IN THE UNITED STATES COURT OF FEDERAL CLAIMS

COMMUNITY HEALTH CHOICE, INC. Plaintiff, v. THE UNITED STATES, Defendant.	)	No. 1:18-cv-00005-MMS The Hon. Margaret M. Sweeney

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

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Plaintiff Community Health Choice, Inc. ("CHC") respectfully submits this Motion for Summary Judgment on Liability and Memorandum of Law in Support. For the reasons stated below and based on the undisputed material facts of record, the Court should find Defendant, the United States of America ("Government"), liable (i) under Section 1402 of the Patient Protection and Affordable Care Act and related statutes and regulations; and (ii) for breach of express and/or implied-in-fact contract.

INTRODUCTION

The 2010 Patient Protection and Affordable Care Act ("ACA") was a major reform of the United States' healthcare system. One of the reforms was the creation of health insurance exchanges, where insurers sell Qualified Health Plans ("QHPs"). To do so, an insurer must be a QHP Issuer ("QHPI"), and one of the requirements for QHPIs is to provide cost-sharing reductions, or CSRs, to insureds. 42 U.S.C. § 18071(a)(2). But although the insurer provides these reductions to its insureds—reducing a patient's out-of-pocket expenses—it is the Government that is supposed to bear the financial burden of CSRs: section 1402 of the ACA provides that "the Secretary [of HHS] ***shall make*** periodic and timely payments to the issuer equal to the value of the [cost-sharing] reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added). It is undisputed that CHC is a QHPI and has reduced cost-sharing for its members, as required by the ACA. But, also undisputed, the Government has failed to make CSR payments since October 2017, after doing so every month since January 2014.

This failure by the Government to make CSR payments is a violation of the Government's statutory obligations to CHC as a QHPI, and one judge of this Court has already granted summary judgment for the insurer on an identical claim. *Mont. Health Co-Op v. United States*, No. 18-143C, 2018 WL 4203938, at *1 (Fed. Cl. Sept. 4, 2018) (Kaplan, J.). 42 U.S.C.

§ 18071(c)(3)(A) is a money-mandating statute that imposes an obligation on the Secretary of HHS to make payments to health insurers that have implemented CSRs under required by the ACA, and there has been no subsequent amendment or repeal of that obligation by Congress. The Government is therefore liable under 42 U.S.C. § 18071 to CHC for unpaid CSR payments, and the Court should grant summary judgment to CHC as to liability.

In addition, the Government has an express contractual obligation to make CSR payments to CHC due to the terms of the parties' QHP Issuer Agreements, which state that "CMS will recoup or net payments due to [CHC] against amounts owed to CMS by [CHC] in relation to offering of QHPs . . . including . . . advance payments of CSRs." (Janda Decl. Ex. A, § III.b; Janda Decl. Ex. B, § III.b). Moreover, the Government has an implied-in-fact contractual obligation to make CSR payments to CHC because an implied contract was formed by the conduct of the parties and the Government's making CSR payments to CHC from 2014 through September 2017. The Government is therefore liable to CHC under an express and/or implied-in-fact contract for unpaid CSR payments, and the Court should grant summary judgment to CHC as to liability on these claims as well.

QUESTIONS PRESENTED

1. The ACA requires insurers to offer cost-sharing reductions, or "CSRs," to certain insureds; and it requires that the Government "shall make . . . payments" to insurers "equal to the value of the reductions." The Government has failed to make these payments since October 2017. Is the Government liable to CHC for its failure to make these payments?
2. In its written contract with CHC, the Government promised to follow a "monthly payments and collections reconciliation process" in which the Government

includes any "net payments due to [CHC] . . . including . . . advance payments of CSRs." The Government has failed to include CSR payments in the reconciliation process since October 2017. Is the Government liable for breach of its express contract with CHC?

3. Both CHC and the Government understood that when CHC provided CSRs to insureds, the Government was obligated to make advance payments to CHC covering the cost of those reductions. CHC has provided the CSRs but the Government now refuses to cover the cost of those reductions. Is the Government liable for breach of an implied-in-fact contract?

STATEMENT OF THE CASE

I. The Patient Protection And Affordable Care Act ("ACA").

Enacted in 2010, the ACA marked a major reform in the United States health care market. Pub. L. No. 111-148, 124 Stat. 119 (2010). It expanded access to health insurance, prohibited insurers from denying coverage based on pre-existing conditions, 42 U.S.C. § 300gg-1(a), and took steps to make health insurance affordable and available to low- and middle-income Americans. *See King v. Burwell*, 135 S. Ct. 2480, 2486–87 (2015). Because of the ACA, the number of uninsured Americans fell by 19.8 million between 2010 and June 2017.[1]

As part of the ACA, Congress authorized the creation of health insurance marketplaces, or "exchanges"—"virtual marketplaces in each state wherein individuals and small groups [can] purchase health coverage." *Mont. Health*, 2018 WL 4203938, at *1 (quoting *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1314 (Fed. Cir. 2018) (citing 42 U.S.C. § 18031(b)(1)). Insurers sell "Qualified Health Plans" ("QHPs") on the exchanges. 42 U.S.C. § 18031. The ACA

[1] Nat'l Ctr. for Health Statistics, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2017*, Ctrs. for Disease Control & Prevention, 1 (2017), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201711.pdf.

categorizes these plans into four benefit levels: bronze, silver, gold, and platinum, which respectively cover 60%, 70%, 80%, and 90% of a patient's qualifying medical costs. 42 U.S.C. § 18022(d)(1). To sell on the exchanges, an insurer must meet the ACA's criteria for "QHP issuers" or "QHPIs." For example, a QHPI must provide essential health benefits, meet network adequacy standards, and be certified in each marketplace in which it participates. 42 U.S.C. § 18021; *see also* 45 C.F.R. § 155.260(b)(2) ("must execute . . . contract or agreement"). It also must comply with the ACA's requirements for cost-sharing reductions, or "CSRs."

II. The CSR Program.

The idea of CSRs is simple: if someone has a qualifying health plan and income level, the Government will help pay her co-payments and deductibles. *Mont. Health*, 2018 WL 4203938, at *2. To do that, the Government pays her insurance company, which then forwards the money to her providers, reducing the amount that the patient must pay them herself. *Id.*

A. Cost-Sharing Reductions Under The ACA.

The ACA defines "cost-sharing" to include "deductibles, coinsurance, copayments, or similar charges." 42 U.S.C. § 18022(c)(3)(A); *see also California v. Trump*, 267 F. Supp. 3d 1119, 1123 (N.D. Cal. 2017). Under the ACA, people whose income is 100%-250% of the poverty level qualify for CSRs if they buy a silver plan. 42 U.S.C. § 18071(c)(1)-(2). The Government then covers half or two-thirds of cost-sharing obligations, depending on the patient's income. *Id.*[2]

[2] *See also* 45 C.F.R. § 156.410(a) ("The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected."); *Cost Sharing Reductions*, U.S. Ctrs. for Medicare & Medicaid Servs., https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/ (last visited Sept. 16, 2018) (CSRs result in "a lower deductible" for the patient as well as "lower copayments or coinsurance"). Once the total of an individual's and Government's cost-sharing payments equals the plan's (original, unreduced) out-of-pocket maximum, the insurer is responsible for all costs.

