IN THE UNITED STATES COURT OF FEDERAL CLAIMS

Nancy G. Atkins, in her capacity as Liquidator of Kentucky Health Cooperative, Inc., Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 17-906C Judge Elaine D. Kaplan

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

Plaintiff, on behalf of Kentucky Health Cooperative, Inc., ("Plaintiff" or "KYHC") respectfully submits this Motion for Summary Judgment and Memorandum of Law in Support of its complaint for damages against the Defendant, the United States of America ("Government"), acting through the Centers for Medicare & Medicaid Services ("CMS") (and CMS's parent agency, the U.S. Department of Health and Human Services ("HHS")).

TABLE OF CONTENTS

INTRODUCTION 1

STATEMENT OF THE ISSUE 3

STATEMENT OF RELEVANT BACKGROUND 4

I. THE ACA CREATED EXCHANGES IN AN EFFORT TO PROVIDE AFFORDABLE HEALTHCARE TO PREVIOUSLY UNDERINSURED AND UNINSURED POPULATIONS. 4

II. CONGRESS CREATED THE RCP INTENTIONALLY AS AN INCENTIVE TO DRAW ENTITIES SUCH AS KYHC INTO THE MARKETPLACE. 5

III. KYHC WAS A QHP ISSUER THAT PARTICIPATED IN THE KENTUCKY EXCHANGE. 7

IV. KYHC OFFERED PREMIUMS RELYING ON THE RCP AS A MITIGATOR OF MARKET INSTABILITY. 8

V. THE GOVERNMENT'S POSITION ON ITS RISK CORRIDORS OBLIGATIONS HAS FLUCTUATED AND IS INCONSISTENT WITH THE ACA. 8

STATEMENT OF UNDISPUTED MATERIAL FACTS 11

JURISDICTION 14

SUMMARY OF ARGUMENT 16

SUMMARY JUDGMENT STANDARD 19

ARGUMENT 20

I. THE GOVERNMENT IS LIABLE FOR ITS FAILURE TO MAKE RCP PAYMENTS UNDER A MONEY-MANDATING STATUTE (COUNT I). 20

A. Section 1342 Requires RCP Payments to Be Made Annually and in Full, Without Regard to Budget Neutrality. 20

1. Congress Intended QHP Issuers to Receive Full Payment. 21

2. Congress Intended QHP Issuers to Receive or Remit Timely Annual Payments. 26

a) The Text and Structure of the ACA Requires Annual RCP Payments 26

b) Originally, HHS Correctly Interpreted the RCP to Require Timely Annual Payments Be Made to QHP Issuers. 28

B. The Government's Liability Does Not Depend on a Dedicated Source of Funding for That Liability. 31

1. The Government's Liability Does Not Turn on the Availability of a Specific Appropriation. 31

2. In Any Event, Appropriations Were Available for CMS to Incur RCP Obligations. 34

3. The 2015 and 2016 Appropriations Acts Did Not Nullify or Modify the Government's RCP Obligations. 36

a) Congress Has Not Amended the RCP. 37

b) Congress's Silence Should Not Be Construed as a Repeal. 41

II. THE GOVERNMENT IS LIABLE FOR BREACH OF IMPLIED-IN-FACT CONTRACT (COUNT II). 42

A. The Government Breached an Implied-in-Fact, *Unilateral* Contract with KYHC. 42

1. There Was Mutuality of Intent to Contract. 42

2. KYHC Accepted the Government's Offer, and the Condition Precedent to Payment Was Satisfied. 45

3. There Was Consideration. 46

4. The Secretary of HHS Had Actual Authority to Contract. 46

B. The Government Breached an Implied-in-Fact *Bilateral* Contract with KYHC. 49

III. THIS COURT CAN AND SHOULD GRANT KYHC THE RELIEF SOUGHT. 51

CONCLUSION 52

TABLE OF AUTHORITIES

Page(s)

Cases

Ace-Fed. Reporters, Inc. v. Barram,
226 F.3d 1329 (Fed. Cir. 2000).....46

Agwiak v. United States,
347 F.3d 1375 (Fed. Cir. 2003).....15

Anderson v. Liberty Lobby, *Inc.*,
477 U.S. 242 (1986).....20

Arcadia v. Ohio Power Co.,
498 U.S. 73 (1990).....27

Army & Air Force Exch. Serv. v. Sheehan,
456 U.S. 728 (1982).....43

ARRA Energy Co. I v. United States,
97 Fed. Cl. 12 (2011).....25, 42

Aycock-Lindsey Corp. v. United States,
171 F. 2d 518 (5th Cir. 1948).....45

Baker v. United States,
50 Fed. Cl. 483 (2001).....43, 45

Blanchette v. Conn. Gen. Ins. Corps.,
419 U.S. 102 (1974).....40, 41

Blue Cross & Blue Shield of N.C. v. United States,
131 Fed. Cl. 457 (2017).....16

Bob Jones Univ. v. United States,
461 U.S. 574 (1983).....18, 30

Brown v. Gardner,
513 U.S. 115 (1994).....21

California v. United States,
271 F.3d 1377 (Fed. Cir. 2001).....47, 48

Castillo v. United States,
530 U.S. 120 (2000).....25

Collins v. United States,
15 Ct. Cl. 22 (1879) 32, 51

Dakota, Minn. & E. R.R. Corp. v. Schieffer,
648 F.3d 935 (8th Cir. 2011) 27

District of Columbia v. United States,
67 Fed. Cl. 292 (2005) 32, 39

Doe v. United States,
100 F.3d 1576 (Fed. Cir. 1996).....15

Engel v. Davenport,
271 U.S. 33 (1926).....22

Fisher v. United States,
402 F.3d 1167 (Fed. Cir. 2005).....14, 15

Fluor Enters., Inc. v. United States,
64 Fed. Cl. 461 (2005) 18, 30

Gibney v. United States,
114 Ct. Cl. 38 (1949) ..... *passim*

Global Computer Enters. v. United States,
88 Fed. Cl. 350 (2009) 18, 30

Greenlee Cty., Ariz. v. United States,
487 F.3d 871 (Fed. Cir. 2007).....15, 24, 37, 38

H. Landau & Co. v. United States,
886 F.2d 322 (Fed. Cir. 1989).....46, 47, 49

Health Republic Ins. Co. v. United States,
129 Fed. Cl. 757 (2017) 16, 29

Hercules, Inc. v. United States,
516 U.S. 417 (1996).....43

Jan's Helicopter Serv., Inc. v. FAA,
525 F.3d 1299 (Fed. Cir. 2008).....15

John Reiner & Co. v. United States,
325 F.2d 438 (Ct. Cl. 1963) 48

Johnson v. United States,
80 Fed. Cl. 96 (2008) 20

King v. Burwell,
135 S. Ct. 2480 (2015) 17, 18, 29, 30

Kyer v. United States,
369 F.2d 714 (Ct. Cl. 1966), *abrogated by Slattery*, 635 F.3d 1298 (Fed. Cir. 2011) 32

La Van v. United States,
53 Fed. Cl. 290 (2002), *aff'd*, 382 F.3d 1340 (Fed. Cir. 2004) 20

Land of Lincoln Mut. Health Ins. Co. v. United States,
129 Fed. Cl. 81 (2016) 16, 22, 23

Landgraf v. USI Film Prod.,
511 U.S. 244 (1994) 40

Lewis v. United States,
70 F.3d 597 (Fed. Cir. 1995) 42

Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach,
523 U.S. 26 (1998) 16, 21

Lopez v. Davis,
531 U.S. 230 (2001) 21

Lorillard v. Pons,
434 U.S. 575 (1978) 22

Lucas v. United States,
25 Cl. Ct. 298 (1992) 45

McCarthy v. Bronson,
500 U.S. 136 (1991) 24-25

Metro. Stevedore Co. v. Rambo,
515 U.S. 291 (1995) 18, 27

Mitchell v. United States,
463 U.S. 206 (1983) 33

Moda Health Plan, Inc., v. United States,
130 Fed. Cl. 436 (2017) ..... *passim*

N.Y. Airways v. United States,
369 F.2d 743 (Ct. Cl. 1966) ..... *passim*

Nat'l Educ. Ass'n.-R.I. v. Ret. Bd. of R.I. Emps.' Ret. Sys.,
890 F. Supp. 1143 (D.R.I. 1995) 43

Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.,
470 U.S. 451 (1985).....43

Nat'l Rural Util. Coop. Fin. Corp. v. United States,
14 Cl. Ct. 130 (1988).....43

Nevada v. Dep't of Energy,
400 F.3d 9 (D.C. Cir. 2005).....47

Prairie Cty., Mont. v. United States,
113 Fed. Cl. 194 (2013), *aff'd*, 782 F.3d 685 (Fed. Cir. 2015).....24, 37

Price v. Panetta,
674 F.3d 1335 (Fed. Cir. 2012).....32

Prudential Ins. Co. of Am. v. United States,
801 F.2d 1295 (Fed. Cir. 1986).....43

Radium Mines Inc. v. United States,
153 F. Supp. 403 (Ct. Cl. 1957).....43, 45, 47

Ransom v. FIA Card Servs., N.A.,
562 U.S. 61 (2011).....20

Salazar v. Ramah Navajo Chapter,
132 S. Ct. 2181 (2012).....24, 34

Santa Fe Pac. R. Co. v. United States,
294 F.3d 1336 (Fed. Cir. 2002).....20

Sale v. Haitian Ctrs. Council, Inc.,
509 U.S. 155 (1993).....23

Sharp v. United States,
580 F.3d 1234 (Fed. Cir. 2009).....23

Silverman v. U.S.,
230 Ct. Cl. 701 (1982).....50

Slattery v. United States,
635 F.3d 1298 (Fed. Cir. 2011) (*en banc*).....*passim*

Todd v. United States,
386 F.3d 1091 (Fed. Cir. 2004).....15

Trilon Educ. Corp. v. United States,
578 F.2d 1356 (Ct. Cl. 1978).....48

TVA v. Hill,
437 U.S. 153 (1978).....37, 41

U.S. Trust Co. of N.Y. v. New Jersey,
431 U.S. 1 (1977).....43

United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.,
484 U.S. 365 (1988).....24

United States v. Fausto,
484 U.S. 439 (1988).....37

United States v. Langston,
118 U.S. 389 (1886).....32, 38, 39

United States v. Welden,
377 U.S. 95 (1964).....41

United States v. White Mountain Apache Tribe,
537 U.S. 465 (2003)..... 14-15

United States v. Will,
449 U.S. 200 (1980).....37, 41

United States v. Winstar Corp.,
518 U.S. 839 (1996).....46, 47

Util. Air Regulatory Grp. v. EPA,
134 S. Ct. 2427 (2014).....17

Wells Fargo Bank, N.A. v. United States,
26 Cl. Ct. 805 (1992) 43

Statutes

The Affordable Care Act ("ACA")..... *passim*

§ 1342 (codified at 42 U.S.C. § 18062) ..... *passim*

§ 1001.....47

§ 1301(a)(1)(C)(iv) 47

§ 1302(a)-(b) 47

§ 1311(c)-(d) 47

§ 2713.....21

§ 2717(a)(2) 21

§ 1104(h) 21

§ 3007(p)(4)(C) 23

28 U.S.C. § 1491(a)(1) 14, 32, 42

31 U.S.C. § 1304(a) 34

31 U.S.C. § 1341(a)(1)(B) 47

42 U.S.C. § 280k(a) 24

42 U.S.C. § 1395w-115(e)(3)(A) 6, 28

42 U.S.C. § 18021(a)(1)(B) 5

Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. No. 113-235) ("2015 Spending Law") ..... *passim*

Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Law") ..... *passim*

Regulations

42 C.F.R. § 423.336 ..... 6, 28

45 C.F.R. § 153.20 1

45 C.F.R. § 153.500 13

45 C.F.R. § 153.510 ..... *passim*

45 C.F.R. § 153.530 ..... 6, 13, 14, 29

45 C.F.R. § 155.20 ..... 1, 18, 26

45 C.F.R. § 156.200 44

45 C.F.R. § 156.210 44

45 C.F.R. § 156.220 44

45 C.F.R. § 156.230 44

45 C.F.R. § 156.260 44

45 C.F.R. § 156.270 44

45 C.F.R. § 156.295 44

45 C.F.R. § 156.410 44

FAR § 1.601(a) 46, 48, 49

Federal Register

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Proposed RCP Rule"), 76 Fed. Reg. 41,930 (July 15, 2011) ..... *passim*

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Final RCP Rule"), 77 Fed. Reg. 17,220 (Mar. 23, 2012) ..... *passim*

