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 REPLY IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO DEFENDANT'S CROSS MOTION TO DISMISS

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INTRODUCTION

The Government's response brief begins by arguing that the Court lacks jurisdiction to hear this case, an argument that has been categorically rejected by every judge to date.[1] That argument is no more credible in this case. The Government then pivots to the merits, devoting the first part of its argument to three points that are not in dispute: (i) that Congress controls the federal purse, (ii) that agencies cannot obligate federal funds absent congressional authority, and (iii) that the federal treasury cannot be drawn upon absent an appropriation.

But then its positions get confusing, with the Government asserting that because the 113th Congress did not appropriate funds to cover the Government's full obligations incurred under Section 1342 of the Affordable Care Act ("ACA")—the risk corridors program ("RCP")—this Court should hold as a matter of law that the 112th enacting Congress *intended* Section 1342 to be self-funding (*i.e.*, budget neutral). Alternatively, the Government posits that even if Congress did not originally intend Section 1342 to be self-funding, the 113th Congress's subsequent appropriation riders effectively amended Section 1342 to make it budget neutral.

As explained in our opening brief and further elaborated upon here, the first argument is at odds with both basic principles of fiscal law and the stated aims of Congress in enacting the ACA (generally) and Section 1342 (specifically). The alternative argument is also incorrect and stems from a mischaracterization of the appropriations riders.

Congress itself, in Section 1342, obligated the United States to make payments according

[1] *See Molina Healthcare of Calif., Inc. v. United States*, 133 Fed. Cl. 14, 28-30 (2017); *Maine Cmty. Health Options v. United States*, 133 Fed. Cl. 1, 3 (2017), *appeal docketed*, No. 17-2395 (Fed. Cir. Aug. 7, 2017); *Blue Cross & Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457, 472-75 (2017), *appeal docketed*, No. 17-2154 (Fed. Cir. June 14, 2017); *Moda Health Plan, Inc., v. United States*, 130 Fed. Cl. 436, 449-51 (2017), *appeal docketed*, No. 17-1994 (Fed. Cir. May 9, 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), *appeal docketed*, No. 17-1224 (Fed. Cir. Nov. 16, 2016).

to a specific statutory formula, as is its constitutional function. If this Court enters judgment in this case, as it should, then Plaintiff will seek to enforce the judgment. Obviously, whatever funds are used to pay that judgment will need to be appropriated, but that is not the concern of this Court. The Court is concerned only with the existence of an obligation and the extent of the liability. It has never been the law that in order to find the Government liable for an unpaid obligation, this Court must first be able to identify a corresponding appropriation to pay the obligation. That is the essence of a judgment; if judgment is for the plaintiff on liability, then it is up to the political branches to appropriate money to pay the judgment. Congress, in its wisdom, created the Judgment Fund to serve precisely that role.

In discerning the meaning of Section 1342, the Government would have the Court ignore the entire stated purpose of Section 1342, which was to stabilize premiums during *each* of the first three years of the ACA exchanges. In exchange for insurers participating in entirely new health insurance marketplaces and offering specific benefits to new enrollees for whom there were inadequate actuarial data with which to price premiums, Congress guaranteed that the Government would share the risk. In each of the first three years, issuers that experienced higher-than-budgeted costs above a certain level were guaranteed a Government payment to mitigate (not eliminate) the resulting losses. The RCP also obligated Qualified Health Plan ("QHP") issuers to *pay to* the Government a portion of gains realized above a certain level (which the Government required on an annual basis). Absent the RCP, the ACA's myriad mandates would have required higher premiums to fully account for the new marketplaces due to the risk of adverse selection (*i.e.*, new enrollment by previously uninsured or underinsured and disproportionately unhealthier individuals, and thus more expensive to insure, than the existing pool of insureds). The RCP thereby moderated otherwise unaffordable premiums.

The Government's post hoc litigation arguments notwithstanding, Congress, HHS, and CMS—along with everyone in the health care industry—understood the RCP's meaning when the ACA was enacted in 2010. Congress expressly "based" the ACA RCP on the existing risk corridors program for Medicare Part D, which has always required payments "in" and "out" to be made annually and in full (not budget neutral). The preamble to HHS's final rule implementing the RCP reflects this understanding (issued subject to notice-and-comment rulemaking): "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. 17,220, 17,238-17,239 (Mar. 23, 2012). Similarly, HHS's first Payment Rule stated that the RCP "is not statutorily required to be budget neutral." 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013). And because Congress never amended Section 1342, that obligation was not abrogated by later appropriations riders.