The payments for CSRs are supposed to work this way: the Government first makes advance payments of the CSRs to the insurer. When a patient receives medical care, the doctor or hospital bills the patient's health insurer. The insurer looks at the terms of the patient's plan to determine what copayment, deductible[3] or co-insurance[4] amounts the patient must pay. The insurer pays the provider for eligible CSRs, and the provider then bills the patient/insured for any remaining amounts.[5] In effect, the insurer is the middleman between the Government and the insured.

This arrangement was enacted by Sections 1402 of the ACA, codified at 42 U.S.C. § 18071, which states in relevant part:

> (a) In general
> In the case of an eligible insured enrolled in a qualified health plan—
> (1) the Secretary shall notify the issuer of the plan of such eligibility; and
> (2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).
> [. . . .]
> (c) Determination of reduction in cost-sharing
> [. . . .]
> (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.

[3] A deductible requires "that you must pay the full cost of your health-care expenses until you reach the deductible amount [for the year], at which point your insurance kicks in and covers the rest." *California v. Trump*, 267 F. Supp. 3d at 1123.

[4] "Co-insurance is triggered after you've reached your annual deductible and requires you to pay a percentage, say 20%, of your [post-deductible] doctor's bill . . . ; the insurance company pays the remaining share." *California v. Trump*, 267 F. Supp. 3d at 1123.

[5] That system applies unless, in the course of a single year, the total of the patient's cost-sharing exceeds the "out-of-pocket maximum" defined by the plan terms. At that point the insurance covers all eligible costs.

42 U.S.C. § 18071(a)(1), (a)(2), (c)(3)(A). The implementing regulations are similar: "[a] QHP issuer will receive periodic advance payments" for the CSR amounts due. 45 C.F.R. § 156.430(b).

42 U.S.C. § 18082, codifying Section 1412 of the ACA, provides additional detail. It clarifies that HHS and the Treasury "shall establish a program under which . . . advance determinations are made . . . with respect to the income eligibility of individuals" buying QHPs. This determines patients' eligibility for, among other things, "the cost-sharing reductions under section 18071." 42 U.S.C. § 18082(a)(1). Under that same program, the Treasury "makes advance payments of such . . . reductions to the issuers of the qualified health plans." 42 U.S.C. § 18082(a)(3). Most specifically, HHS must "notify the Secretary of the Treasury and the Exchange" about which insurers should receive CSR payments for which insureds, and the Treasury "shall make such advance payment" as specified in the notice. 42 U.S.C. § 18082(c)(3).

In short, as the court described the CSR program in *California v. Trump*: "[T]he federal government estimates in advance the amount of subsidy . . . and makes a CSR payment in that amount to your insurance company. As a result, the insurer can reduce your cost sharing . . . on the federal government's dime." 267 F. Supp. 3d at 1123. The overall effect is that insurers provide their silver QHPs to moderate-income individuals, who then get Government help covering their copays and deductibles. The Government uses the insurance company as an intermediary to deliver this money to the patient's providers. The patient gets reduced copays and deductibles; the insurance company and doctors get the same bottom-line result as for non-CSR insureds; and the CSR payment—from Government to insurer to provider—bridges that financial gap.

B. Insurers Must Offer CSRs Even If The Government Fails To Make The Required CSR Payments.

The ACA requires the insurer to reduce the patient's cost-sharing obligations by reducing co-pays and deductibles for qualifying insureds. 42 U.S.C. § 18071(a)(2). This requirement is not

conditional on the insurer receiving the advance payment from the Government. As a result, if the Government fails to meet its obligation to make the required CSR payments, the financial burden for the CSR program shifts to the insurer: patient deductibles and copays still may not increase, and the insurer must pay the CSRs out of its own pocket. When spread across many thousands of insureds, that can add up to catastrophic losses for the insurer. That is what happened here.

III. CHC And The Government Sign A QHP Issuer Agreement Requiring CSR Payments.

CHC is a Texas not-for-profit corporation that has participated in the Texas Health Insurance Exchange as a QHP Issuer since it was implemented in 2014. (Janda Decl. ¶¶ 2, 3.) CHC focuses on serving low-income, underserved individuals and was created specifically to provide affordable insurance to those individuals. (*Id.* ¶ 2.) CHC entered QHP Issuer Agreements with Centers for Medicare & Medicaid Services ("CMS") for calendar years 2014 through 2018. (*Id.* ¶¶ 3, 4, 6; Janda Decl. Ex. A (2017 QHP Issuer Agreement, executed September 21, 2016); Janda Decl. Ex. B (2018 QHP Issuer Agreement, executed October 2, 2017).) In each agreement, CHC committed to offering health insurance coverage on the exchange for the applicable year. Terminating a QHP Issuer Agreement "does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and . . . specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year," Janda Decl. Ex. A § V.d., so as of signing the Agreement each fall, CHC was committed to its members for the coming benefit year.

The parties signed their 2017 Agreement to "memorialize the duties and obligations of the parties" for that year. (Janda Decl. Ex. A 1, ¶ 4; *see also* Janda Decl. ¶ 4.) It confirms that the Government signatories, Marketplace Chief Executive Officer and Director Kevin J. Counihan and Acting Chief Information Officer of CMS George C. Hoffman, "are officials of CMS who are

authorized to represent CMS for purposes of this Agreement." (Janda Decl. Ex. A 10 (containing two signature pages paginated as 10); Janda Decl. ¶ 4.)

The 2017 QHP Issuer Agreement also states that "[i]t is anticipated that periodic APTCs,[6] ***advance payments of CSRs***, and payments of FFE user fees will be due between CMS and [CHC]." (Janda Decl. Ex. A 1, ¶ 3 (emphasis added).) The Government promised that:

> As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [CHC] against amounts owed to CMS by [CHC] in relation to offering of QHPs or any entity operating under the same tax identification number as [CHC] (including overpayments previously made), including the following types of payments: APTCs, ***advance payments of CSRs***, and payment of Federally-facilitated Exchange user fees.

(*Id.* § III.b (emphasis added); *see also* Janda Decl. ¶ 5.) Thus, the QHP Issuer Agreement contractually requires the Government to make a net monthly payment to CHC that includes, among other things, the required CSR payments. These payments ensured that the Government would bear the financial burden of the legally required CSRs. (Janda Decl. ¶¶ 7, 9, 12.)