HHS Notice of Benefit and Payment Parameters for 2014 ("2014 Payment Rule"), 78 Fed. Reg. 15,410 (Mar. 11, 2013) ..... *passim*

HHS Notice of Benefit and Payment Parameters for 2015 ("2015 Payment Rule"), 79 Fed. Reg. 13,744 (Mar. 11, 2014) 9, 14

Exchange and Insurance Market Standards for 2015 and Beyond ("Exchange Establishment Rule"), 79 Fed. Reg. 30,240 (May 27, 2014) 9, 12

HHS Notice of Benefit and Payment Parameters for 2016 ("2016 Payment Rule"), 80 Fed. Reg. 10,750 (Feb. 27, 2015) 9-10, 12

Regulatory Guidance

CMS, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" (Apr. 5, 2013), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf. 13

CMS, "2015 Letter to Issuers in the Federally-facilitated Marketplaces" (Mar. 14, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf 10, 14

CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("April 2014 Memo") 9, 14, 25

CMS, "FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces" (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf 10

CMS, "The Three Rs: An Overview" (Oct. 1, 2015), *available at* https://www.cms.gov/ Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html 5, 7, 25

CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015).....2, 10, 13

CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("2014 Payment Memo") 13, 14, 17

CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016).....10, 13

CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016) ("2015 Payment Memo") 2, 14, 17

CMS, "Agreement Between Qualified Health Plan Issuer and Centers for Medicare and Medicaid Services," *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/qhp-issuer-agreement.pdf.....49

Legislative Materials

161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015) 40

S. Rep. No. 114-74 (June 25, 2015).....40

Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013).....9, 39

Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014).....39

Other Authorities

Fed. R. Evid. 201 2

RCFC 56(c).....20

RCFC 52.1 22

The Hon. Jeff Sessions, the Hon. Fred Upton, B-325630 (Comp. Gen.), 2014 WL 4825237 (Sept. 30, 2014) ("GAO Op.").....18, 34, 47

HHS OIG, "Medicare Part D Reconciliation Payments for 2006 and 2007" (Sept. 2009), *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf.....29

GAO, 15-447, Patient Protection and Affordable Care Act (Apr. 2015) ("GAO Rep."), *available at* http://www.gao.gov/assets/670/669942.pdf.....6, 17, 22

GAO, *Principles of Fed. Appropriations Law*, *available at* http://www.gao.gov/legal/redbook/overview 35, 37

CBO, "The Budget and Economic Outlook: 2014 to 2024" ("Budget Outlook") (Feb. 2014), *available at* https://www.cbo.gov/publication/45010 .....24, 26

Black's Law Dictionary (10th ed. 2014).....45

Doug Norris *et al*., *Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details*, Health Watch (Oct. 2013), *available at* https://www.soa.org/library/newsletters/ health-watch-newsletter/2013/october/hsn-2013-iss73-norris.aspx. 5-6

Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20, 2016), *available at* https://energy commerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and 10, 13

MedPAC, "Chapter 6: Sharing Risk in Medicare Part D," Report to the Congress: Medicare and the Health Care Delivery System (June 2015), *available at* http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report-.pdf?sfvrsn=0 22

Transcript of Oral Argument, *Montana Health CO-OP v. United States*, No 16-1427C (Fed. Cl. Feb. 9, 2017) 23

Order, *Maine Cmty. Health Options v. United States*, No. 16-967C (Fed. Cl. Mar. 9, 2017), ECF No. 30 .....16, 30

Def.'s Mem. In Supp. of Mot. Summ. J., *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) 34

1 Ralph C. Nash & John Cibinic, Federal Procurement Law (3d ed. 1977).....46

Ralph C. Nash & John Cibinic, Formation of Government Contracts (1982).....49

INTRODUCTION

In 2010, Congress passed the Affordable Care Act ("ACA")[1] to create a new marketplace—the health insurance "exchanges"—for individuals and small groups to purchase healthcare insurance. The creation of the exchanges, among other things, increased the number of individuals purchasing health insurance. The newly created exchanges, comprised of large numbers of previously uninsured and underinsured individuals, presented various risk factors for health insurers. Recognizing this degree of uncertainty created by the exchanges, Congress created the "risk corridors program" ("RCP") as a risk mitigation measure for the exchanges to ensure that both the Government and the insurers would have some protection against outsized gains or losses in each of the first three benefit years[2] (2014, 2015, and 2016) of the exchanges. Congress knew that without such a backstop measure it could not achieve the ACA's stated goals of increased *and* affordable health insurance because insurers would either not offer plans on the exchanges at all or offer plans only at unaffordable premiums.

The RCP established a mandatory but temporary (first three years) framework through which health insurers *and the Government* shared in the risk while they collected more precise health costs data associated with this newly insured population. The RCP required plans that realized lower-than-expected allowable costs in a benefit year to *pay* a portion of the differential *to the Government* ("payments in"), and, conversely, required the Government to pay plans that realized higher-than-expected allowable costs in a benefit year to payment of a portion of the differential ("payments out"). The RCP was limited to the first three years of the exchanges to

[1] The ACA is actually comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).
[2] 45 C.F.R. § 155.20 ("*Benefit year* means a calendar year . . . ."); 45 C.F.R. § 153.20.

help "stabilize" premiums (by smoothing out "gains" and "losses") in the first three years of the exchanges.

At issue in this case is the extent of the Government's obligation to make "payments out" to KYHC. The RCP does not discriminate between the Government and insurers: both have potential but binding payment obligations under the statutory formula. When KYHC experienced lower-than-expected costs in its first year,[3] it made ***full*** "payment in" to HHS as required by the RCP. The converse did not occur. Although the Government has required full "payments in," it has refused to make full "payments out" regarding 2014 individual plans when KYHC experienced "losses" triggering the Government's payment obligations. Specifically, the Government has made only partial payment (approximately 15.9 percent) toward its 2014 RCP obligations, and conceded that the balance is an "obligation of the United States Government for which full payment is required." *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 33).[4] CMS has made no payment at all to KYHC for benefit year 2015, and has publicly stated that none will be forthcoming anytime soon (if ever). *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016) ("2015 Payment Memo") (Add. A at 38). The Government's refusal to make full payments is a clear violation of its statutory obligations under Section 1342 of the ACA.

The Government's position can be summarized as follows: If KYHC's participation in the exchanges yielded net revenue gains within the specified RCP thresholds, the allowable costs would be retrospectively calculated to be too low, and the Government would benefit and require

[3] KYHC experienced lower-than-expected costs for its participation in the small group marketplace for benefit year 2014 and made timely payment to CMS in accordance with the RCP.

[4] Attached to this Memorandum is Addendum A ("Add. A") containing public HHS statements cited in this Memorandum, of which this court may take judicial notice. *See* Fed. R. Evid. 201.

full "payment in." But if KYHC's allowable costs were retrospectively calculated to be too high, KYHC would be left alone to shoulder the losses. This position is demonstrably unfair and one-sided, disregards Section 1342's unambiguous and money-mandating "shall pay" language, and contradicts the fundamental risk-*sharing* purpose of the RCP.

STATEMENT OF THE ISSUE

The RCP mandates full and annual "payments in" and "payments out" once costs from the previous benefit year have been calculated and approved by HHS/CMS. This is how Congress wrote the law and it is how HHS originally construed, and announced it would administer, the program. But part way through the applicable performance period, HHS reversed course and began to adopt a series of evolving and inconsistent positions regarding the Government's obligation to pay insurers like KYHC the full amount they are owed under the RCP.

In litigation, the Government has asserted that the RCP must be administered in a budget-neutral manner, *i.e.*, "payments out" cannot exceed "payments in" during a particular year. This novel position is not reflected in the text of the ACA; was never raised for public comment during the notice-and-comment rulemaking process on HHS's RCP implementing regulations; directly contradicts HHS's earlier positions; and has never been explained by HHS. It also violates the fundamental premise of the RCP: a "heads-the-Government-wins, tails-the-insurer-loses" payment scheme would do nothing to "stabilize" premiums; it would instead create (and, in due course, did in fact create) the very *instability* the RCP was designed to prevent. Under the Government's current rationale, it is a one-way payment stream.

KYHC brought healthcare insurance to the people of Kentucky, as Congress envisioned when it crafted the ACA's system of payment requirements and incentives. *See*

Compl. ¶¶ 16, 26. Under the RCP, the Government owes KYHC payments for those years based on demonstrated higher-than-budgeted costs.

There are three questions to answer in this case: (1) How much does the Government owe KYHC?; (2) When does the Government owe it?; and (3) Has the Government somehow been relieved of its obligation to make payment?

The answers are simple: (1) Based on the undisputed facts, the Government owes KYHC $64,789,497.96 for benefit year 2014 and $77,311,836.24 for benefit year 2015, *see infra* Section I.A.1; (2) the money is presently due, *see infra* Section I.A.2; and (3) the Government's payment obligation under the RCP has *not* been abrogated, *see infra* Section I.B.3. Accordingly, KYHC is entitled to judgment.

STATEMENT OF RELEVANT BACKGROUND

I. THE ACA CREATED EXCHANGES IN AN EFFORT TO PROVIDE AFFORDABLE HEALTHCARE TO PREVIOUSLY UNDERINSURED AND UNINSURED POPULATIONS.

In March 2010, the ACA was enacted to bring healthcare to otherwise uninsured and underinsured individuals. Its core provisions require, among other things: individuals to carry health insurance; states to facilitate online exchanges for buying and selling insurance; and private health insurance companies to guarantee coverage and provide myriad essential health benefits to insured individuals at no additional cost. Congress, through the ACA, decided to intervene in the marketplace and sought to foster affordability and competitiveness. To this end, Congress implemented risk mitigation programs, including the RCP, to expand the risk tolerance of entrants to the individual and small group markets served by the exchanges, where consumers could purchase health plans that meet certain standards established by CMS and the exchanges

("qualified health plans" or "QHPs"). A "QHP issuer" is any health insurer selling a QHP on the exchanges.

II. CONGRESS CREATED THE RCP INTENTIONALLY AS AN INCENTIVE TO DRAW ENTITIES SUCH AS KYHC INTO THE MARKETPLACE.

Expanding healthcare coverage comes at a cost and a price. For example, under the ACA, QHP issuers must cover a variety of essential health benefits at no additional cost to enrollees. The ACA's myriad mandates would require higher premiums for QHPs to fully account for the new health insurance marketplace. Congress understood this fundamental premise. So, to mitigate that risk to insurers while at the same time moderating otherwise unaffordable premiums, Congress included three marketplace premium stabilization programs, commonly referred to as the "Three Rs": (1) the RCP; (2) a transitional Reinsurance program (which, like the RCP, was a temporary program for 2014-2016, the first three benefits years under the exchanges); and (3) a permanent Risk Adjustment program. *See* CMS, "The Three Rs: An Overview" (Oct. 1, 2015), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html ("Three Rs Overview"). The "Three Rs" were intended to serve a specific objective within the framework of the ACA: to mitigate the risk that QHP issuers operating on the new exchanges would otherwise face in light of the ACA's expansion of typical coverage requirements and their attendant costs. *See, e.g.*, 42 U.S.C. § 18021(a)(1)(B) (requiring coverage of "essential health benefits.").[5] The RCP encouraged participation in the marketplaces by insurers such as KYHC.[6]

[5] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Final RCP Rule"), 77 Fed. Reg. 17,220, 17,220 (Mar. 23, 2012) ("These risk-spreading mechanisms [the 3 Rs] . . . are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets.").

[6] The Society of Actuaries explained how the RCP was understood when issuers set premiums

Congress expressly modeled the ACA RCP on Medicare Part D's RCP. *See* § 1342(a) ("The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 . . . [which] shall be based on [the Medicare Part D RCP]."). This is a critical factor in the analysis. Medicare Part D's RCP is not budget neutral and payments (both in and out) are made annually. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year"); 42 C.F.R. § 423.336 (same); GAO, 15-447, Patient Protection and Affordable Care Act (Apr. 2015) ("GAO Rep.") at 14, *available at* http://www.gao.gov/assets/670/669942.pdf ("[T]he payments that CMS makes to issuers [under the Medicare Part D program] are not limited to issuer contributions.").

HHS implemented the RCP in the Code of Federal Regulations through a notice-and-comment rulemaking as directed by ACA Section 1342, largely parroting the statute. *See* 45 C.F.R. § 153.510. HHS also requires QHP issuers to submit their revenue and cost data on an annual basis, at which point after review and approval by CMS, QHP issuers are eligible to receive required payments under the RCP's payment methodology. *Id.* §§ 153.510, 153.530.