For the reasons stated here and in Plaintiff's complaint and opening brief, judgment should be entered in Plaintiff's favor.

ARGUMENT

I. THIS COURT HAS JURISDICTION OVER PLAINTIFF'S CLAIMS.

A. Jurisdiction Arises Under the Tucker Act.

The Government challenges jurisdiction by alleging that Plaintiff is not entitled to payment *now*. According to the Government, because Section 1342 does not expressly dictate a payment due date, HHS may administer payments across the "three-year" horizon of the RCP, such that payment is not due until no earlier than late 2017. As the Government acknowledges (Govt. Br. at 15 n.9), every other Court decision addressing this argument has rejected it. In its brief, the Government re-casts a merits-related issue (the right to presently due money) as a jurisdictional one. The Federal Circuit has rejected this line of argument because "[t]here is no requirement in the Tucker Act that there must be a finding that money is due before the Court of

Federal Claims can exercise its jurisdiction," including allegations "that an agency has misinterpreted its statutory mandate to pay out monies." *Kanemoto v. Reno*, 41 F.3d 641, 647 (Fed. Cir. 1994) (citations and quotations omitted); *see, e.g.*, *Lummi Tribe of Lummi Reservation v. United State*s, 99 Fed. Cl. 584, 594 (2011) (where statute at issue mandated that the Government "shall . . . make grants" and "shall allocate any amounts" pursuant to a particular formula, jurisdiction existed because "[s]uch mandatory language is sufficient to confer jurisdiction on this court") (citing *Eastport S.S. Corp. v. United States*, 372 F.2d 1002, 1009 (Ct. Cl. 1967), *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007), and *Wolfchild v. United States*, 96 Fed. Cl. 302, 339 (2010)). Similarly, the RCP mandates that the Government "*shall pay*" certain amounts pursuant to a statutorily prescribed formula. The Government's failure to do so is therefore properly challenged in this Court, and the Court has jurisdiction to hear it. *Accord Molina*, 133 Fed. Cl. at 28-30.

The Government's "three-year payment framework" is not entitled to deference. *See* Govt. Br. at 17. Deference is only appropriate where the statute is ambiguous. *See Chevron U.S.A., Inc. v. Nat'l Res. Def. Council*, 467 U.S. 837, 842 (1984). For the reasons explained in Plaintiff's opening brief and below, Section 1342—by its plain language and in the context of the ACA as a whole—is not ambiguous: full and annual payment is a statutory requirement.

Even if Section 1342 were ambiguous, deference would still not be due because the Government's position is unreasonable. To believe the Government's litigating position, the Court would have to ignore HHS's implementing regulation, promulgated by way of notice-and-comment rulemaking. *See* 45 C.F.R. § 153.510. That regulation reiterates what is obvious from the text of Section 1342: payments out under the RCP are mandated without regard or limitation to payments in (and vice versa). Nowhere in that rulemaking record did HHS ever so much as

hint that the RCP was a "self-funding" program. To the contrary, as noted, HHS said the *opposite* was true. *See* 78 Fed. Reg. at 15,473 ("The [RCP] 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."). Thus, not only would the Government's litigating position vitiate the RCP's entire purpose (sharing of risk), but also the Government's "budget-neutral" argument has none of the hallmarks of reasoned decision-making:[2] (1) it is procedurally defective because it was never raised as part of the notice-and-comment rulemaking process; (2) it is inconsistent with the agency's original position that the RCP should not, and would not, be administered in a budget-neutral manner, and the agency has not acknowledged or explained its reversal of its original position;[3] and (3) it was announced *via sub-regulatory guidance* as an about-face from the agency's original position (of March 2013) only after HHS's original position drew the ire of some members of Congress.[4] *See* Pl.'s Br. at 9.