CHC set rates for the calendar-year 2017 plans in 2016, as required by the parties' 2017 QHP Issuer Agreement and related regulations. (*Id.* ¶ 10; *see also* Janda Decl. Ex. A 1, ¶ 1.) *E.g.*, 45 C.F.R. § 156.420. CHC offered and sold ACA-qualified health insurance plans to individuals during the "open enrollment" period beginning on October 1, 2016, for health insurance coverage effective January 1, 2017. (Janda Decl. ¶ 11.) Once CHC entered contracts with its members in 2016, it could no longer change the premiums it was charging them for their 2017 plans. (*Id.* ¶ 10.)

Approximately 58% of CHC's 2017 insureds—over 80,000 in all—were eligible for CSRs. (*Id.* ¶ 13.) Throughout 2017, when those insureds incurred health-care charges that were subject to CSRs, CHC calculated its payment obligations using the reduced cost-sharing amounts required

[6]APTCs are refundable tax credits payable directly from the Government to insurers to reduce individuals' premiums. *Mont. Health*, 2018 WL 4203938, at *1 (citing Section 1401 of the ACA, 26 U.S.C. § 36B). They are not directly at issue in this case.

by the ACA. (*Id.* ¶¶ 8, 13.) As a result, CHC paid millions of additional dollars to health-care providers each month in 2017. (*Id.* ¶ 13.) CHC also has fulfilled the other terms of its 2017 QHP Issuer Agreement. (*Id.* ¶ 8.)

On October 2, 2017, CHC and CMS entered a similar QHP Issuer Agreement for 2018. (Janda Decl. Ex. B; *see also* Janda Decl. ¶ 6.) During the "open enrollment" period beginning on November 1, 2017, CHC offered and sold ACA-qualified health insurance plans to individuals for coverage during 2018. (Janda Decl. ¶ 14.) Throughout 2018 CHC has continued to cover the required CSRs under those plans for qualifying insureds and has otherwise fulfilled the terms of its 2018 QHP Issuer Agreement. (*Id.* ¶ 15.)

IV. The Government Stopped CSR Payments In October 2017.

For 45 straight months—from the beginning of the CSR program in January 2014 until September 2017—the Government made timely CSR payments. (*Id.* ¶ 16.) During that period HHS took the view that Congress had permanently appropriated funding for CSR payments in 31 U.S.C. § 1324. *See U.S. House of Reps. v. Burwell*, 185 F. Supp. 3d 165, 174 (D.D.C. 2016), *vacated in part sub nom. U.S. House of Reps. v. Azar*, 14-cv-01967-RMC (D.D.C. May 18, 2018) (granting joint motion upon settlement). Thus, consistent with their contractual and statutory obligations, HHS and CMS made monthly CSR payments, including to CHC, on or about the 20th day of each month. (Janda Decl. ¶ 16.) They explained that this "fulfill[ed] the Secretary's obligation to make 'periodic and timely payments equal to the value of the reductions' under section 1402(c)(3) of the Affordable Care Act." 78 Fed. Reg. 15409, 15486 (Mar. 11, 2013).

That changed on October 12, 2017—just 10 days after CMS and CHC signed the 2018 QHP Issuer Agreement (*see* Janda Decl. Ex. B)—when the Government reversed course and declared in a memo from the Acting Secretary of HHS to the Administrator of CMS that "CSR

payments to issuers must stop, effective immediately." (Janda Decl. ¶ 17; Janda Decl. Ex. C.[7]) Soon after this announcement, CMS notified CHC that it would receive no further CSR payments in October or future payment cycles. (Janda Decl. Ex. C.) The purported reason for this change, according to the memo, was an opinion from the Attorney General that the permanent appropriation in 31 U.S.C. § 1324, "for refunding internal revenue collections as provided by law," does not cover CSR payments. (Janda Decl. Ex. C.) Since no other appropriation had been made, the White House Press Secretary issued a statement, saying that it would stop making the CSR payments, justifying its decision as follows:

> The bailout of insurance companies through these unlawful payments is yet another example of how the previous administration abused taxpayer dollars and skirted the law to prop up a broken system. Congress needs to repeal and replace the disastrous Obamacare law and provide real relief to the American people.[8]

Thus, the Government has not made any CSR payments to CHC since September 2017, and it has stated that it will not make future CSR payments either. (Janda Decl. ¶¶ 17, 18; Janda Decl. Ex. C.) Pursuant to Section 1402, CHC still provides CSRs to its insureds. (Janda Decl. ¶¶ 19, 20.) But without the required CSR payments from the Government, CHC has been left to bear this financial burden on its own. For 2017, the year-end CSR reconciliation process has been completed and shows that the Government has shorted CHC a total of $11,174,299.10 in CSR payments. (*Id.* at ¶ 19.) CMS has verified this amount. (*Id.*; Janda Decl. Ex. D.) For 2018, CHC has continued to provide CSRs for its insureds, but the Government has failed to make any CSR payments to CHC. (Janda Decl. ¶¶ 18, 20.)

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[7] This memo is publicly available at https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[8] Timothy Jost, *Administration's Ending of Cost-Sharing Reduction Payments Likely to Roil Individual Markets*, HeathAffairs.org (Oct. 13, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171022.459832/full/ (quoting White House press office statement).

V. Procedural Background.

CHC filed the original complaint in this case in January 2018, alleging that the Government failed to make a different set of payments required by the ACA: risk-corridors payments for 2014, 2015, and 2016. (*See generally* Dkt. 1.) Those claims are not the subject of this motion, as the Court stayed them pending the Federal Circuit's risk-corridors decisions in *Land of Lincoln Mutual Health Insurance Co. v. United States*, No. 17-1224, and *Moda Health Plan, Inc. v. United States*, No. 17-1994. (Dkt. 9.) The Federal Circuit reached a decision in *Land of Lincoln* and *Moda* on June 14, 2018. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018) (pet. for rehg. pending). CHC's risk-corridors claims remain stayed until the appellate process in *Moda* and *Land of Lincoln* is complete. (Dkt. 11.)

In February, the Court allowed CHC to amend its complaint to include CSR-related claims. (Dkt. 5–7.) The Court has since lifted the stay with respect to those claims and set a September 26 deadline for the Government to respond to them. (Dkt. 11). This motion is about those claims.