HHS made no mention of budget neutrality when it proposed its RCP implementing regulations. By meaningful contrast, HHS indicated in the preamble to the proposed rule that the RCP's companion program, the risk adjustment program, was, in fact, budget neutral. Patient

---

for the 2014 benefit year: "The goal of the [RCP] is to protect health insurance issuers against this pricing uncertainty of their plans, temporarily dampening gains and losses in a risk-sharing arrangement between issuers and the federal government. Since the protection is only available for QHPs, it also provides a strong incentive for issuers to participate in the health insurance exchanges set up by the ACA. Lastly, it provides an incentive for issuers to manage their administrative costs optimally." Doug Norris *et al*., *Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details*, Health Watch at 5 (Oct. 2013), *available at* https://www.soa.org/library/newsletters/ health-watch-newsletter/2013/october/hsn-2013-iss73-norris.aspx.

Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Proposed RCP Rule"), 76 Fed. Reg. 41,930, 41,938 (July 15, 2011) (Add. A at 5). This makes sense because this permanent risk adjustment program is designed to share risk *among QHP issuers*, whereas the temporary RCP is designed to share risk between QHP issuers *and the Government*. *See* Three Rs Overview. Accordingly, the final, codified regulations do not reflect a budget-neutral RCP. Indeed, in its preamble, HHS said just the opposite—that HHS anticipated making ***prompt*** payment to QHP issuers after making the annual determination of the amount due (or owed by the QHP issuer). *See* Final RCP Rule, 77 Fed. Reg. at 17,238-39 (Add. A at 10-11). A year later, in its first annual "Payment Rule" articulating the payment policies and requirements for marketplace participation, HHS stated:

> ***The risk corridors program is not statutorily required to be budget neutral***. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013) ("2014 Payment Rule") (emphasis added) (Add. A at 14).

III. KYHC WAS A QHP ISSUER THAT PARTICIPATED IN THE KENTUCKY EXCHANGE.

KYHC is a corporation organized under the laws of Kentucky with its principal place of business in Louisville, Kentucky. KYHC was a member-led, non-profit CO-OP QHP issuer on the Kentucky exchange. It offered comprehensive health insurance benefits to individuals, families, and businesses. Overall, KYHC served approximately 51,000 individuals on the exchange in Kentucky during benefit years 2014 and 2015. KYHC conducted and participated in countless outreach and educational sessions throughout its service area on the availability of ACA coverage, the mechanics of the marketplace, and the benefit plans it offered. By any account, KYHC pursued the ACA's goal of connecting the people in its service area to insurance

coverage opportunities with the understanding that a broader base of insured is better for the individuals within the pool and the overall functioning of the marketplaces.[7]

IV. KYHC OFFERED PREMIUMS RELYING ON THE RCP AS A MITIGATOR OF MARKET INSTABILITY.

The ACA's success depended on QHP issuers participating in the market at a reasonable price point for the millions of uninsured and underinsured Americans that Congress intended to obtain or augment their insurance. The RCP was created to mitigate the risk of the anticipated growth in the insurance market and incentivized KYHC to offer competitive premiums for healthcare benefits to consumers. Accordingly, the RCP was necessary to achieve the ACA's purpose and objectives.

V. THE GOVERNMENT'S POSITION ON ITS RISK CORRIDORS OBLIGATIONS HAS FLUCTUATED AND IS INCONSISTENT WITH THE ACA.

In March 2013, HHS issued its first Payment Rule to set the payment parameters for the Three Rs for the forthcoming year.[8] In it, HHS stated unambiguously (in response to a commenter) that the RCP "is not statutorily required to be budget neutral" and HHS would make payments "regardless of the balance of payments and receipts." 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). QHP issuers then submitted their rates to HHS for review by May 2013 and their participation in the exchanges was fixed and irrevocable in or around September 2013. *See* Compl. ¶ 36.

Although HHS's comment in the 2014 Payment Rule was consistent with the ACA's text, it caused some in Congress to threaten to defund the ACA entirely. Of particular note, in

[7] On October 29, 2015, KYHC was placed into rehabilitation and then liquidation on January 15, 2016. Compl. ¶ 15.

[8] The "Payment Rule" is an annual CMS rule that identifies any changes CMS intends to make in the next year with respect to, among other things, the three premium stabilization programs.

November 2013, legislation was introduced to strike the RCP from the ACA. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013).

Subsequently, in March 2014, HHS indicated *for the first time* in the preamble to its 2015 Payment Rule that it now intended to administer the risk corridors program in a "budget-neutral" manner, and that if payments in were not sufficient to cover payments out in a given year, it would offset current-year liabilities with future collections, directly contradicting its statement in the preamble to the 2014 Payment Rule it had issued a year earlier. HHS Notice of Benefit and Payment Parameters for 2015 ("2015 Payment Rule"), 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014) (Add. A at 17). HHS's reversal occurred after KYHC had already set premiums and enrolled members for the 2014 benefit year. HHS never expressed this new point of view during its notice-and-comment rulemaking on its RCP implementing regulations and did not even acknowledge that it was reversing course. In a follow-up guidance letter, HHS stated that it anticipated RCP "payments in" would cover "payments out," but that it would "establish in future guidance or rulemaking" what it would do if that assumption proved wrong. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("April 2014 Memo") (describing how payments would be calculated) (Add. A at 19-20). Even this statement is inconsistent with a budget neutral position.

Moreover, CMS soon thereafter acknowledged that, notwithstanding its newly announced intent to administer the RCP in a budget-neutral manner, ***full payment*** remained due to QHP issuers.[9] Exactly *when* full payment would be remitted has never been clarified, given the

[9] *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond ("Exchange Establishment Rule"), 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) (emphasis added) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . ") (emphasis added) (Add. A at 23). That acknowledgment would be repeated numerous times over the next two-and-a-half years. *See* HHS Notice of Benefit and Payment

Government's various confusing and conflicting statements. Under any rational reading of the ACA, payment is due on an annual basis. Indeed, despite stating in its April 11, 2014 Memorandum that it would announce through future rulemaking or guidance how the Government would cover RCP obligations in the event amounts collected were less than amounts owed, HHS has never done so.

Meanwhile, Congress, which had not substantively amended the RCP, instead limited its funding sources. In the FY 2015 and 2016 appropriations bills, passed after QHP issuers had already set and submitted their premiums for benefit years 2015 and 2016 (in the fall of 2014 and 2015, respectively),[10] Congress prohibited CMS and HHS from using two specified funds, as well as funds transferred from other accounts funded by congressional appropriations, to make

---

Parameters for 2016 ("2016 Payment Rule"), 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 26); CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) ("HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which ***full payment is required***.") (emphasis added) (Add. A at 33); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("Sept. 2016 Memo") ("[T]he Affordable Care Act requires the Secretary to make ***full payments*** to issuers" and HHS will "record payments due as an obligation of the United States Government for which ***full payment*** is required") (emphases added) (Add. A at 35); Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20, 2016), *available at* https://energycommerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (emphasis added) (quoting Acting Administrator of CMS's testimony as part of hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight") (Add. A 41-42).

[10] CMS, "2015 Letter to Issuers in the Federally-facilitated Marketplaces," at 8 (Mar. 14, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf (QHP agreements expected to be signed in October/November 2014); CMS, "FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces," at 8 (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (QHP agreements expected to be signed in September 2015).

RCP payments lawfully owed to QHPs.[11] The Spending Laws did not nullify or modify the Government's RCP obligations and left other funding sources available as well.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. KYHC is a corporation organized under the laws of Kentucky with its principal place of business in Louisville, Kentucky.

2. KYHC was a QHP issuer that participated on the exchanges in the Commonwealth of Kentucky.

3. In 2014 and 2015, KYHC provided health insurance on the state-based (federally-facilitated platform) marketplace in Kentucky.

4. Pub. L. No. 111-148, § 1342 (ACA Section 1342), as codified at 42 U.S.C. § 18062, created the risk corridors program. In relevant part that Section states:

> (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall*** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under [the Medicare Part D program].
>
> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 of the target amount, the 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; and
>
> (B) a participating plan's allowable costs ***for any plan year*** are more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.
>
> Pub. L. No. 111-148, § 1342 (emphases added). Section 1342 also includes a provision dealing with "payments in," requiring QHP issuers to pay amounts to HHS if the plans'

[11] The Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. No. 113-235) ("2015 Spending Law") and the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113) ("2016 Spending Law") (collectively, the "Spending Laws").

actual costs are less than its targeted costs. *Id.* § 1342(b)(2). For both "payments out" and "payments in," the statute defines "allowable costs" and "target amount." *Id.* § 1342(c).

5. HHS recognized in the preamble to its proposed RCP implementing regulations that the RCP "serves to protect against uncertainty in the Exchanges by limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930 (Add. A at 4).

6. HHS implemented the RCP at 45 C.F.R. § 153.510, stating in part (emphases added):

> (b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
>
> (1) When a QHP's allowable costs ***for any benefit year*** are more than 103 percent but not more than 108 percent of the target amount, ***HHS will pay the QHP issuer*** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
>
> (2) When a QHP's allowable costs ***for any benefit year*** are more than 108 percent of the target amount, ***HHS will pay to the QHP issuer*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

7. In the preamble to that rule, HHS recognized that "QHP issuers who are owed these amounts will want ***prompt payment, and payment deadlines should be the same for HHS and QHP issuers.***" Final RCP Rule, 77 Fed. Reg. at 17,238 (emphasis added) (Add. A at 10). And it reiterated that the RCP "serves to protect against uncertainty in rate setting by qualified health plans ***sharing risk in losses and gains with the Federal government***." *Id.* at 17,220 (emphasis added) (Add. A at 8).

8. In the 2014 Payment Rule (published on March 11, 2013) HHS stated in the preamble: "The risk corridors program is not statutorily required to be budget neutral. ***Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.***" 78 Fed. Reg. at 15,473 (emphasis added) (Add. A at 14).

9. On May 27, 2014, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . ." and committed to "***use other sources of funding for the risk corridors payments***, subject to the availability of appropriations" if there is a shortfall. *See* Exchange Establishment Rule, 79 Fed. Reg. at 30,260 (emphases added) (Add. A at 23).

10. On February 27, 2015, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . ." and indicated that "***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations." *See* 2016 Payment Rule, 80 Fed. Reg. at 10,779 (emphases added) (Add. A at 26).

11. On November 19, 2015, HHS stated that "HHS is recording those amounts that remain unpaid following [its] 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which full payment is required." *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 33). HHS stated further that it "will explore other sources of funding for the risk corridors payments, subject to the availability of appropriations. This includes ***working with Congress on the necessary funding for outstanding risk corridors payments***." *Id.* (emphasis added).

12. On September 9, 2016, in a memorandum, HHS recognized that the ACA "requires . . . ***full payments*** to issuers" and it will "record risk corridors payments due as an obligation of the United States Government for which ***full payment is required.***" *See* Sept. 2016 Memo (emphases added) (Add. A at 35).

13. On September 14, 2016, in testimony before the House Energy and Commerce Committee, regarding whether CMS must make RCP payments even in the absence of an appropriation, the Acting Administrator of CMS Andrew Slavitt testified: "Yes, ***it is an obligation*** of the federal government." *See* Energy and Commerce Committee Press Release (emphasis added) (Add. A at 41-42).

14. KYHC timely submitted its 2014 premiums to HHS by May 2013. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("2014 Payment Memo") (Add. A at 30-31); Compl. ¶ 36.

15. During 2013, KYHC timely submitted QHP applications to CMS for its participation in the Kentucky exchange, and CMS certified KYHC as a QHP issuer, culminating in a QHP Issuer Agreement for benefit year 2014 signed by both parties.

16. KYHC's commitment to participate in the exchanges was fixed and irrevocable in or around September 2013, when a QHP Issuer Agreement for KYHC's participation in the exchange was fully executed. *See* Compl. ¶ 36; CMS, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" at 20 (Apr. 5, 2013), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

17. Pursuant to its obligations under the ACA and 45 C.F.R. §§ 153.500 *et seq.*, KYHC submitted all data required for the RCP payment and charge calculations for the 2014 benefit year by the statutory deadline of July 31, 2015. *See* 45 C.F.R. § 153.530(d); 2014 Payment Memo (Add. A at 30-31).

18. During 2014, KYHC timely submitted a QHP application to CMS for its participation in the Kentucky exchange, and CMS certified KYHC as a QHP issuer, culminating in a QHP Issuer Agreement for benefit year 2015 signed by both parties.