B. Plaintiff's Claims Are Ripe.

The Government's contention that Plaintiff's claims are not ripe, Govt. Br. at 18 n.10, is similarly misplaced. Plaintiff has met the Federal Circuit's two-prong ripeness test of "fitness" and "hardship." *See CBY Design Builders v. United States*, 105 Fed. Cl. 303, 331 (2012).

Plaintiff meets the "fitness" prong because "further factual development would not significantly advance [this Court's] ability to deal with the legal issues presented." As noted in

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[2] *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2120 (2016) ("One basic procedural requirement of administrative rulemaking is that an agency must give adequate reasons for its decisions.").

[3] *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (where an agency changes course, it must at least "display awareness that it is changing position" and "show that there are good reasons for the new policy").

[4] *Cf. Sandifer v. U.S. Steel Corp.*, 678 F.3d 590, 599 (7th Cir. 2012), *aff'd*, 134 S. Ct. 870 (2014) ("Naturally the Department of Labor does not acknowledge that its motive in switching sides was political; that would be a crass admission in a brief or in oral argument, and unlikely to carry weight with the judges.").

Plaintiff's opening brief, HHS has conceded that the Government owes KYHC full RCP payments for the 2014 and 2015 plan years, it has conceded the precise amounts due, and Plaintiff has not received most of those payments, and never will under the 2015 and 2016 Spending Riders, according to the Government. *See Blue Cross & Blue Shield of N.C.*, 131 Fed. Cl. at 474. In light of the parties' agreement, there is no "further factual development" that will affect the Court's ability to deal with the issues presented by Plaintiff's claims. The Government's suggestion that it "may collect sufficient funds this year to pay risk corridors claims in full" (Govt. Br. at 18 n.10) is a canard. No one, including the Government, believes that it will make full payment on its risk corridors obligations absent a judgment from this Court.

Plaintiff meets the "hardship" prong because the complained-of conduct has already caused an "immediate and substantial impact" on KYHC's ability to repay creditors and continues to do so. *See id*. The Government's unpaid balance of $142,101,334.20 alone establishes objective hardship. *See Coal. for Common Sense in Gov't Procurement v. Sec'y of Veteran Affairs*, 464 F.3d 1306, 1316 (Fed. Cir. 2006); *Inter-Tribal Council of Ariz., Inc. v. United States*, 125 Fed. Cl. 493, 504 (2016) ("years of missed payments and lack of security" established hardship by threatening the sustainability of the trust at issue). KYHC has already entered liquidation due in part to the Government's failure to make RCP payments. The Government's continued refusal to pay amounts due adversely impacts hospitals, healthcare providers, and thousands of individuals previously insured by KYHC, who are strained by the delay in payment and need to be reimbursed from KYHC's estate as soon as possible.

II. PLAINTIFF IS ENTITLED TO SUMMARY JUDGMENT ON ITS STATUTORY CLAIM (COUNT I).

A. Section 1342 Mandates Full, Annual Payment.

The text of Section 1342 resolves the two central issues presented by this case—(1)

whether full payment is due and (2) ***when*** RCP payments are due. This Court's inquiry begins with the statute. *See Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011); *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). Part and parcel to its statutory analysis, the Court must also consider the RCP's purpose and how it fits within the ACA's statutory scheme as a whole. *See 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))); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."). Here, Plaintiff's position comports with Section 1342's plain meaning and the ACA's broader context. In contrast, the Government's argument is unsupported by the text of the statute and would frustrate the ACA's central purpose and core objective.

The statute itself, as explained in Plaintiff's opening brief (Pl.'s Br. at 26-31), permits only one reasonable interpretation: full payments, both in and out, are due on an annual basis. After all, the ACA is a federal overlay to the health insurance market which undeniably operates on an annual cycle: plans are approved by state insurance commissions annually, premiums are adjusted annually, open enrollment is offered annually, regulatory reporting occurs annually, etc. It was onto that existing commercial platform that Congress imposed the ACA which, among other things, requires that the new marketplaces operate on the same annual basis: it speaks of issuers offering QHPs for the "plan year" (*i.e.*, the calendar year), calculating their target allowable costs for the upcoming plan year, and then submitting their allowable costs to HHS at the end of the plan year. Congress underscored the annual nature of the program by making the RCP explicitly "based on" the equivalent risk corridors program in Medicare Part D. It is a basic

tenet of statutory construction that Congress is presumed to be aware of how a statutory program is administered. *See Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85 (1988) ("We generally presume that Congress is knowledgeable about existing law pertinent to the legislation it enacts."). If Congress intended a different outcome, *i.e.*, for the ACA to *change* the key element of annual payment present in the Medicare Part D risk corridors program that Section 1342 was "based on," the presumption requires Congress to have said so.