Recently, Judge Kaplan of this Court granted summary judgment for another insurer on an identical CSR statutory claim. *Mont. Health*, 2018 WL 4203938, at *1 ("[T]he government violated a statutory obligation created by Congress in the ACA when it failed to provide Montana Health its full cost-sharing reduction payments for 2017, and . . . Congress's failure to appropriate funds to make those payments did not vitiate that obligation.").[9]

ARGUMENT

The ACA plainly states that the Government "shall make periodic and timely payments to the issuer" for CSRs. The Government cannot wiggle out of that statutory requirement. The mere

[9] Judge Kaplan entered judgment for Montana Health on its statutory claim and did not address its implied-in-fact-contract claim. *Mont. Health*, 2018 WL 4203938, at *3 n.4.

failure by Congress to appropriate the necessary money does not repeal or annul the Government's legal obligation to pay, or this Court's ability to determine and enforce that obligation.

In addition to its statutory obligation to make CSR payments, the Government made an express contractual promise to make monthly CSR payments to CHC. This promise is contained in CHC's QHP Issuer Agreement with CMS. The Government is liable for breach of this express contract. Moreover, an implied-in-fact contract was formed by the conduct of the Government and CHC in implementing the ACA, working with each other on QHP offerings and contracts, and the Government's making 45 monthly CSR payments from 2014 through late 2017.

The Court should therefore grant summary judgment that the Government is liable to CHC for CSR payments.[10]

I. Legal Standard For Summary Judgment.

A party is entitled to summary judgment if "there is no genuine dispute as to any material fact and the [party] is entitled to judgment as a matter of law." RCFC 56(a). "A genuine dispute exists when 'the evidence is such that a reasonable jury could return a verdict for the nonmoving party.'" *8x8, Inc. v. United States*, 854 F.3d 1376, 1380 (Fed. Cir. 2017) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). "A material fact is one that 'might affect the outcome' of the case." *Id.* (quoting *Anderson*, 477 U.S. at 248).

Questions of statutory or contractual interpretation, as well as "other matters of law," may be decided on a motion for summary judgment. *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002); *Cal. Fed. Bank, FSB v. United States*, 245 F.3d 1342, 1346 (Fed. Cir. 2001). As to the existence of a contract, the Court should grant summary judgment when there is

[10] CHC presently moves for summary judgment as to liability only. CHC does not believe there will be any dispute as to the damages amount for 2017, but damages for 2018 are ongoing. Damages are discussed in this memorandum only insofar as damages are a required element of CHC's claims.

no genuine issue for trial. *See La Van v. United States*, 53 Fed. Cl. 290, 296 (2002), *aff'd*, 382 F.3d 1340 (Fed. Cir. 2004).

II. This Court Has Jurisdiction Over CHC's Claims Under The Tucker Act.

In *Montana Health*, Judge Kaplan held that this Court has jurisdiction over statutory CSR claims identical to those CHC asserts here.[11] *See* 2018 WL 4203938, at *4. Under the Tucker Act, this Court has jurisdiction to "render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States." 28 U.S.C. § 1491(a)(1). "The Tucker Act serves as a waiver of sovereign immunity and a jurisdictional grant, but it does not create a substantive cause of action." *Mont. Health*, 2018 WL 4203938, at *4 (citing *Jan's Helicopter Serv., Inc. v. Fed. Aviation Admin.*, 525 F.3d 1299, 1306 (Fed. Cir. 2008)). A separate source of law, therefore, must create a right to money damages. *Id.* (quoting *Jan's Helicopter Serv.*, 525 F.3d at 1306).

"[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." *Moda*, 892 F.3d at 1320 n.2 (quoting *Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007)). "The 'use of the word "shall" generally makes a statute money-mandating.'" *Mont. Health*, 2018 WL 4203938, at *4 (quoting *Greenlee Cty.*, 487 F.3d at 877). The statute at issue here, Section 1402 of the ACA, states that insurers "shall notify the Secretary of [cost-sharing] reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the

[11] Though not addressed in *Montana Health*, this Court also has jurisdiction over CHC's express and implied-in-fact contract claims. *Hercules Inc. v. United States*, 516 U.S. 417, 423 (1996) (quoting 28 U.S.C. § 1491(a)) ("The Tucker Act confers upon the [Court of Federal Claims] jurisdiction to hear and determine, *inter alia*, claims against the United States founded upon any 'express or implied' contract with the United States.").

reductions." 42 U.S.C. § 18071(c)(3)(A); *see also* 45 C.F.R. § 156.430(b)(1) (insurers "will receive periodic advance payments"). "These provisions supply money-mandating sources of law for purposes of establishing this Court's Tucker Act jurisdiction." *Mont. Health*, 2018 WL 4203938, at *4 (citing *Moda*, 892 F.3d at 1320–21, 1320 n.2 (holding that Section 1342 of the ACA is money mandating because it states that "[t]he Secretary shall establish and administer" a risk corridors program and that "the Secretary shall pay" an amount according to a statutory formula)).

In other CSR litigation, the Government has identified this Court as the proper forum for this claim. In *United States House of Representatives v. Burwell*, the Government asserted:

> Under the Tucker Act, a plaintiff may bring suit against the United States in the Court of Federal Claims to obtain monetary payments based on statutes that impose certain types of payment obligations on the government. If the plaintiff is successful, it 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.

Defendants' Memorandum in Support of Their Motion for Summary Judgment at 20, *U.S. House of Reps.*, 185 F. Supp. 3d 165 (No. 14-cv-01967-RMC), 2015 WL 9316243 (internal citations omitted).

This Court has jurisdiction under the Tucker Act over CHC's claim for monetary relief under Section 1402 of the ACA, as well as its claims for breach of express and implied-in-fact contract.[12]

[12] The *Montana Health* court further concluded that, contrary to the Government's argument that the suit should be dismissed because there is no cause of action for damages under Section 1402, "[p]laintiffs have never been required to make some separate showing that the money-mandating statute that establishes this court's jurisdiction over their monetary claims also grants them an express (or implied) cause of action for damages." 2018 WL 4203938, at *4 n.5; *see also Fisher v. United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005) ("If the court's conclusion is that the Constitutional provision, statute, or regulation meets the money-mandating test, the court shall declare that it has jurisdiction over the cause, and shall then proceed with the case in the normal course. . . . [T]he determination that the source is money-mandating shall be determinative both as

III. The Government Has Transparently Violated The CSR Statute.

A. The ACA Plainly Requires CSR Payments.

The ACA's plain language requires the Government to make CSR payments to insurers like CHC: "the Secretary ***shall make*** periodic and timely payments to the issuer equal to the value of the [cost-sharing] reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added). "The determination of a statute's meaning begins (and often ends) with its language. Where 'Congress has expressed its intention by clear statutory language, that intention controls and must be given effect.'" *Mont. Health*, 2018 WL 4203938, at *5 (quoting *Rosete v. OPM*, 48 F.3d 514, 517 (Fed. Cir. 1995)). "That is, where 'statutory language is clear and unambiguous, the inquiry ends with the plain meaning.'" *Id.* (quoting *McGee v. Peake*, 511 F.3d 1352, 1356 (Fed. Cir. 2008)).