19. KYHC's commitment to participate in the Kentucky exchange was fixed and irrevocable in or around October 2014, when the QHP Issuer Agreement for KYHC's participation in the exchange was fully executed. *See* Compl. ¶ 71; CMS, "2015 Letter to Issuers in the

Federally-facilitated Marketplaces" at 8 (Mar. 14, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

20. KYHC submitted all data required for the RCP payment and charge calculations for the 2015 benefit year by the statutory deadline of July 31, 2016. *See* 45 C.F.R. § 153.530(d); 2015 Payment Memo (Add. A at 38-39).

21. CMS has conceded that, under the RCP, it owes KYHC $77,074,941.10 for benefit year 2014 and $77,311,836.24 for benefit year 2015. 2014 Payment Memo (Add. A at 30-31); 2015 Payment Memo (Add. A at 40-42).

22. CMS has publicly stated in sub-regulatory guidance that it will not make full payment for benefit years 2014 and 2015 until a later—but as-of-yet undetermined—date, if at all. *See* 2015 Payment Memo (Add. A at 38).

23. For benefit year 2015, HHS stated in sub-regulatory guidance that it would implement the RCP in a budget-neutral fashion and use any funds received from QHP issuers to first pay down the $2.5 billion shortfall in 2014 benefit year payments. 2015 Payment Rule, 79 Fed. Reg. at 13,787 (Add. A at 17); April 2014 Memo (Add. A at 19-20). HHS anticipated that "payments in" would match "payments out" over the three-year RCP period, but "***will establish in future guidance*** or rulemaking how [it] will calculate risk corridors payments" if that does not turn out to be the case. *Id.* (emphasis added.)

24. To date, KYHC has received only $12,285,443.14 of the $77,074,941.10 the Government determined that it owes under the RCP for the 2014 benefit year and still owes $64,789,497.96. Compl. ¶¶ 17, 53, 65, 77, 83, 94, 96.

25. To date, KYHC has not received any RCP payments for the 2015 benefit year and is owed $77,311,836.24. Compl. ¶¶ 17, 56, 73, 77, 83, 95, 96.

26. HHS has not announced a date by which it intends to make any remaining payments for benefit years 2014 and 2015.

JURISDICTION

This Court has Tucker Act jurisdiction because the ACA's RCP is an act of Congress that (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]" and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." 28 U.S.C. § 1491(a)(1); *see United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472-73 (2003); *Fisher v. United States*, 402 F.3d 1167,

1173-74 (Fed. Cir. 2005) (en banc in relevant part) (citations omitted). The Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007) (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). The RCP mandates that HHS "shall pay" to QHP issuers certain statutorily determined amounts. Since KYHC was a QHP issuer under the ACA, it falls within "the class of plaintiffs entitled to recover under the money-mandating source [and] the Court of Federal Claims has jurisdiction." *Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008).

Tucker Act jurisdiction is also "limited to actual, presently due money damages from the United States." *Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (citations and quotations omitted). KYHC is entitled to presently due money damages because it has fulfilled all statutory requirements for payment. *See Doe v. United States*, 100 F.3d 1576, 1580, 1582 (Fed. Cir. 1996) (jurisdiction existed where plaintiff had fulfilled all statutory conditions for payment). KYHC has submitted all required information to HHS demonstrating its entitlement to payment in specific amounts under the formula contained in Section 1342 of the ACA. HHS has conceded that it owes KYHC $64,789,497.96 for benefit year 2014 and $77,311,836.24 for benefit year 2015.

Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded." *Fisher*, 402 F.3d at 1173. KYHC has pled that the ACA is money-mandating, requires full and timely payment, sets forth statutory requirements for receipt of payment that KYHC fulfilled, and requires payment the Defendant has not made. *See, e.g.*, Compl. ¶¶ 20-21, 28-35, 42-45, 61-77. Accordingly, this Court's jurisdiction is beyond dispute. *See Blue Cross & Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457, 468-70 (2017); Order 2,

Maine Cmty. Health Options v. United States, No. 16-967C (Fed. Cl. Mar. 9, 2017), ECF No. 30; *Moda Health Plan, Inc., v. United States*, 130 Fed. Cl. 436, 449-51 (2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 776 (2017); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 95-98 (2016).

SUMMARY OF ARGUMENT

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

1. *Statutory Mandate to Pay*. For each year, a QHP issuer's costs are to be calculated. If there is a cost overrun above a certain amount, the Government owes the issuer money, and if there is a cost savings above a certain amount, the issuer owes money to the Government. Both calculations are governed by the statutory formula. *Moda*, 130 Fed. Cl. at 451-57 (holding that the Government was liable to Moda Health as a QHP issuer because the ACA RCP requires full annual payments as evidenced by: the text of Section 1342; HHS's implementing regulations; Congress's object and purpose in creating the RCP; and Congress's express modeling of Section 1342 on Medicare Part D's annual RCP).

The plain text of the statute answers the question of "how much" money the Government owes KYHC by, in mandatory terms, stating *if* a QHP issuer's allowable costs are more than a specified percentage above the target amount, *then* the Government "shall" reimburse the QHP pursuant to the prescribed formula. It is a long-accepted principle of statutory interpretation that when Congress uses the term "shall," it creates a mandatory obligation that the Government cannot, in its discretion, dispense with. *See Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Not surprisingly, HHS has acknowledged on multiple occasions that full payment is due. *See supra* note 9. HHS has also published memoranda stating the

amounts owed to KYHC and other QHPs for benefit years 2014 and 2015. 2014 Payment Memo (Add. A at 30-31); 2015 Payment Memo (Add. A at 38-39).

The statute also answers the question of "when" the Government's RCP obligations are due. Section 1342's express language states that if a plan's allowable costs "for any ***plan year***" exceed the target amount, the Secretary "***shall pay to the plan***" the statutorily specified amounts. Although it does not expressly state that payments must be made on an annual basis, the statute cannot logically be read to require anything other than payment at the conclusion of the "plan year."[12] *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) ("[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme." (quoting *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2441 (2014) (internal quotations omitted))).

Finally, the statute answers the question of whether the Government's obligation has changed (it has not) because it remains intact in precisely the form in which it was enacted.

The Government posits that it can short-pay KYHC and other plans for 2014, and not pay it and other plans anything at all for 2015 until further notice. In fact, under the Government's "evolving" view of the statute, payment is due to health plans *either* sometime after the end of the three-year RCP *or* perhaps never. The Government's position on when (or even whether) it intends to make payment is entirely unclear, other than it is *not now*. But the Government's position requires this Court to ignore the plain language of Section 1342. Most notably, Congress specifically modeled the ACA RCP on the Medicare Part D RCP, which requires full annual payments. *See* GAO Rep. at 14. In the ACA RCP, Congress also directed HHS to establish risk *corridors* (plural) for each "plan year" 2014, 2015, and 2016. "[P]lan year" means

[12] HHS reiterated that when allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the specified amounts. 45 C.F.R § 153.510 (emphasis added).

12 consecutive months under the ACA[13] and Congress *intentionally* used the plural "corridors." *See Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing" (quotation and citations omitted)).

Congress acted intentionally when it created the RCP. The RCP's mandate was to *stabilize* insurance premiums in each of the first three years of the exchanges' existence. Withholding payment (if paying at all) until long after the year for which Congress intended the payment to be made only exacerbates premium rate inflation and risk for subsequent years and thus vitiates the RCP's objective of *stabilizing* premiums. *See King*, 135 S. Ct. at 2494 ("It is implausible that Congress meant the Act to operate in this manner."); *see also Bob Jones Univ. v. United States*, 461 U.S. 574, 586 (1983) (statutory interpretations that frustrate the object and purpose of the statute are disfavored); *Global Computer Enters. v. United States*, 88 Fed. Cl. 350, 406 (2009) (same); *Fluor Enters., Inc. v. United States*, 64 Fed. Cl. 461, 479 (2005) (same).

Congress's post-ACA legislative efforts do not negate the Government's obligation to make the required payments under a money-mandating statute. First, Congress's intent in 2010 when it passed the ACA is unambiguous: Congress said the United States "shall pay" when QHP issuers satisfied the statutory "payments out" trigger. Second, as a matter of law, that payment obligation was not dependent on Congress simultaneously specifying the source for the obligated payments. Third, in any case, there was an appropriation available to fund the Government's RCP obligations when it first incurred them in 2014, the first year of the exchanges. The Hon. Jeff Sessions, the Hon. Fred Upton, B-325630 (Comp. Gen.), 2014 WL 4825237, at *3 (Sept. 30, 2014) ("GAO Op."). Congress's subsequent efforts to bar RCP payments from specific sources through the annual appropriations process merely hampered or narrowed HHS's ability to make

[13] *See* 45 C.F.R. § 155.20.

payment but did not abridge the underlying legal obligations. And subsequent Congresses have not substantively modified the law. *See* Addendum B ("Add. B") at 3. The Government's liability to KYHC remains in full force.

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

Empowered by the ACA's authorization to contract with QHP issuers, the Government held out a unilateral offer of formulaic approved RCP payments to induce KYHC and other QHP issuers to begin performance, and KYHC accepted such offer by beginning performance. Consideration flowed both ways, where the Government benefited from KYHC's performance as a QHP issuer, and KYHC benefited from the Government's promise of payment under the formula.

Alternatively, the parties entered into a bilateral contract—culminating in the signed QHP Issuer Agreement(s)—in which the parties agreed that KYHC would be bound to considerable duties and obligations in exchange for RCP payments.

In either scenario, KYHC has fulfilled its contractual duty and condition precedent to the Government's full payment. The Government's failure to uphold its side of the bargain is a clear contractual breach.

SUMMARY JUDGMENT STANDARD

This case presents a clear question of statutory interpretation appropriate for summary disposition, as all material facts are undisputed. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with

affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." RCFC 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-16 (2008). A fact is material if it "might affect the outcome of the suit under the governing law," *Anderson v. Liberty Lobby*, *Inc.*, 477 U.S. 242, 248 (1986), and a dispute of material fact is genuine "if the evidence is such that a reasonable finder of fact could return a verdict for the nonmoving party." *Johnson*, 80 Fed. Cl. at 116 (citing *Liberty Lobby*, *Inc.*, 477 U.S. at 248). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Id.* at 116 (quoting *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002)). The existence of a contract is a mixed question of law and fact, and the court may grant summary judgment when there is no genuine issue for trial. *See La Van v. United States*, 53 Fed. Cl. 290 (2002), *aff'd*, 382 F.3d 1340 (Fed. Cir. 2004).

ARGUMENT

I. THE GOVERNMENT IS LIABLE FOR ITS FAILURE TO MAKE RCP PAYMENTS UNDER A MONEY-MANDATING STATUTE (COUNT I).

A. Section 1342 Requires RCP Payments to Be Made Annually and in Full, Without Regard to Budget Neutrality.

KYHC is entitled to summary judgment because, based on the undisputed facts and as a matter of law, the Government owes it a partial unpaid balance of RCP payments for 2014 and a total unpaid balance for 2015. This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and quotations omitted)). The RCP's text and the ACA's structure require (1) full payment, rather than payments subject to budget neutrality, and (2) annual payments.