The guarantee of an annual payment was the *only* way to mitigate risk sufficiently to prevent significant financial hardship to QHP issuers who, absent annual payment, treat unpaid RCP receivables as non-admitted assets, and endure the adverse impact of doing so on their financial solvency.[5] This was particularly true for non-profit CO-OPs, like KYHC, which were designed to provide coverage on the exchanges, and had no other lines of business. It can hardly be doubted *at this point* that the Government's failure to honor this commitment has caused the exchanges, and particularly CO-OPs like KYHC, to experience exactly what Congress intended to avoid: insurers exiting the exchanges and insureds experiencing skyrocketing premiums. The sheer number of health plans that went out of business operating on the exchanges evidences the impact of the Government's *current* interpretation.[6] *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," and "one of the goals of the [ACA]—the creation of 'effective health insurance markets,' [§

[5] *See* Nat'l Ass'n of Ins. Comm'rs, INT 15-01: ACA Risk Corridors Collectability (Nov. 5, 2015), *available at* http://www.naic.org/documents/committees_e_app_eaiwg_related_int_1501_risk_corridors.pdf.

[6] *See also* New York Times, "A Quick Guide to Rising Obamacare Rates" (Oct. 25, 2016), *available at* https://www.nytimes.com/2016/10/26/upshot/rising-obamacare-rates-what-you-need-to-know.html?_r=0 (noting that many insurers "have either left the market or have had to raise their prices sharply to cover the cost of providing coverage").

18091(2)(I)–(J)]—would be unattainable."). Testifying under oath in federal court in mid-December 2016, Kevin Counihan—then HHS's Director and Marketplace CEO at CMS—acknowledged that the Government's "non-payment of the risk corridor payments" in 2014 (beyond the partial 12.6% payment) "had a deleterious effect on the solvency of some insurance companies." Tr. of Bench Trial 2612:9-10, *United States v. Aetna, Inc., et al.*, CA No. 16-1494 (Bates, J.) (D.D.C. Dec. 16, 2016). There is no question that the Plaintiff in this case has been injured by the Government's failure to honor its statutory obligations.[7]

The Government's argument that payments are not due annually ignores everything about both the text of the statute and the practice of the health insurance industry. And the Government's position is further belied by HHS's attempts to make annual payments (albeit incomplete ones). The Government's partial annual payments would be illogical unless HHS understood that the program (including payment) was intended to operate on an annual cycle.

And then there is Congress's purpose and objective in creating the RCP, a backdrop against which the Government does not even try to defend its position. The RCP—along with the transitional reinsurance program in Section 1341 and the permanent risk adjustment program in Section 1343 (together with RCP referred to as the "Three Rs")—served a specific objective: to mitigate the risk that QHP issuers operating on the new exchanges were assuming in light of the ACA's expansion of myriad coverage requirements and their attendant costs. *See, e.g.*, 42

[7] American Academy of Actuaries Individual and Small Group Markets Committee, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*, at 13, 16 (Jan. 2017) (noting that issuer participation in exchanges declined between 2015 and 2016 due to the failure of issuers and adverse financial conditions, explaining that "[t]he failure to pay the full [RCP] amounts led to financial difficulty for many plans, in particular many Consumer Operated and Oriented Plans (Co-Ops)," and referencing KYHC as an example), *available at* https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

U.S.C. § 18021(a)(1)(B) (requiring coverage of "essential health benefits.").[8] The RCP was one of the enticements that drew a new insurer such as KYHC into the marketplaces in the first place. *See* Pl.'s Br. at 5 n.6. To this end, HHS publicly affirmed on multiple occasions that the RCP was a risk-sharing program between insurers *and the Government*. *See* 77 Fed. Reg. at 17,220 (noting 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***." (emphasis added)).[9]