Judges of this Court and others have consistently interpreted Section 1402 to "clearly and unambiguously impose[] an obligation on the Secretary of HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans as required by the ACA." *Id.* at *5. In addition to Judge Kaplan's detailed analysis in *Montana Health*, here is how courts have described the CSR requirement:

- "[T]he Affordable Care Act requires the federal government to pay insurance companies to cover the cost-sharing reductions. The federal government is failing to meet that obligation." *California v. Trump*, 267 F. Supp. 3d at 1133.
- "As set forth in the statute, insurers offering qualified health plans are required to reduce eligible individuals' cost-sharing obligations by specified amounts, and the Secretary of HHS and/or the Treasury Secretary is required to reimburse the insurers for the cost-sharing reductions they made." *Common Ground Healthcare Coop. v. United States*, 137 Fed. Cl. 630, 635 (2018) (citation and footnote omitted).
- "Section 1412 of the ACA requires . . . eligibility determinations [to be] made in advance [for] . . . the cost-sharing reductions under section 1402. [Then] Treasury makes . . . reductions to the issuers of the qualified health plans [on such Exchange] in order to reduce the premiums payable." *U.S. House of Reps.*, 185 F. Supp. 3d at 172.

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to the question of the court's jurisdiction and thereafter as to the question of whether, on the merits, plaintiff has a money-mandating source on which to base his cause of action.").

The Federal Circuit's recent decision *Moda* decision reinforces this conclusion. *See Mont. Health*, 2018 WL 4203938, at *5. In *Moda* the Court of Appeals held that ACA Section 1342's command—that the Secretary "shall pay" risk-corridors payments—is "unambiguously mandatory." 892 F.3d at 1320. Although the ACA's risk corridors are modeled on Medicare Part D's risk corridors, the Federal Circuit found it "immaterial" that the ACA does not "provide 'budget authority in advance of appropriations acts,' as in the corresponding Medicare statute." *Id.* at 1322. The risk corridors payment obligation was "created by the statute itself, not by the agency." *Id.* ("[A rule that a statutory obligation cannot exist absent budget authority] would be inconsistent with [*United States v.*] *Langston*, [118 U.S. 389, 393 (1886),] where the obligation existed independent of any budget authority and independent of a sufficient appropriation to meet the obligation."). Therefore, "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 statute here uses mandatory language indistinguishable from *Moda*: "the Secretary shall make . . . payments," 42 U.S.C. § 18071(c)(3)(A), and "shall make . . . advance payment," *id.* at § 18082(c)(3). "[T]he statutory language clearly and unambiguously imposes an obligation on the Secretary of HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans as required by the ACA." *Mont. Health*, 2018 WL 4203938, at *5. When Congress speaks so clearly, the task of interpretation "begins with the statutory text, and ends there as well." *Nat'l Ass'n of Mfrs. v. Dep't of Defense*, 138 S. Ct. 617, 631 (2018). The ACA plainly creates a legal obligation for the Government to pay CSRs to qualifying insurers.

B. Any Failure To Appropriate Funds To Make CSR Payments Does Not Vitiate The Government's Payment Obligation.

The Government has suggested in other cases that a statutory command that it "shall make" payments means nothing unless a later Congress appropriates the money. That is profoundly wrong. Initially, the question is still open whether Congress actually has appropriated funds for CSR payments.[13] Regardless of the answer to that question, however, overwhelming precedent, our long constitutional tradition, and sound policy dictate that the Government's statutory obligations do not vanish just because Congress neglects to appropriate money to perform them.

First, the Government's suggestion is "completely contrary to a mountain of controlling case law holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation." *Molina Healthcare of Cal., Inc. v. United States*, 133 Fed. Cl. 14, 36 (2017) (citing *Lopez v. Davis*, 531 U.S. 230, 241 (2001); *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998); *Gilda Indus., Inc. v. United States*, 622 F.3d 1358, 1363 (Fed. Cir. 2010)); *see also Moda*, 892 F.3d at 1321 ("[I]t has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances."); *Amgen Inc. v. Apotex Inc.*, 827 F.3d 1052, 1061 (Fed. Cir. 2016), *cert. denied*, 137 S. Ct. 591 (2016); *Mont. Health*, 2018 WL 4203938, at *5. Mere Congressional silence as to an appropriation—which is all the Government can point to

[13] *See Mont. Health*, 2018 WL 4203938, at *6–8 (making no findings and addressing no argument on whether there had been an appropriation while concluding that the lack of an appropriation did not change the Government's obligation to make CSR payments); *California v. Trump*, 267 F. Supp. 3d 1119, 1127–28 (N.D. Cal. 2017) (denying a preliminary injunction and concluding that "it initially appears the Administration has the stronger legal position" on "whether Congress has appropriated money for the CSR payments," but noting that "both sides have reasonable arguments"); *U.S. House of Reps.*, 185 F. Supp. 3d at 168 (concluding that Section 1402 could not be funded through the permanent appropriation for tax credits in Section 1401 of the ACA), *vacated in part sub nom. U.S. House of Reps. v. Azar*, 14-cv-01967-RM (D.D.C. May 18, 2018) (granting joint motion upon settlement).

here—has never been held to repeal or amend the authorizing statute that required payment in the first place. Indeed, this Court has long rejected that view:

> It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute . . . . The failure to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims.

N.Y. Airways, Inc. v. United States, 369 F.2d 743, 748 (Ct. Cl. 1966) (citations omitted).

Second, well-established practice confirms this. Congress has created many "appropriated entitlements"—permanent legal requirements for Government payments "whose source of funding is in an annual appropriation act." *A Glossary of Terms Used in the Federal Budget Process*, U.S. Gov't Accountability Off., 13 (2015), https://www.gao.gov/assets/80/76911.pdf (listing Veterans' compensation and Medicaid as examples). And it is well recognized that "if Congress does not appropriate the money necessary to fund the payments" for such programs, "eligible recipients may have legal recourse" based on the permanent statute that requires the payments. *Id.*; *see also Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) ("[T]he jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid.") So even if there has been no current appropriation for CSR payments, that simply means that the program is set up the same way as others have been: the obligation to pay exists independently of whether an appropriation occurs, and that obligation is enforceable in court.

Third, sound policy supports this rule and practice: The Government's upside-down reading of the word "shall" would cripple Congress's ability to obtain private-sector assistance in implementing statutory programs. When Congress wants to encourage certain activity, it often enacts a statute requiring Government payments to private parties who engage in that activity. But

that works only if private parties can trust that "shall pay," in a statute, means "shall pay." The Government here seeks the opposite outcome. Citizens will be forced to read "shall pay" as meaning "shall *not* pay unless a later Congress passes an appropriation." That will dramatically undermine the incentive to engage in the activity that Congress is trying to encourage.