1. Congress Intended QHP Issuers to Receive Full Payment.

The enacting Congress effectuated the RCP's risk mitigating purpose by plainly and unambiguously mandating full payment to QHP issuers as defined in its "Payment Methodology" without regard to budget neutrality. First, the text mandates that the Government "***shall pay to the plan***" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). "[T]he mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion." *Lexecon*, 523 U.S. at 35. Moreover, Congress used "shall" and "may" throughout the ACA, often within the same section of the law, underscoring Congress's deliberate intent to invoke their distinct meanings. *See, e.g.*, ACA §§ 2713, 2717(a)(2), and 1104(h); *see also Lopez v. Davis*, 531 U.S. 230, 241 (2001) ("Congress' use of the permissive 'may' . . . contrasts with the legislators' use of a mandatory 'shall' in the very same section."). The enacting Congress used "shall" to signify mandatory obligations and "may" to impose discretionary ones. Unsurprisingly, HHS agreed and acknowledged that the RCP "is not statutorily required to be budget neutral" and, in recognition of the statutory mandate to make payment, promised payment "[r]egardless of the balance of payments and receipts." 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). *See, e.g.*, *Moda*, 130 Fed. Cl. at 456 (finding "the unambiguous language of Section 1342 dispositive" of the fact that Congress did not intend the RCP to be budget neutral).[14]

Second, Congress expressly determined that the RCP was not budget neutral by deliberately modeling the ACA's RCP on the Medicare Part D RCP, the only other similar risk

[14] In *Moda*, Judge Wheeler found, as KYHC argues here, that the RCP is unambiguously *not* budget neutral under the plain meaning of Section 1342, as HHS/CMS contemporaneously and repeatedly recognized (as did everyone in the industry). *Moda*, 130 Fed. Cl. at 455-57. HHS's multiple and consistent statements shortly after the ACA's passage buttress KYHC's interpretation that the statute is unambiguously not budget neutral.

mitigation program in the healthcare industry, and which is not budget neutral. *See* ACA § 1342(a); GAO Rep. at 14 ("for the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers is not limited to issuer contributions."). Part D's non-budget neutrality undoubtedly is a critical design feature applicable to the ACA's RCP because (1) non-budget neutrality is a foundational and essential component to an RCP's effectiveness as an incentive to QHP issuers to enter the exchanges and offer affordable premiums, and (2) the ACA does not otherwise declare that such a central feature of the program on which it modeled the RCP should not apply. Both RCP provisions were specifically designed to mitigate risk in new healthcare markets to enable insurers to offer essential health benefits affordably.[15] A budget-neutral program would not adequately mitigate risk. If "payments out" were subject to "payments in" and issuers located in all 50 states experienced losses across the board, issuers would not receive the very benefit the RCP was created to provide. The ACA created a new market, and risk had to be effectively mitigated. *Cf. Engel v. Davenport*, 271 U.S. 33, 38-39 (1926) ("The adoption of an earlier statute by reference makes it as much a part of the later act as though it had been incorporated at full length." (citations omitted)).[16] Congress expressly modeled the ACA RCP on the Medicare Part D RCP. If Congress had intended the

[15] MedPAC, "Chapter 6: Sharing Risk in Medicare Part D," Report to the Congress: Medicare and the Health Care Delivery System (June 2015) at 140, *available at* http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report-.pdf?sfvrsn=0 ("Also, risk corridors limit each plan's overall losses or profits if actual spending is much higher or lower than anticipated. Corridors provide a cushion for plans in the event of large, unforeseen aggregate drug spending.").

[16] We note that *Land of Lincoln* dismissed the Part D scheme's relevance because Congress purportedly omitted certain text. 129 Fed. Cl. at 105. For reasons that are unclear, that case was considered deferentially on the "administrative record" (RCFC 52.1) despite there being no agency proceeding below. Regardless, it ignores that Congress is presumed to legislate with awareness of how a program on which later-enacted legislation is based is administered. *See Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978).

ACA *not* to track this defining and core characteristic of Part D, surely Congress would have said so explicitly. It did not.

Government counsel has elsewhere treated Congress's specific direction that Section 1342 be "based on" Medicare Part D as superfluous. *See, e.g.*, *Land of Lincoln*, 129 Fed. Cl. at 105; Transcript of Oral Argument ("Montana Tr.") at 125:1-3, 13-19, *Montana Health CO-OP v. United States*, No 16-1427C (Fed. Cl. Feb. 9, 2017) ("I don't think it does much other than to say there is supposed to be this program."). The Government ignores Section 1342's express directive and the essence of the "based on" reference and instead reads out its obligation to make full, annual RCP payments as Medicare Part D requires.

Third, the enacting Congress specifically made numerous sections of the ACA budget neutral, *see, e.g.*, ACA § 3007(p)(4)(C) ("The payment modifier established under this subsection shall be implemented in a budget neutral manner."), yet it *omitted* from Section 1342 any reference to budget neutrality. To suppose that Congress carefully considered imposing budget neutrality selectively throughout the ACA yet neglected to do so in connection with the RCP is patently unreasonable. It would insert into Section 1342 a budget-neutrality requirement that Congress chose not to insert. Courts "may not add terms or provisions where Congress has omitted them . . . ." *Sale v. Haitian Ctrs. Council, Inc.*, 509 U.S. 155, 168 n.16 (1993).[17]

[17] Although the Government has elsewhere argued that the Congressional Budget Office (CBO) assumed that government payments would not exceed amounts collected under the RCP, CBO statements do not bear on congressional intent. *See* Proposed RCP Rule, 76 Fed. Reg. at 41,948. As the Federal Circuit has noted, "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent." *Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009) (recognized as repealed by implication by statute on unrelated grounds). A CBO budget score might thus be relevant to the question of what Congress may have assumed to be the economic impact of a law with new budget implications, but that is an entirely different question from what Congress intended to be the substantive impact of the law. In any event, in the only report in which the CBO actually addressed the issue, it concluded the RCP was *not* budget

Congress's *exclusion* of words specifically limiting RCP payments to appropriated funds underscores its intent to accomplish the opposite. Congress often uses explicit language, such as "subject to the availability of appropriations," to limit a statute's budget impact. *See, e.g.*, *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2188-89 (2012) (noting that certain payments were "subject to the availability of appropriations" under the statute at issue); *see also Prairie Cty., Mont. v. United States*, 113 Fed. Cl. 194, 199 (2013), *aff'd*, 782 F.3d 685 (Fed. Cir. 2015) ("the language 'subject to the availability of appropriations' is commonly used to restrict the government's liability to the amounts appropriated by Congress for the purpose." (citing *Greenlee Cty.*, 487 F.3d at 878-79)).

In the RCP, Congress chose not to include such limiting language in any form, despite having done so elsewhere within the ACA itself. *See, e.g.*, 42 U.S.C. § 280k(a) ("The Secretary . . . shall, ***subject to the availability of appropriations***, establish a 5-year national, public education campaign . . . ." (emphasis added)). Especially when read in the context of the ACA as a whole, the lack of any language of budgetary limitation in Section 1342 confirms that Congress did not intend the RCP to be budget neutral or "subject to the availability of appropriations." *See United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) ("A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme—because the same terminology is used elsewhere in a context that makes its meaning clear, or because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." (citations omitted)); *see also Brown v. Gardner*, 513 U.S. 115, 118 (1994) ("Ambiguity is a creature not of definitional possibilities but of statutory context."); *McCarthy v. Bronson*, 500 U.S. 136, 139 (1991)

---

neutral. *See* CBO, "The Budget and Economic Outlook: 2014 to 2024" ("Budget Outlook") at 9 (Feb. 2014), *available at* https://www.cbo.gov/publication/45010.

(statutory language must be read in its proper context and not viewed in isolation); *Castillo v. United States*, 530 U.S. 120, 124 (2000) (same). The Government simply cannot add words to § 1342 that Congress excluded, particularly where those very words appear *elsewhere* in the law.[18]

Finally, Congress has repeatedly introduced (and failed to pass) legislation intended to *make* the RCP budget neutral. *See infra* Section I.B.3.a. Obviously, if the RCP was designed to be budget neutral, such legislative efforts would have been unnecessary. *See, e.g.*, *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 22 n.6 (2011) (noting that congressional attempts to amend a law provide support for the proposition that the law in its current form does not already do what the amendment proponents are seeking). The RCP's purpose was to induce participation in the healthcare insurance market by mitigating risk that might otherwise lead QHP issuers to either not participate or charge higher premiums. HHS's acknowledgment of this connection between inducement and risk on multiple occasions illustrates its awareness that it is liable for full payment. *See supra* note 9.

It can hardly be doubted that if the tables were turned and more money was due into the program than owed out, the Government would demand full payment on a plan year or annual basis. And, it has in fact demanded reciprocal payments calculated on an annual basis, including payment from KYHC. Indeed, the Government has argued that Congress believed it was far more likely that the RCP would generate more payments in than out based on Medicare Part D's RCP performance, as reflected in its guidance letter. *See* April 2014 Memo (pointing out in Example 1 that if the Government collected more for a year than it owed, it would "retain" the

[18] Moreover, the argument that the RCP was intended to be budget neutral effectively converts the RCP into the risk adjustment program, which *is* budget neutral. That program was intended to share risk *among QHP issuers*. *See* Three Rs Overview. As noted ante, the RCP was designed to serve a distinct purpose by sharing risk *between QHP issuers and the Government.*

remainder for future use) (Add. A at 19).[19] The Government and insurers should be held to the same standard.

2. Congress Intended QHP Issuers to Receive or Remit Timely Annual Payments.

The ACA's text and structure unambiguously anticipate that RCP payments—both "in" and "out"—will be made on an annual basis. And this is exactly how HHS originally understood the obligation and stated it would apply its congressional mandate. *See* Final RCP Rule, 77 Fed. Reg. at 17,238-39 (identifying that the same deadlines should apply to both "payments in" and "payments out") (Add. A at 10-11); 2014 Payment Rule, 78 Fed. Reg. at 15,473 (setting a 30-day deadline from determination of charges for QHP issuers to make "payments in") (Add. A at 14).

a) The Text and Structure of the ACA Requires Annual RCP Payments.

The RCP's text requires HHS to pay QHP issuers the amount owed annually. First, the RCP explicitly states that "for any plan year . . . [HHS] shall pay to the plan" the delineated amounts. "Plan year" means 12 consecutive months under the ACA. 45 C.F.R. § 155.20 (in related Exchange Establishment Rule, defining "*Plan year*" as a "consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise."); *see Moda*, 130 Fed. Cl. at 451-53 (the calculation of payment amounts in and out of the program on a "plan year" basis reflects an annual program). CMS strictly enforced this annual payment structure when collecting payments from plans who realized lower-than-expected allowable costs.

Second, the RCP's "Payment Methodology" also constructs an annual program by predicating the appropriate payment amounts on figures that are calculated annually. The RCP

[19] The CBO agreed. *See* Budget Outlook at 59 (predicting $8 billion in net revenue from RCP).

mandates payments to any QHP issuer that, for the applicable year, had "allowable [health care] costs" that were more than three percent greater than a "target amount." *See* ACA § 1342(b). The RCP defines "allowable costs" and the "target amount" in section (c) with reference to "a plan for any year" and the "amount of a plan for any year." *See* ACA §§ 1342(c)(1)(A), 1342(c)(2), 1342(b). "Target amounts" necessary to calculating RCP payments are based on payments and receipts under the related risk adjustment and reinsurance provisions, which are annual.[20] 45 C.F.R. § 153.510(a)-(d), (g). The scheme is unmistakably annual.

Third, the enacting Congress, by referencing the plural "corridors" when it directed that HHS "shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," did so intentionally to create separate risk corridor**s** for each of the calendar year**s** referenced. ACA § 1342(a) (emphases added); *see Metro. Stevedore*, 515 U.S. at 296 ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing") (quotation and citations omitted); *Dakota, Minn. & E. R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) (finding that Congress's use of the plural was evidence of its intent); *Moda*, 130 Fed. Cl. at 451-52 (holding that Section 1342 requires *annual* payments and finding that Section 1342 "offer[s] clues as to Congress's intent" by requiring an RCP for "calendar years 2014, 2015, and 2016" rather than "calendar years 2014-2016"). Congress is presumed to draft law purposefully. *See Arcadia v. Ohio Power Co.*, 498 U.S. 73, 79 (1990) ("In casual conversation, perhaps, such absentminded duplication and omission are possible, but Congress is not presumed to draft its laws that way."). Congress intended to create three sets of risk corridors, one for each year the RCP was in effect.

[20] In fact, the government has required or remitted annual payment under the risk adjustment and reinsurance programs. And CMS has made annual (albeit incomplete) RCP payments toward its 2014 obligations.

Fourth, Congress further underscored the annual payment structure dictated by the RCP's plain text by mandating that the RCP "shall be based on the program for regional participating provider organizations under [the Medicare Part D risk mitigation program]," which provides for a distinct risk corridor in each year, to be paid annually. ACA § 1342(a). Medicare Part D explicitly provides for a "risk corridor" specific to each year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year . . ."); *see also* 42 C.F.R. § 423.336(a)(2)(i) (same). Part D also requires payment for each risk corridor in the year following the corridor. *See* 42 C.F.R. § 423.336(c)(2) (CMS makes payments "in the following payment year . . . ."); *see also Moda*, 130 Fed. Cl. at 452 (noting Congress's explicit directive that the RCP be "based on" the Medicare Part D's annual RCP). Congress reinforced its explicit provision for annual payments in the text of the RCP by reference to the only other comparable risk mitigation program—a program premised on annual payments.[21]

b) Originally, HHS Correctly Interpreted the RCP to Require Timely Annual Payments Be Made to QHP Issuers.