Common sense (and binding precedent) dictates that when Congress says the Government "shall pay" a program participant if certain conditions are satisfied, Congress's direction is *mandatory* if the conditions are satisfied. *See Molina*, 133 Fed. Cl. at 36. This is, and should be, a hard principle to attack. Yet the Government ignores (and would have the Court ignore) what it previously acknowledged: the RCP was created to serve as a risk-sharing program *between* insurers *and the United States*. The Government now argues instead that the RCP merely shares risk *among insurers*. *See* Govt. Br. at 7 (representing that "amounts collected from profitable insurers are used to fund payments to unprofitable insurers").[10]

This makes no sense. Under its current "self-funding" RCP theory, the Government asks this Court to believe that the 112th enacting Congress *designed* Section 1342 to expose QHP

[8] 77 Fed. Reg. at 17,220 ("These risk-spreading mechanisms [the Three 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.").

[9] The Government contends the comments of HHS are irrelevant because an agency cannot obligate public funds absent statutory authority. Govt. Br. at 48. The Government misses the point. HHS did not create the obligation—Section 1342 does that. But HHS's contemporaneous comments are relevant because they undermine the representations the Government now makes in litigation about the meaning of Section 1342. *See Moda*, 130 Fed. Cl. at 457.

[10] The Government's assertion that the RCP would "indemnify" insurers' risk by "creating a government guarantee" (Govt. Br. at 41) is counterfactual, as is its repeated argument that Plaintiff is somehow claiming taxpayer funds to "make up shortfalls in insurer's profits" (Govt. Br. at 37). By design, even full RCP payments would not eliminate KYHC's losses or come anywhere close to guaranteeing a profit—the RCP mitigates loss by paying back a percentage of the losses; *it does not make insurers whole or profitable*.

issuers to the full brunt of *all* risk posed by the untested marketplace—a market it created and enticed insurers to join—by conditioning "payments out" of the program on the amount of "payments in," if any, and require those issuers to carry potentially substantial losses on their books from year to year. Under the theory peddled by the Government, if all QHP issuers lost money in the exchanges, not one penny of risk corridors payment would be made to any plan to mitigate those losses. Such a construction would assist to usher in the very eventuality the RCP was designed to prevent, and would result in the Government sharing no risk at all. *See King*, 135 S. Ct. at 2496 ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them."); *see also N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973) ("We cannot interpret federal statutes to negate their own stated purposes."); *Cathedral Candle Co. v U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1364 (Fed. Cir. 2005) (unreasonable interpretation if "at odds with the purposes served by the regulation."). "It is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494.

Instead of offering a defense, the Government goes in the opposite direction and tries to debate the stabilizing purpose of the RCP—the very premise of the program. *See* Govt. Br. at 42 n.23. But the Government's suggestion that the RCP was *not* a stabilization program contradicts everything that HHS said about the RCP prior to this litigation, ***and*** other portions of the Government's own brief. *See* Govt. Br. at 6 (acknowledging that the RCP, in combination with its sister "Three R" programs, was designed as a "premium-stabilization" program).

The Government rests its case on two other notions: (1) that it has no obligation to pay because Congress never appropriated the necessary funds; or, alternatively, (2) whatever obligation was created by Section 1342, Congress repealed it by implication through the appropriations acts for 2015 and 2016. As discussed below, neither argument has merit.

B. The Government's Liability Does Not Depend on There Also Being a Dedicated Appropriation for That Liability.

The Government is quick to invoke the Appropriations Clause, which states that "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law," Govt. Br. at 2 (quoting U.S. Const. art. I, § 9, cl. 7), but that clause has nothing to do with the business of this Court, which is to decide whether the Government has failed to pay Plaintiff pursuant to an obligation of the United States. Under the Government's theory, Congress's failure to appropriate funds for HHS to make RCP payments demonstrates that Section 1342 did not obligate the United States in the first instance. But this confuses the United States' *obligation to pay* with HHS's *ability to pay*. This Court (and Plaintiff's complaint) is concerned only with the former. 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)[11]; *see also Strong v. United States*, 60 Ct. Cl. 627, 630 (1925) (awarding statutorily mandated military pay despite lack of an appropriation); *Parsons v. United States*, 15 Ct. Cl. 246, 246-47 (1879) (awarding statutorily mandated payment despite lack of an appropriation, noting that "*the absence of an appropriation*