This is fully consistent with the Federal Circuit's recent *Moda* decision. There, after the Court of Appeals found a statutory payment obligation as described above, it held Congress later suspended that obligation *by passing a statute*. 892 F.3d at 1329 ("[A]ppropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program."). Whether or not that is a correct interpretation of the later statute,[14] it at least is consistent with the basic constitutional principle: when a statute requires the Government to do something, that obligation normally can be wiped out only by another statute that amends or repeals the obligation. But the Government can point to no such statute here. Congress enacted a law that says the Government "shall make" payments—and then *did nothing else*. The *Moda* court's reasoning compels judgment in favor of CHC in the context of CSRs.

Indeed, Judge Kaplan in *Montana Health* correctly described the CSR legal landscape as being more like *United States v. Langston*, 118 U.S. 389 (1886). 2018 WL 4203938, at *6–7. In *Langston*, the Supreme Court held that a salary fixed by statute "should not be deemed abrogated or suspended by subsequent enactments which merely appropriate a less amount." 118 U.S. at 394. Judge Kaplan contrasted that with *United States v. Mitchell*, on which the Federal Circuit relied in *Moda*. In *Mitchell* the Supreme Court held that a salary statute had been implicitly amended by subsequent appropriations bills where Congress's intent was "plain upon the face of the statute." 109 U.S. 146, 150. Here, in even starker contrast, there is no subsequent enactment at

[14] A petition for rehearing is currently pending in *Moda*. CHC regards *Moda* as wrongly decided regarding its interpretation of the effect of the later appropriations statutes.

all. "All that exists is the payment obligation spelled out by the plain language of § 1402 and the 'bare failure to appropriate funds' that the Supreme Court found insufficient to establish the congressional intent necessary to vitiate a statutory payment obligation in *Langston*." *Mont. Health*, 2018 WL 4203938, at *7 (quoting *Moda*, 892 F.3d at 1323). In short, Congress created a statutory obligation to make CSR payments and then took no further action to alter that obligation, and such silence has never been sufficient to change existing law.

In related litigation, the Government has seemingly acknowledged the view that a statutory mandate to pay continues even if there is no appropriation for it. Before the Government stopped making CSR payments, the House of Representatives sued to stop them based on an alleged lack of appropriations, and the Government stated the following:

- If there is no appropriation, insurers "could bring damages actions under the Tucker Act premised on the government's failure to make the mandatory cost-sharing reduction payments that the Act requires." Defendants' Memorandum in Opposition to Plaintiff's Motion for Summary Judgment at 12–13, *U.S. House of Reps.*, 185 F. Supp. 3d 165 (No. 14-cv-01967-RMC), 2016 WL 452190.

- If the ACA contains no permanent appropriation for CSR payments (as the Government now contends), then it "would require the government to make the cost-sharing payments but provide no appropriation for doing so," and the Government could not "avoid Tucker Act litigation" if "the ACA did not permanently fund the cost-sharing reduction payments that the Act directs the government to make." Defendants' Reply Memorandum in Support of Their Motion for Summary Judgment at 9, *U.S. House of Reps.*, 185 F. Supp. 3d 165 (No. 14-cv-01967-RMC), 2016 WL 836055 (quoting *Greenlee Cty.*, 487 F.3d at 877).

In sum, the ACA creates a legal obligation on the part of the Government to make CSR payments. Unlike in *Moda*, here there is no dispute that nothing has happened to repeal or suspend that obligation, so the Government must make the payments.

C. The Government's "Periodic," "Timely," And "Advance" CSR Payments Are Long Since Due.

The CSR payments are not only required by law, but also well overdue. Section 1412 of the ACA requires that the Secretary of the Treasury "shall make" the CSR payments *in advance*.

42 U.S.C. § 18082(c)(3). As explained above, cost-sharing payments are amounts that a patient herself ordinarily is required to pay to her provider. The ACA reduces this for certain moderate-income patients, by requiring the Government to pay a portion of their cost-sharing amounts to the insurer in a "periodic," "timely" and "in advance" fashion, and by then requiring the insurer to remit those funds to health-care providers. 42 U.S.C. §§ 18071(a)(2), 18071(c)(3)(A); *see also Mont. Health*, 2018 WL 4203938, at *2.

In this context, it is abundantly clear what it means for payments to be "advance" and "timely": insurers do not have to front the cost of the reduction by paying the doctor first, and then waiting to recoup the money from the Government after-the-fact. Instead, the statute requires the Government to make "advance" payments to insurers—which can only mean before the insurer is required to pay the expense.

The Government has not done that. Since October 2017, CHC has continued to pay health-care providers the additional amounts it is required to pay by the CSR statute. But the Government has not paid anything. This is the opposite of "advance" and "timely" payments. By the plain terms of the statute, these payments are long past due, and more are coming due each month.

In summary, the ACA indisputably requires CSR payments. And the Government admittedly has stopped making those payments. Lack of appropriations may be the *reason* for the Government's failure to meet its legal obligation—but it is not an *excuse* that would allow the Government to avoid liability in this Court. There are no disputes regarding the material facts on CHC's claim as to liability, and CHC is entitled to judgment for its CSR payments as a matter of law. The Court should grant summary judgment as to liability for CHC on its statutory claim, with damages to be addressed in further proceedings.

IV. The Government Has Breached Its Express Contractual Promise To Make Monthly CSR Payments To CHC.

The parties' express contract also requires the Government to make CSR payments. Under the section "CMS Obligations," it provides: "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [CHC] against amounts owed to CMS by [CHC] in relation to offering of QHPs . . . including . . . advance payments of CSRs." (Janda Decl. Ex. A, § III.b.) The Government honored that promise until September 2017—but it has not included CSR payments in its monthly reconciliation process since then. The Government has thus breached its contract with CHC.[15]

A. The Government Has Violated Its Express Promise In The QHP Issuer Agreement.

The parties' QHP Issuer Agreement provides that the Government is obligated to make CSR payments. "Determining the obligation or duty that arises out of a contract 'is a legal question of contract interpretation,'" that "is 'generally amenable to summary judgment.'" *Kogan v. United States*, 112 Fed. Cl. 253, 264 (2013) (citations omitted) (quoting *San Carlos Irr. & Drainage Dist. v. United States*, 877 F.2d 957, 959 (Fed. Cir. 1989) and *Varilease Tech. Grp., Inc. v. United States*, 289 F.3d 795, 798 (Fed. Cir. 2002)). "[T]he intention of the parties to a contract control[s] its interpretation," *id.* (quoting *Beta Sys., Inc. v. United States*, 838 F.2d 1179, 1185 (Fed. Cir. 1988)), and that intention "must, in the first instance, be derived from the language of the contract," *id.* (quoting *Nicholson v. United States*, 29 Fed. Cl. 180, 194 (1993)). "The plain language of the contract will be viewed as controlling if it is unambiguous on its face." *Id.* (citing *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1040–41 (Fed. Cir. 2003) (en banc)). The contractual language "'must be given that meaning that would be derived from the contract by a

[15] Although there are several other cases addressing CSRs under the ACA pending in this Court, no other case includes a claim based on an express contract.

reasonably intelligent person acquainted with the contemporaneous circumstances.'" *Id.* (quoting *TEG–Paradigm Envtl., Inc. v. United States*, 465 F.3d 1329, 1338 (Fed. Cir. 2006).

