed.

CREDIT(S)

(Pub.L. 111-148, Title I, § 1402, Mar. 23, 2010, 124 Stat. 220; Pub.L. 111-152, Title I, § 1001(b), Mar. 30, 2010, 124 Stat. 1031.)

Notes of Decisions (3)

Footnotes

1 So in original. Probably should be "out-of-pocket".

2 So in original. Probably should be "18031(d)(3)(B)(ii)(I)".

42 U.S.C.A. § 18071, 42 USCA § 18071

Current through P.L. 115-231. Also includes P.L. 115-233 to 115-243, 115-247, 115-249, and 115-250. Title 26 current through P.L. 115-253.

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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,

[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

[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.

[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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