HHS's original interpretation of Section 1342 was consistent with the text of the law and KYHC's expectation of annual payment, and it is the only interpretation that is consistent with the RCP's purpose. First, HHS immediately recognized that the RCP "serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government," Final RCP Rule, 77 Fed. Reg. 17,220 (Add. A at 8), and will do so by "limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930 (Add. A at 4). It reiterated that principle in its final rule, and accordingly indicated that it would

[21] *See, e.g.*, HHS OIG, "Medicare Part D Reconciliation Payments for 2006 and 2007" (Sept. 2009) at 14, *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf.

"address the risk corridors payment deadline in the HHS notice of benefit and payment parameters," noting that:

> HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. *QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.*

77 Fed. Reg. at 17,238 (emphasis added) (Add. A at 10).

In its first Payment Rule, HHS set a 30-day deadline for issuers to remit payment upon notification of charges. *See* 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). And, as HHS stated in its implementing regulations, it believed the same deadline should apply to both payments in and payments out of the program. Significantly, HHS requires issuers to submit their data to HHS annually to facilitate calculation of RCP payments. 45 C.F.R. § 153.530(d). CMS has enforced this rule with those plans (including KYHC) that experienced lower-than-expected allowable costs.

Thus, not so long ago, there was no disagreement that Congress intended both RCP payments to the Government and from the Government be made annually. And for good reason: that is the only reading that is consistent with the overall purpose and structure of the ACA. A premium rate stabilization program would not do much good if insurers could not rely on annual premiums and complete and timely payment if warranted. As the Supreme Court pointed out, Congress designed the ACA to prevent an economic "death spiral," in which "premiums rose higher and higher, and the number of people buying insurance sank lower and lower, [and] insurers began to leave the market entirely." *King*, 135 S. Ct. at 2486. A program by which the Government mitigated insurers' risk by sharing in that risk was necessary to incentivize health insurance companies to enter and remain on the online marketplaces. *See, e.g.*, *Health Republic*, 129 Fed. Cl. at 776 ("If these programs did not provide for prompt compensation to insurers

upon the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges. Further, if enough insurers left the exchanges, one of the goals of the Affordable Care Act—the creation of 'effective health insurance markets,'—would be unattainable." (internal citations omitted)); Order 2, *Maine Cmty. Health Options*, No. 16-967C (Fed. Cl. Mar. 9, 2017), ECF No. 30 ("There is no indication that the statute means anything other than what it says, namely, that Congress adopted a risk-sharing program operated on a yearly basis.").

HHS's current position that the Government can delay RCP payments until some indefinite time in the future, if at all, despite its acknowledgment that the RCP requires full payment to KYHC and others, subverts Congress's intent. To suggest, as HHS has, that QHP issuers of all sizes that sustain significant losses, and report on their costs and receipts on an annual basis as the ACA requires them to do, can readily bear those losses over multiple years, all while keeping premiums affordable for enrollees in each successive year, is anathema to the structure and purpose of the ACA. A QHP issuer does not have the ability to print money if operating in a deficit. Furthermore, numerous health plans, including KYHC itself, have been placed in liquidation. "It is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494 (citations omitted); *Bob Jones*, 461 U.S. at 586 (statutory interpretations that frustrate the object and purpose of the statute are disfavored); *Global Computer Enters.*, 88 Fed. Cl. at 406 (same); *Fluor Enters.*, 64 Fed. Cl. at 479 (same).

The Government's position is made even less credible by its continued expectation that QHP issuers with lower-than-expected allowable costs (such as KYHC) make complete annual payment, as statutorily required. That happened and the government made certain that it was

paid on an annual and timely basis. The Government's obligation to make timely payments is no different.

B. The Government's Liability Does Not Depend on a Dedicated Source of Funding for That Liability.

The Government will likely contend in this case (as it has in other RCP litigation) that Section 1342's "shall pay" directive actually means shall pay *subject to appropriations*. The Government has posited that Congress never specified an appropriation to fund the RCP in the first instance and then prohibited payment from certain program funds in 2014 and 2015 appropriations riders, thus abrogating any mandate to pay that the Government otherwise had. The Government is wrong.

1. The Government's Liability Does Not Turn on the Availability of a Specific Appropriation.

As discussed *supra* at Section I.A.1, Congress did not limit the Government's RCP liability with its typical words of limitation (*e.g.*, "subject to appropriations"). Nor, as a matter of fiscal law, does the Government's liability for full and annual RCP payments turn on whether Congress specifically appropriated funds to the agency. The Government's error is its conflation of two distinct concepts: (1) Congress's creation of a legal "obligation" to pay in the first instance; and (2) the fiscal mechanics of the Government later fulfilling that obligation. The Government's position also ignores the role of the Judgment Fund. *See, e.g.*, *Moda*, 130 Fed. Cl. at 461-62.

It has long been understood that:

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

Collins v. United States, 15 Ct. Cl. 22, 35 (1879) (emphases added). Under the Tucker Act, KYHC may recover unpaid funds when the Government fails to meet its obligation under a money-mandating statute. *See, e.g.*, *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012); *District of Columbia v. United States*, 67 Fed. Cl. 292, 302-05 (2005). The RCP is unequivocally money-mandating because, *inter alia*, it dictates that the Government "shall pay" RCP payments. Whether, when, and how Congress appropriates the required funds are irrelevant to this Court's decision regarding the legal *obligation* to make the payments in the first instance. There is no requirement for Congress to create a specific appropriation. *See, e.g.*, *United States v. Langston*, 118 U.S. 389, 391-94 (1886) (finding the Government liable for statutory promise of payment in absence of a specific appropriation).

The Federal Circuit's seminal decision in *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011) (*en banc*), drives home the point. *Slattery* addressed whether the Government could be sued under the Tucker Act for breaches committed by a Government entity that was not funded by appropriations ("NAFI"). The Government argued that because a NAFI is not funded by appropriations, this Court lacks jurisdiction to adjudicate claims for a NAFI breach. After canvassing the long line of cases from the Court of Claims, Federal Circuit, and Supreme Court, the Federal Circuit abrogated its own contrary precedent[22] and held that the Tucker Act's broad grant of jurisdiction for any claim "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), was *not* limited to the subset of instances where a specific appropriation could be identified. It held, "the jurisdictional foundation of the Tucker

[22] *See Kyer v. United States*, 369 F.2d 714 (Ct. Cl. 1966), *abrogated by Slattery*, 635 F.3d 1298 (Fed. Cir. 2011).

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." *Slattery*, 635 F.3d at 1321. Critically, the Court ruled that any resulting judgment—despite the lack of appropriations involved in creating the original obligation—*could be satisfied by the Judgment Fund*. *See id.* at 1317 (Judgment Fund's purpose "was to avoid the need for specific appropriations to pay [Court of Claims] judgments").

Although *Slattery specifically* addressed jurisdiction over a claim for breach of a NAFI contract, the holding applies with equal force here because the Tucker Act draws no distinction between constitutional, statutory, or contract claims against the Government. And while the Government has framed this as a "merits" issue in its other RCP cases, the Government's attempts to force RCP plaintiffs to identify a specific appropriation as a predicate condition to state a claim under Section 1342 amounts to a second "jurisdictional" test of the very sort rejected in *Slattery*. *See id*. at 1316 (reasoning that Tucker Act jurisdiction is determined by identification of a money-mandating statute and there is no need to identify a specific appropriation for what in essence would amount to a "second waiver" of sovereign immunity (citing *Mitchell v. United States*, 463 U.S. 206, 218 (1983))).

The critical point is this: because Congress did not condition "payments out" on "payments in" (for the reasons explained above), the only limitation on KYHC's right to annual payment on its statutory claim is its ability to demonstrate, as a factual matter, that it performed as a QHP issuer on the exchanges on an annual basis and qualifies for RCP payments under the Section 1342 formula (as echoed in CMS's implementing regulation). If it can make that showing (as it has), then judgment may be awarded and executed against the Judgment Fund. *See, e.g.*, *Moda*, 130 Fed. Cl. at 461 ("The Judgment Fund pays plaintiffs who prevail against the Government in this Court, and it constitutes a separate Congressional appropriation."); *Gibney v.*

United States, 114 Ct. Cl. 38, 52 (1949) ("Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether . . . Congress appropriate an insufficient amount . . . or nothing at all, are questions . . . which do not enter into the consideration of case in the courts."). Outside of the Court of Federal Claims, the Government acknowledges this reality and recognizes that, if a plaintiff is successful:

> it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund, 31 U.S.C. § 1304(a). **The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund**.

Def.'s Mem. In Supp. of Mot. Summ. J. 11, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (emphasis added) (citing *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2191-92 (2012)).

2. In Any Event, Appropriations Were Available for CMS to Incur RCP Obligations.

Although the Court's analysis can stop with the observation that Congress created a legal obligation to make full payments, this Court may observe, as Judge Wheeler did in *Moda*, that the Government's proposition that CMS had no appropriated funds available to pay RCP obligations is, in any event, incorrect. For FY 2014, the first year in which the exchanges were operational and the RCP was in effect, GAO opined in a report dated September 30, 2014, that two sources of funding for RCP payments were available: (1) the 2014 CMS Program Management (PM) appropriation, and (2) "payments in" from profitable plans. *Moda*, 130 Fed. Cl. at 447; GAO Op. at *3. The CMS PM appropriation for FY 2014 included CMS's "other responsibilities" through September 30, 2014, includ[ing] the risk corridors program." GAO Op. at *3.

Any argument by the Government that payments were not *due* until the following fiscal year, FY 2015, and therefore CMS's FY 2014 PM appropriation is irrelevant to the formation of

an obligation, would misconstrue black-letter fiscal law. The availability of funds "relates to [an Agency's] authority to ***obligate*** the appropriation"—which occurred in FY 2014 when QHP issuers submitted their rates and opted to participate in the exchanges in the forthcoming year—and does not relate to whether that obligation is *due or payable* in current or subsequent fiscal years. I GAO, *Principles of Fed. Appropriations Law* ["GAO Redbook"], at 5-3 - 5-4 (emphasis added) (3d ed. 2004), *available at* http://www.gao.gov/legal/redbook/overview; *see* II GAO Redbook at 7-4 - 7-5. It is black-letter appropriations law that an "expired appropriation remains available for 5 years *for the purpose of paying obligations incurred* prior to the account's expiration and adjusting obligations that were previously unrecorded or under recorded." I GAO Redbook at 1-37 (emphasis added).[23] A legal "obligation arises when the definite commitment is made, *even though the actual payment may not take place until a future fiscal year* . . . . [T]he term 'obligation' includes both matured and unmatured commitments . . . . An unmatured commitment is a liability which is *not yet payable* but for which a definite commitment nevertheless exists." II GAO Redbook at 7-4 - 7-5 (emphasis added). Thus, there were appropriations available for CMS to form FY 2014 obligations, notwithstanding that CMS would not *pay* its RCP obligations until the following year. *See id.*; *Moda*, 130 Fed. Cl. at 457 n.13.

The same logic applies to FY 2015. As Judge Wheeler noted, appropriations were available for CMS to commit 2015 RCP obligations (notwithstanding that payment would occur the following fiscal year) because Congress passed three continuing resolutions in the first several months of FY 2015 (covering October 2014)—*before* Congress passed the 2015

[23] An agency should record non-discretionary expenditures "*imposed by law*" as "obligations." II GAO Redbook at 7-43 (emphasis added). The fact that CMS *recorded* RCP payments as Government obligations in the fiscal years in which they were incurred (e.g., FY 2014) "evidences the obligation but does not create it." *Id.* at 7-8. CMS's actions are therefore highly *probative* that it formed an FY 2014 obligation.

Spending Law (in December 2014) that first restricted sources of RCP payments. These continuing resolutions allocated roughly $750 million in unrestricted funds to the CMS PM appropriation. *Moda*, 130 Fed. Cl. at 457 n.13. Since unrestricted funds were available in or around October 2014, when KYHC's participation in the exchanges during benefit year 2015 was fixed and irrevocable, there can be no legitimate argument that CMS lacked funds to form FY 2015 RCP obligations.

For all the reasons discussed *supra* Section I.A., the text and purpose of Section 1342 unambiguously establish that Congress intended the Government to make full RCP payments, and statutorily required HHS to collect and remit payments under the RCP's formula, necessarily requiring HHS to incur obligations under the RCP's formula. When and how those obligations would later be paid is irrelevant to the question of the Government's liability.