The QHP Issuer Agreement explicitly states that the parties are entering into the Agreement "to memorialize [their] duties and obligations," (Janda Decl. Ex. A 1, ¶ 4), and that "[i]t is anticipated that periodic . . . advance payments of CSRs[16] . . . will be due between CMS and QHPI [CHC]," (*id.* 1, ¶ 3). In a section entitled "CMS Obligations," the Agreement further states that "[a]s part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI in relation to offering of QHPs . . . , including the following types of payments: . . . advance payments of CSRs . . . ." *Id.* § III.b. These contract provisions are unambiguous and evidence the parties' intent that CMS would be obligated to make CSR payments.[17]

The Government has failed to make any CSR payments to CHC since October 2017, much less "advance payments of CSRs" "as part of a monthly payments and reconciliation process," and thus has breached the contract. In addition, the fact of damages is undisputed: CHC is contractually entitled to receive payments that it has not received. Both CHC and CMS have stated that the Government has shorted CHC $11,174,299.10 in CSR payments for 2017 alone. (Janda Decl. ¶ 19; Janda Decl. Ex. D.)

B. The QHP Issuer Agreement Is A Binding Contract.

The QHP Issuer Agreement is a binding contract. The requirements for a binding contract with the United States are (1) mutual intent to contract, (2) offer and acceptance, (3) consideration, and (4) execution or ratification by a Government representative with actual authority to bind the

[16] "CSR" is defined in the Agreement as having "the meaning set forth in 45 CFR 155.20" (Janda Decl. Ex. A § I.i.), one of the regulations implementing the ACA.

[17] CHC met the requirements for CSR payments by offering and delivering QHPs that conformed to all statutory, regulatory and contractual requirements. (Janda Decl. ¶ 8.)

United States. *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997); *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995). All are easily satisfied here.

1. There Was Mutual Intent To Contract And Offer And Acceptance Of The Contract By CHC And The United States.

"As a threshold condition for contract formation, there must be an objective manifestation of voluntary, mutual assent. To satisfy its burden to prove such a mutuality of intent, a plaintiff must show, by objective evidence, the existence of an offer and a reciprocal acceptance." *Anderson v. United States*, 344 F.3d 1343, 1353 (Fed. Cir. 2003) (citations omitted). The QHP Issuer Agreement itself is such objective evidence: it states that "QHPI [CHC] and CMS are entering into this Agreement to memorialize the duties and obligations of the parties." (Janda Decl. Ex. A 1, ¶ 4.) The QHP Issuer Agreement is plainly an offer, and its execution by both parties shows reciprocal acceptance. *See Davis Wetlands Bank, LLC v. United States*, 114 Fed. Cl. 113, 121 (2013) (quoting *Anderson*, 344 F.3d at 1353) (concluding that an agreement that "contains definite terms and recites the obligations contained and acceptance manifested by the signatures from [representatives of the parties]" showed offer and acceptance sufficient to form a contract).

2. There Was Consideration By CHC And The United States.

"Consideration is a bargained-for performance or return promise." *Molina*, 133 Fed. Cl. at 42 (citing Restatement (Second) of Contracts § 71). The QHP Issuer Agreement memorializes promises on the part of both parties. First, it states generally that the parties agree to the terms "in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge." (Janda Decl. Ex. A 1.) Second, its sets forth specific promises by, and obligations for, each party. (*See, e.g.*, *id.* § II.b ("QHPI hereby acknowledges and agrees to accept and abide

by the standard rules of conduct set forth herein . . . ."); *id.* § III.a ("CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions.").)

3. The CMS Representatives Who Entered Into The Agreement Had Actual Authority To Bind The United States.

Either express actual authority or implied actual authority can bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). The QHP Issuer Agreement is signed by CMS representatives Kevin J. Counihan, Marketplace CEO, and Acting CIO George C. Hoffmann. (Janda Decl. Ex. A 10 (containing two signature pages paginated as 10).) As the Marketplace Chief Executive Officer and Director, Mr. Counihan was responsible for managing the federal exchanges.[18] QHPIs are integral to the federal exchanges. 45 C.F.R. § 155.260(b)(2). Further, the QHP Issuer Agreement expressly states that "[t]he undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement." (Janda Decl. Ex. A 10 (containing two signature pages paginated as 10).) The CMS officials who signed the Agreement with CHC had actual authority to bind the Government. Alternatively, Mr. Counihan had implied authority to bind the Government. Authority is implied when it is "considered to be an integral part of the duties assigned to a government employee." *H. Landau & Co.*, 886 F.2d at 324 (citation omitted).

Moreover, HHS ratified the Agreement by its subsequent CSR payments. "Ratification is the affirmance by a person of a prior act which did not bind him but which was done or professedly done on his account, whereby the act, as to some or all persons, is given effect as if originally authorized by him." *Telenor Satellite Servs., Inc. v. United States*, 71 Fed. Cl. 114, 120 (2006) (internal quotations omitted) (quoting *Schism v. United States*, 316 F.3d 1259, 1289 (Fed. Cir. 2002)). "Ratification can only occur if the person with authority has knowledge of the activity."

[18] Press Release, U.S. Department of Health & Human Services, *HHS and CMS Announce New Members of the Management Team Ahead of 2015 Open Enrollment* (Aug. 26, 2014).

Id. (citing *Schism*, 316 F.3d at 1289). The Secretary of HHS had actual authority to contract, as agency heads have contract-making authority "by virtue of their position," FAR 1.601(a). Further, Section 1402 directs that the Secretary "shall establish" the CSR program, and the Secretary has wide-reaching authority and obligation to implement and administer the ACA. *See, e.g.*, 42 U.S.C. § 18022(b)(1) (Secretary shall define essential health benefits); § 18031(c) (outlining responsibilities of the Secretary with respect to exchanges); § 18081(a) (Secretary shall establish program for determining eligibility for various provisions). The Secretary knew of the CSR payments, as the payments came from HHS via CMS and extended over several years (Janda Decl. ¶¶ 16, 17), and the Secretary admitted in late 2015 in *United States House of Representatives v. Burwell* that the payments began in January 2014 and continued. Answer ¶ 35, *U.S. House of Reps.*, 185 F. Supp. 3d 165 (No. 14-cv-01967-RMC), 2015 WL 7069900 ("[A]dmit that the Secretary of the Treasury began making advance payments of cost-sharing reductions, as required under Section 1412 of the [ACA] in January 2014, and has continued to make such advance payments since that date."). By making the CSR payments to CHC, the Secretary ratified the Agreement and bound the Government to fulfill the Agreement's CSR payment obligations.

For the reasons stated, CHC is entitled to receive, and the Government is obligated to pay, CSR payments under its 2017 and 2018 contracts. The Court should therefore grant summary judgment as to liability for CHC on its breach of contract claim, and CHC will address damages in further proceedings.

V. The Government Has Breached Its Implied-In-Fact Contractual Obligation To Make CSR Payments.

In the alternative, CHC entered into a valid implied-in-fact contract with the Government that included CSR payments.[19] The requirements for a binding implied-in-fact contract with the United States are similar to those for an express contract: mutuality of intent, offer and acceptance, consideration, and actual authority in the Government representative to bind the United States. *Trauma Serv. Grp.*, 104 F.3d at 1325. "An implied-in-fact agreement must be 'founded upon a meeting of the minds, which, although not embodied in an express contract, is inferred, as a fact, from conduct of the parties showing, in the light of the surrounding circumstances, their tacit understanding.'" *Id.* at 1326 (quoting *Hercules Inc.*, 516 U.S. at 424); *see also Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986) (implied-in-fact contract "is not created or evidenced by explicit agreement of the parties, but is inferred as a matter of reason or justice from the acts or conduct of the parties").

There was a meeting of the minds between the Government and CHC regarding CSR payments: the parties understood that CHC would issue QHPs, the Government would make advance payments of CSRs to CHC for eligible insureds, and CHC would provide CSRs to those insureds. This mutuality of intent to contract is inferred, first, by the Government's enactment of Sections 1402 and 1412, which direct the Secretaries of HHS and Treasury to make CSR payments in specific sums to QHPIs. The statutes show that the Government intended to make CSR payments to QHPIs, and the Government, having certified CHC as a QHPI (Janda Decl. ¶ 3; Janda Decl. Ex. A), understood that CHC intended to provide CSRs to eligible individuals.

[19] Other cases addressing CSR payments under the ACA have pled implied-in-fact contract claims, but no decisions have yet been rendered on those claims. *See Mont. Health*, 2018 WL 4203938, at *3 n.4 (declining to reach contract claim in light of favorable disposition of plaintiff's statutory claim).

Second, mutuality of intent is evidenced by the QHP Issuer Agreement. Even if it were not a binding contract, the Agreement still shows a meeting of the minds. The parties said that they "anticipated that periodic . . . advance payments of CSRs . . . will be due between CMS and QHPI [CHC]," (Janda Decl. Ex. A 1, ¶ 3), that "advance payment of CSRs" would be included in the monthly reconciliation process (*id.* § III.b), and that CHC "has developed its products for the [exchange] based on the assumption that . . . CSRs will be available to qualifying Enrollees," (*id.* § V.b). And, the Government's CSR payments to CHC for 45 months show that the parties mutually understood their CSR obligations.

In *Radium Mines, Inc. v. United States*, federal law set a "Guaranteed Minimum Price" with the "purpose . . . to induce persons to find and mine uranium" and proscribed how to make an offer. 153 F. Supp. 403, 405–06 (Ct. Cl. 1957). If a person's offer met the conditions set forth, the "Commission will forward to the person making the offer a form of contract," and then pay the person as described in the regulation. *Id.* at 405.

Here, the ACA mandates that the Government bear the financial burden of CSRs. Insurers agreed to participate in the federal exchanges on the understanding that this mandate would be followed. Further, like in *Radium Mines*, insurers entered into contracts with the Government in the form of QHP Issuer Agreements, which included as a term that the Government would make advance payments of CSRs as part of a monthly reconciliation process.[20] The court's reasoning in *Radium Mines* that "no one could have prudently engaged in its production unless he was assured

[20] In *Moda*, the Federal Circuit reversed the judgment on the implied-in-fact contract claim, concluding that "no statement by the government evinced an intention to form a contract." *Moda*, 892 F.3d at 1330. As with the issue of the effect of lack of appropriations for the statutory claim, *Moda*'s reasoning is inapplicable to the CSR program, because here, the Government's intention to form a contract was evinced in the QHP Issuer Agreements, which included the Government's obligation to make monthly advance payments of CSRs. The Agreements show that offering QHPs on the exchanges and receiving CSR payments was "the traditional quid pro quo contemplated in *Radium Mines*." *Id.*

of a Government market," 153 F. Supp. at 406, applies equally here: like the radium ore, the QHP is a product custom-made for the federal exchange. So the ACA's provisions regarding CSR payments constituted "an offer, which ripened into a contract when it was accepted by [CHC]'s putting itself in a position to supply the [QHPs] described in it." *Id.*

In addition to mutual intent to contract, there was offer and acceptance. CHC accepted the Government's offer by agreeing to become a QHP Issuer and by participating in the Texas Health Insurance Exchange, selling ACA-qualified plans to insureds eligible for CSRs, and complying with all relevant statutes and regulations. (Janda Decl. ¶¶ 4, 6–8, 12.) These same features were the consideration on the part of CHC, while the CSR payments, made under the authority of HHS, were consideration on the part of the Government. The parties' agreement is further confirmed by their execution of QHP Issuer Agreements expressly incorporating "the laws and common law of the United State of America" and by the Government's consistent performance of its obligation to make full and timely CSR payments until October 2017.

As described above regarding the express contract, the HHS Secretary and CMS officials had either express or implied-in-fact authority to bind the Government, and the contract was additionally ratified by the Government. The implied-in-fact contract was authorized by representatives who had actual authority to bind the United States and was entered into with mutual assent and consideration by both parties.

By terminating CSR payments, the Government has breached its implied-in-fact contract with CHC, and CHC has suffered damages as a result. The Court should grant summary judgment on liability in favor of CHC on its breach of implied-in-fact contract claim, with damages to be determined in further proceedings.

CONCLUSION

The Court should grant summary judgment in favor of CHC as to liability on all counts.

Dated: September 26, 2018

s/ William L. Roberts

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CERTIFICATE OF SERVICE

I hereby certify that on September 26, 2018, a copy of the foregoing Plaintiff's Motion for Summary Judgment and Memorandum of Law in Support was filed electronically with the Court's Electronic Case Filings (ECF) system. I understand that notice of this filing will be sent to all parties by operation of the Court's ECF system.

s/ William L. Roberts
William L. Roberts