3. The 2015 and 2016 Appropriations Acts Did Not Nullify or Modify the Government's RCP Obligations.

The fact that Congress has curtailed HHS's ability to make RCP payments through appropriations legislation in the last two budget cycles, years after the ACA's passage and well after the exchanges were under way and obligations were confirmed by HHS, does *not* alter the Government's RCP *liability*. First, and as discussed above, the existence of a legal obligation is distinct from the means by which the Government fulfills that obligation. Second, the Government's temporary restrictions on specific sources for fulfilling those obligations did not modify the RCP; the Government's legal obligation remains. Indeed, as noted, the very fact that Congress has tried on multiple occasions to modify or repeal the ACA as a whole and the RCP specifically, and yet failed to do so, highlights the important distinction between appropriations legislation (for annual funding of discretionary government operations) and substantive legislation (which fixes rights and obligations, including of the United States itself). *See Moda*,

130 Fed. Cl. at 455-62 (finding that Congress did not intend Section 1342 to be budget-neutral and that neither the 2015 nor 2016 Spending Laws abrogated or effectuated a repeal or amendment of the RCP).

a) Congress Has Not Amended the RCP.

To date, Congress has neither repealed nor amended the RCP. *See* Add. B at 3. Through the Spending Laws, Congress curtailed CMS's funding sources to make RCP payments. But that fact is irrelevant to this lawsuit by KYHC.

The legal standard for finding that limiting language in appropriations laws vitiated a preexisting statutory right, and thus extinguished Tucker Act relief, is stringent—the right is presumed to remain valid. While Congress possesses the legal authority to prospectively amend preexisting substantive statutory obligations, it must do so "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted). Moreover, and of direct relevance here, "[t]his rule applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980). Because appropriations laws "have the limited and specific purpose of providing funds for authorized programs," the statutory instructions included in them are presumed not to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). "[I]t can be strongly presumed that Congress will specifically address language on the statute books that it wishes to change." *United States v. Fausto*, 484 U.S. 439, 453 (1988); *Greenlee Cty.*, 487 F.3d at 877 ("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." (citing *N.Y. Airways*, 369 F.2d at 748)). Restricting appropriations alone, without more, does not amend the underlying legislation. *See Greenlee*

Cty., 487 F.3d at 877; *Gibney*, 114 Ct. Cl. at 53 (noting that the court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation"). Nor does it absolve the Government of its obligation to make payments mandated by law. *See id.*

The Spending Laws did not amend the RCP either.[24] Binding precedent illustrates this basic point. In *Langston*, the diplomatic representative to Haiti sued when Congress failed to appropriate sufficient funds to pay his statutorily set salary. 118 U.S. at 390. Under the original statute, "[t]he representative at Ha[i]ti shall be entitled to a salary of $7,500 a year" and a subsequent appropriation set the salary "for the service of the fiscal year ending June 30, 1883, out of any money in the treasury, not otherwise appropriated, for the objects therein expressed" at $5000. *Id.* at 390-91. The Supreme Court emphasized the importance of clear language repealing or amending a statute. For example, it distinguished the language of the appropriation at issue from one in which Congress clearly indicated an intent to repeal previously set salaries, because the subsequent appropriation explicitly set out a new compensation system designed to replace the prior one. *Id.* at 392-93. The Court reasoned that the appropriation at issue did not contain "any language to the effect that such sum shall be 'in full compensation' for those years" or other provisions "from which it might be inferred that congress intended to repeal the act." *Id.* at 393. Reiterating that "[r]epeals by implication are not favored," the Supreme Court held that it must give effect to both provisions where possible and:

> While the case is not free from difficulty, the court is of opinion that, according to the settled rules of interpretation, a statute fixing the annual salary of a public officer at a named sum, without limitation as to time, should not be deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount for the services of

[24] Appropriations were available to make 2015 RCP payments because Congress passed three continuing resolutions in the first two-and-a-half months of FY 2015 (before enacting the 2015 Spending Law that first restricted sources of RCP payments). *See supra* Section I.B.2.

> that officer for particular fiscal years, and which contained no words that expressly, or by clear implication, modified or repealed the previous law.

Id. at 393-94; *see also Gibney*, 114 Ct. Cl. at 49-50 ("There is nothing in the wording of the [appropriations] proviso . . . which would warrant a conclusion that it was intended to effect the repeal of the [original] codified provisions of the act . . . .").

Because the language in the Spending Laws limited only the use of funds appropriated to *one specific account* and did not expand the limitation to other sources of funds using Congress's typical language to do so, those acts were comparable to the subsequent appropriations at issue in the line of cases finding that Congress did not intend to amend substantive law. *Moda*, 130 Fed. Cl. at 457-62 (citing *Langston*, 118 U.S. at 393; *Gibney*, 114 Ct. Cl. at 48; *N.Y. Airways*, 369 F.2d at 744; *District of Columbia*, 67 Fed. Cl. at 335). Because the Spending Laws do not "bar any appropriated funds from being used for a given purpose," they do not "clearly manifest" an intent to repeal or amend.[25]

Congress knows how to amend or repeal laws it does not like. The stringency of the legal standard ensures that when Congress's actions disturb the settled expectations of private parties induced by the words of a statute after the fact, its intent must be clear and manifest. Moreover, it is fundamental to the separation of powers that if Congress does not have the President's support or sufficient votes to override a veto, it cannot pass new legislation. The 113th Congress, which passed the 2015 Spending Law, directly considered two pieces of proposed legislation to amend the ACA to limit or eliminate RCP payments. *See* Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014) (seeking to amend the RCP to "ensur[e] budget neutrality."); Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013)

[25] Indeed, the Court noted that precisely that language was used elsewhere in the 2015 Spending Law but was notably absent from the RCP provision. *See Moda*, 130 Fed. Cl. at 462.

(seeking to eliminate the RCP). Neither bill passed. During the 2016 budget process, Congress considered an amendment that sought to prohibit HHS from collecting fees or making payment under the RCP effective January 1, 2016. 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015). But the Senate voted against the amendment. Congress also considered more narrow legislation that would have required the RCP to be administered on a budget-neutral basis. *See, e.g.*, S. Rep. No. 114-74, 12 (June 25, 2015); *see also id*. at 121, 126. These efforts failed as well.

In other words, Congress considered modifying or repealing the RCP on several occasions—and *did not*. But the efforts to do so highlight what is patently clear about the RCP as enacted in 2010, which remains unmodified to date: *its obligation to make "payments out" was not constrained by budget neutrality*. To interpret appropriations bills to have accomplished what substantive legislation failed to effectuate would render our constitutional system of checks and balances a nullity. Congress could have repealed the ACA. It did not. Congress could have amended the RCP. It did not. Congress changed CMS's funding authority to make RCP payments from certain accounts to some degree. But that is a mere administrative or historical point; they did not modify the Government's legal obligation. *See Blanchette v. Conn. Gen. Ins. Corps.*, 419 U.S. 102, 134 (1974) ("Before holding that the result of the earlier consideration has been repealed or qualified, it is reasonable for a court to insist on the legislature's using language showing that it has made a considered determination to that end . . . ." (citations and quotations omitted)). Because Congress has not amended or repealed the RCP, the Government remains liable.[26]

[26] The presumption against retroactivity also counsels against an interpretation that Congress modified or repealed the RCP. *See Landgraf v. USI Film Prod.*, 511 U.S. 244, 265-66 (1994).

b) Congress's Silence Should Not Be Construed as a Repeal.

Where Congress did not expressly amend the RCP, this Court should not find that it did implicitly. As a general rule, "[a]mendments by implication, like repeals by implication, are not favored." *United States v. Welden*, 377 U.S. 95, 102 n.12 (1964); *see also United States v. Will*, 449 U.S. 200, 221 (1980). This rule "applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill" since it is generally presumed that appropriation laws do not alter substantive law. *Hill*, 437 U.S. at 190; *see also Will*, 449 U.S. at 221-22. "A new statute will not be read as wholly or even partially amending a prior one unless there exists a 'positive repugnancy' between the provisions of the new and those of the old that cannot be reconciled . . . ." *Blanchette*, 419 U.S. at 134 (citations and quotations omitted). The 2015 and 2016 Spending Laws merit no effect beyond their express words: a decision to foreclose certain sources of RCP funding.

In *New York Airways*, Congress's 1965 appropriation deliberately underfunding subsidy payments under the Federal Aviation Act (pursuant to which helicopter companies had already rendered services) did not amend the original statute. 369 F.2d at 744-45. The Court of Claims further held that the original statute empowered the implementing agency to obligate the United States for the payment of an agreed subsidy in the absence or deficiency of a congressional appropriation. *Id.* Similarly, in the absence of explicit amendment, this Court should not find that Congress impliedly repealed or amended the RCP. Congress has, at best, demonstrated an effort by some members to "curtail and finally eliminate" RCP payments. *See id.* at 751. The Government still owes KYHC the money to which it is statutorily entitled.[27]

[27] The law disfavoring repeal by implication echoes the same principles guiding the anti-retroactivity principle. *See supra* note 26.

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

This Court has jurisdiction over implied contract claims, 28 U.S.C. § 1491(a)(1), and the Judgment Fund is available to pay judgments. *Slattery*, 635 F.3d at 1303, 1317-21. All elements of an implied contract are met here,[28] and KYHC is entitled to the contractually obligated amounts. The Government held out a unilateral offer of RCP payments to induce KYHC and other QHP issuers to begin performance by expanding coverage for millions of Americans. The QHP issuers accepted by beginning performance, rendering the offer irrevocable prior to issuance of the Spending Laws. Alternatively, the parties entered into a *bilateral* contract—culminating in the signed QHP Issuer Agreement(s)—in which the parties agreed that KYHC would be bound to a raft of duties and obligations in exchange for RCP payments, *inter alia*. In either scenario, HHS's failure to uphold its side of the bargain constitutes a textbook contractual breach.

A. The Government Breached an Implied-in-Fact, *Unilateral* Contract with KYHC.

1. There Was Mutuality of Intent to Contract.

The Government contracts when its conduct or language "allows a reasonable inference" that it intended to do so. *ARRA Energy*, 97 Fed. Cl. at 27. The surrounding circumstances include the statutory purpose, context, legislative history, or any other objective indicia of actual intent.[29] KYHC's well-pled facts show that the combination of Section 1342, HHS's implementing regulations, and the Government's conduct (before and after Plaintiff agreed to become a QHP) support that the "conduct of the parties show[], in the light of the surrounding

[28] Implied contracts require: (1) mutuality of intent; (2) unambiguous offer and acceptance; (3) consideration; and (4) actual authority of the Government contracting representative, or ratification. *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995).

circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996); *see, e.g.*, Compl. ¶¶ 84-97.

This longstanding test is best illustrated in *Radium Mines Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957), where the court found that a regulation establishing a guaranteed minimum Government purchase price for uranium was not "a mere invitation to the industry to make offers to the Government," and was an intent to contract, because the regulation's purpose was to "induce persons to find and mine uranium." *Id.* at 405-06. In other words, the case focused on the regulations' "promissory" nature in finding an implied-in-fact contract.[30] The Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes.[31] *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

---

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

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

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

Applying this precedent, it is clear that the purpose of the RCP was to minimize risks for insurers and thereby *induce* them to offer insurance coverage to previously uninsured or underinsured population. The Government recognized that insurers would be unwilling to enter this market without significant risk premium to protect against uncertainties. As such, the RCP payment scheme was designed to mitigate uncertainty, and it—along with HHS's express and repeated assurances of full payment—drew insurers to enter the market and offer affordable coverage. The RCP's promissory nature evidences the Government's intent to enter into a binding contract to make full RCP payments to plans that performed in accordance with RCP's requirements.

The fact that the RCP contained numerous requirements[32] that QHP issuers had to fulfill in order to receive payment also establishes that the Government was required to make payment once those requirements were met. In *New York Airways*, this Court described the mandatory statutory payment in that case as creating an implied contract once the plaintiff had satisfied the requirements for payment. 369 F.2d at 751 (holding that the actions of the parties at least support the existence of an implied in fact contract because the agency's order was "in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer").

Similarly, when the Government includes "numerous requirements . . . to receive the payments" those payments are "compensatory in nature," and one can accept such offer for

[32] These include submission of, or compliance with, Government standards regarding: (1) "issuer participation" (45 C.F.R. § 156.200); (2) detailed rate and benefit submissions (45 C.F.R. § 156.210); (3) enrollment data, claims payment policies and practices, and periodic financial disclosures (45 C.F.R. § 156.220); (4) a provider network that meets federal standards (45 C.F.R. § 156.230); (5) enrollment of individuals during specified enrollment periods (45 C.F.R. § 156.260); (6) standards governing termination of coverage or enrollment (45 C.F.R. § 156.270); (7) reporting of prescription drug distribution and costs (45 C.F.R. § 156.295); and (8) cost-sharing reductions and monitoring of cost-sharing payment requirements (45 C.F.R. § 156.410).

payment through satisfaction of the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F. 2d 518, 521 (5th Cir. 1948). Here, the ACA contained a host of requirements for fixed payment, and when the QHP issuers met such requirements, the mutuality of intent formed an implied-in-fact contract, obligating the Government to pay QHP issuers.[33]

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

The Government *offered* RCP payments to insurers through the language of Section 1342, regulations, and HHS's numerous publications and affirmations. Insurers then *accepted* this offer by beginning performance and providing QHP services, thus executing an enforceable unilateral contract.[34] Specifically, KYHC accepted the Government's offer by complying with the numerous and extensive QHP administrative requirements and actually serving the high-cost, at-risk population of formerly uninsured individuals. Courts have found such exchange to constitute unambiguous offer and acceptance without any explicit reference to an offer or contract.[35] The Government's offer became irrevocable at the point of acceptance—the subsequent Spending Laws neither unwound the enforceable contract nor relieved the Government of its burden to make full payment.

[33] Further, none of the countervailing factors in *Baker* are present here. 50 Fed. Cl. at 491-93.
[34] In a unilateral contract, the offeree may only accept the offer by performing its contractual obligations. *See Contract*, Black's Law Dictionary (10th ed. 2014) (defining "unilateral contract" as "[a] contract in which only one party makes a promise or undertakes a performance."); *Lucas v. United States*, 25 Cl. Ct. 298, 304 (1992) (explaining that a prize competition is a unilateral contract because it requires participants to submit entries in return for a promise to consider those entries and award a prize).
[35] *Radium Mines*, 153 F. Supp. at 405-06 (risk stabilization and minimum prices constituted offer which "induced" companies to accept through performance); *N.Y. Airways v. United States*, 369 F.2d 743 (Ct. Cl. 1966) (finding published "board rate" for aviation transportation services constituted an offer that plaintiff accepted through performance).

3. There Was Consideration.

Consideration at the time of contract formation flowed both ways. QHP issuers are the backbone of the Government's effort to provide coverage through the exchanges and, *but for* the Government's promise of risk stabilization, insurers would not have offered plans with such restrictive and elaborate conditions. When KYHC agreed to offer QHPs, the Government and KYHC committed to an intricate set of specific, reciprocal obligations.[36] The Government benefitted by KYHC's servicing of formerly uninsured and underinsured, high-cost enrollees at reasonable premiums (that accounted for anticipated RCP risk-sharing) in compliance with its extensive QHP standards. Indeed, the calculation of RCP payments is based on the costs incurred by QHP issuers to provide those benefits. In exchange, KYHC received consideration because HHS committed that *only* QHP issuers would receive RCP payments (to the exclusion of other insurers), 45 C.F.R. § 153.510, and that HHS would make timely and full RCP payments. *Ace-Fed. Reporters, Inc. v. Barram*, 226 F.3d 1329, 1332 (Fed. Cir. 2000) (Government buying from "between two and five authorized sources," to the exclusion of others, was "consideration" with "substantial business value.").

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

Actual authority to contract can be express or implied—either is sufficient to bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). Agency Heads have contract-making authority "by virtue of their position." FAR § 1.601(a) (contractual authority in each agency flows *from* the Agency Head to delegated officials).[37]

---

[36] *See supra* note 32.

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

Moreover, Section 1342's instruction that the Secretary "shall establish" the RCP and "shall pay" RCP payments, along with the Secretary's broad obligation to administer and implement the ACA,[38] give the Secretary the express (or at least implied) authority to enter into binding QHP Issuer Agreements to implement the ACA. *See Winstar Corp*., 518 U.S. at 890 n.36; *H. Landau*, 886 F.2d at 324. Coverage through exchanges is carried out exclusively through private insurers' QHPs, and the ability to contract with them is "integral" to the Secretary's ability to effectuate her statutory duty to implement the RCP. *See id*. Indeed, where contracts have been inferred from statutes promising payment, the Government's authority to contract is clear. *See, e.g.*, *Radium Mines*, 153 F. Supp. at 405-06; *N.Y. Airways*, 369 F.2d at 751-52.

There is also no Anti-Deficiency Act ("ADA") (31 U.S.C. § 1341(a)(1)(B)) issue here.[39] First, the Secretary *did* have authority to make RCP payments under CMS's "Program Management" appropriation and the amounts collected under the RCP, as determined by GAO, whose opinions are given "special weight." *Nevada v. Dep't of Energy*, 400 F.3d 9, 16 (D.C. Cir. 2005); GAO, B-325630, HHS—Risk Corridors Program, 3-5 (Sept. 30, 2014), *available at* http://gao.gov/assets/670/666299.pdf. Second, *even if* no appropriated funds were available (they were), the ADA expressly permits agencies to enter into contracts whenever "authorized by law." 31 U.S.C. § 1341(a)(1)(B) (officials restricted from contracting "before an appropriation is made ***unless authorized by law***."); *see, e.g*., *California v. United States*, 271 F.3d 1377, 1383-84 (Fed. Cir. 2001) (Interior Secretary entered into a binding contract, which was not *ultra vires* despite the fact that "[n]o funds were appropriated" and Congress likely did not "contemplate a

---

Government "is generally implied" where such authority is integral to execute program duties).

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

[39] That Act provides that the Government "may not . . . involve [the] government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law."

breach-of-contract claim arising from [the statute]," because Congress "expressly authoriz[ed] the Secretary . . . to negotiate and enter into *an agreement* . . . ."). Here, similarly, the ACA expressly authorized the HHS Secretary to (1) enter into QHP Issuer Agreements with insurers, (2) to "establish and administer" the RCP program, and (3) mandated that he "shall pay" RCP funds. Per precedent, the Secretary had actual authority (by position) and was impliedly authorized (by statute) to enter into binding agreements, regardless of appropriations, and the resulting agreements were not *ultra vires*. *See California*, 271 F.3d at 1383-84.

Third, HHS's "actual authority" (to enter into binding agreements) is separate and distinct from whether HHS's contracts were *ultra vires*. "Actual authority" exists as a function of position, FAR 1.601(a); its existence does not flow from whether a particular action complied with all statutory and regulatory requirements in existence. *Even if* entering into this QHP contract violated the ADA (it did not), the Secretary's unauthorized commitment still *binds* the Government unless the illegality (vis-a-vis the ADA) was patent and "palpably illegal." *John Reiner & Co. v. United States*, 325 F.2d 438, 440 (Ct. Cl. 1963) ("[T]he court should ordinarily impose the binding stamp of nullity only when the illegality is plain."); *Trilon Educ. Corp. v. United States*, 578 F.2d 1356, 1360 (Ct. Cl. 1978) ("[Government] officers must find their way through a maze of statutes and regulations . . . . It would be unfair for [contractors] to suffer for every deviation . . . . [T]he court has preferred to allow the contractor to recover on the ground that the contracts were not palpably illegal to the [contractor's] eyes."). Here, the ACA's express authorization for the Secretary to enter into QHP Issuer Agreements and "establish," "administer," and "pay" RCP amounts to insurers demonstrate clear authority. The alleged conflict with the ADA was not "palpably illegal" because an ADA violation, if any, requires a

complex analysis of Government accounting that Contractors unquestionably lacked insight into at the time that they "accepted" by beginning performance.

B. The Government Breached an Implied-in-Fact *Bilateral* Contract with KYHC.

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

First, the parties' offer and acceptance was unambiguously evidenced by entering into the QHP Issuer Agreements. The agreements were signed by officials of CMS who are authorized to represent CMS. The agreements formally offered KYHC participation as a QHP issuer on the exchanges. KYHC accepted this offer through its signature on the agreements, agreeing to offer plans as QHP issuers on the exchanges, subjecting themselves to various performance standards.

Second, as discussed *supra* II.A.3, consideration flowed both ways, where the Government benefited from KYHC's performance as a QHP issuer, and KYHC benefited from the Government's promise of payment exclusively to QHP issuers.

Third, Kevin Counihan and other directors of CMS who signed the QHP Issuer Agreements had express actual authority to contract. FAR § 1.601(a). The QHP Issuer Agreements expressly memorialized their authority, stating, "The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement." *See e.g.*, CMS, "Agreement Between Qualified Health Plan Issuer and Centers for Medicare and Medicaid Services," *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/qhp-issuer-agreement.pdf. At minimum, Mr. Counihan and the other directors had implied actual authority by nature of their positions. *See H. Landau*, 886 F.2d at 324 ("Authority to bind the [g]overnment is generally implied when such authority is considered

to be an integral part of the duties assigned to a [g]overnment employee.") (quoting Ralph C. Nash & John Cibinic, Formation of Government Contracts (1982)). Even if, *arguendo*, Mr. Counihan and the other directors lacked actual authority to bind the Government, the Government continued to accept and benefit from KYHC's performance as a QHP issuer on the Exchanges, with the knowledge of—and lack of repudiation by—the HHS Secretary, thereby effecting an institutional ratification. *See Silverman v. United States*, 230 Ct. Cl. 701, 710 (1982) (finding institutional ratification where although an official did not have contracting authority, the agency accepted "the benefits flowing from" the official's "promise of payment."). HHS recognized its obligation to make full payment, and promised the same, through fall 2016.

Fourth, mutual intent to contract can be inferred from the parties' conduct and surrounding circumstances. A QHP Issuer Agreement was the culmination of the QHP certification process, where issuers such as KYHC apply to become a QHP issuer, and then CMS—as administrator of Federal Facilitated Marketplaces (FFM)—reviews the application and certifies the issuer as a QHP.[40] QHP certification is a prerequisite for issuers to participate in the exchanges under the ACA. KYHC and CMS engaged in this QHP certification process and entered into the QHP Issuer Agreements for KYHC's participation in the Kentucky marketplace for each benefit year. The QHP certification process, along with the ultimate QHP Issuer Agreement, evidences the mutual intent of KYHC and CMS to enter into a bilateral implied-in-fact agreement, where the parties would perform their respective obligations pursuant to Section 1342 of the ACA.

[40] In state-based marketplaces, the states themselves perform this function.

* * * * *

In sum, the ACA created an implied-in-fact contract with insurers like KYHC under which the Government owed KYHC RCP payments if KYHC sold QHPs on the exchanges pursuant to QHP issuer standards and suffered losses. KYHC sold QHPs on the exchanges as a QHP issuer and suffered losses. The Government breached its reciprocal contractual duty by failing to make full risk corridors payments as promised. Therefore, there is no genuine dispute that the Government is liable to KYHC under the implied-in-fact contract, and KYHC is entitled to summary judgment on that basis.

III. THIS COURT CAN AND SHOULD GRANT KYHC THE RELIEF SOUGHT.

This Court can enter judgment for KYHC irrespective of how such a judgment will be satisfied by the political branches. "This court . . . does not deal with questions of appropriations, but with the legal liabilities incurred by the United States . . . ." *Collins*, 15 Ct. Cl. at 35. As noted, "[t]he judgment of a court has nothing to do with the means—with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them." *Gibney*, 114 Ct. Cl. at 52; *see Slattery*, 635 F.3d at 1317 ("The purpose of the Judgment Fund was to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims."); *N.Y. Airways*, 369 F.2d at 748 ("The failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in [this Court]."). If this Court determines that KYHC is owed funds under the RCP, it will be for the Government to determine how to fulfill that obligation.

CONCLUSION

KYHC respectfully requests that its motion for summary judgment be granted because, based on the undisputed facts, the Government owes KYHC timely annual and complete RCP payments as a matter of law. Specifically, KYHC requests monetary relief in the amounts to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b), *i.e.*, $64,789,497.96 (for benefit year 2014) and $77,311,836.24 (for benefit year 2015), totaling $142,101,334.20. Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

Dated: July 26, 2017

Respectfully submitted,

/s/ Stephen McBrady

Stephen McBrady
CROWELL & MORING LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 624-2500
Fax: (202) 628-5116
SMcBrady@crowell.com

Counsel for Plaintiff Nancy G. Atkins, in her capacity as Liquidator of Kentucky Health Cooperative

OF COUNSEL:
James Regan
Daniel Wolff
Xavier Baker
Sharmistha Das
CROWELL & MORING LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 624-2500

CERTIFICATE OF SERVICE

I certify that on July 26, 2017, a copy of the forgoing "Plaintiff's Motion for Summary Judgment and Memorandum of Law in Support," along with (1) Addendum A and (2) Addendum B, 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.

/s/ Stephen McBrady
Stephen McBrady
CROWELL & MORING LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 624-2500
Fax: (202) 628-5116
SMcBrady@crowell.com