[11] The Government also mischaracterizes the import of KYHC's counsel's statement in another case regarding claim accrual. *See* Govt. Br. at 45 n.25. It is true (as counsel stated) that a *claim* does not accrue until the RCP cost data has been submitted the year following the relevant plan year, but that has nothing to do with when the ***Government's obligation*** to the QHP issuer arises, which, as plaintiff has briefed, occurs "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." Pl.'s Br. at 35 (quoting II GAO, Principles of Fed. Appropriations Law ["GAO Redbook"], at 7-4 - 7-5 (3d ed. 2006), *available at* https://www.gao.gov/legal/red-book/overview (emphasis added)).

constitutes no bar to the recovery of a judgment in cases where the liability of the government has been established." (emphasis added)).

Precisely because Congress has "the power of the purse," it can mandate payment irrespective of whatever additional authority it vests in an agency to obligate the Government on its own. There is no question Congress can obligate the United States by substantive legislation to pay money. *See United States v. Mitchell*, 463 U.S. 206, 218 (1983); *Collins*, 15 Ct. Cl. at 35. That is precisely what Congress did in Section 1342. *Slattery* flatly rejects the position that the United States is only liable for financial obligations if the subject agency has been funded by an appropriation. 635 F.3d 1298, 1317-21 (Fed. Cir. 2011).[12]

Significantly, when Congress intends an obligation to turn on the existence of an appropriation, it knows how to say so, as it did in at least four other ACA sections by inserting "subject to the availability of appropriations." 42 U.S.C. §§ 280k(a), 300hh-31(a), 293k-2(e), 1397m-1(b)(2)(A).[13] Case in point, one of the Government's featured cases, *Prairie County, Montana v. United States*, addressed a statute that, unlike Section 1342, ***expressly*** made the Government's obligation "subject to the availability of appropriations." *Compare* Govt. Br. at 34-35, 40-41 *with* 782 F.3d 685, 687-88 (Fed. Cir. 2015) ("the [statute's] plain language . . .

[12] The Government's efforts to evade the applicability of *Slattery v. United States*, 635 F.3d 1298, 1317 (Fed. Cir. 2011) (en banc) are unavailing. *Slattery*'s jurisdictional holding counsels rejection of the type of second jurisdictional test the Government attempts to apply to RCP plaintiffs. That its holding is limited to jurisdiction, Govt. Br. at 46 n.26, simply underscores the fact that the Government continues to improperly frame the availability of an appropriation as a merits issue when it is, in truth, a second jurisdictional test. The *Molina* court rejected this "supposed two-pronged test" as "completely contrary to a mountain of controlling case law holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation." *Molina*, 133 Fed. Cl. at 36.

[13] HHS's recognition that RCP was not intended to be budget neutral while the other two premium stabilization programs were, underscores the point. 45 C.F.R. § 153.230(d) (reinsurance program will be budget neutral); 78 Fed. Reg. at 15,441 (Risk Adjustment methodology provides for a "budget-neutral revenue redistribution among issuers.")

limits the government's liability . . . to the amount appropriated by Congress."). The Government fails to articulate any plausible reason why Section 1342 should be read as though it contains this limiting language when it plainly does not. The Supreme Court has long admonished federal courts not to read into a statute words Congress elected to exclude. *See Sale v. Haitian Ctrs. Council, Inc.*, 509 U.S. 155, 168 n.16 (1993) (courts "may not add terms or provisions where congress has omitted them . . . .").

The Government fares no better in citing *Nevada v. Department of Energy*, 400 F.3d 9, 13 (D.C. Cir. 2005) (Govt. Br. at 21) for the proposition that a plaintiff seeking to enforce a money-mandating statute must identify not just a "command" but also "an appropriation." Plaintiff in that case challenged the reasonableness of the Department of Energy's refusal to pay out more than its appropriation allowed. That is not the issue here—Plaintiff has not sued HHS for arbitrarily and capriciously refusing to pay. There is no dispute that HHS's budget authority was curtailed by the 2015 and 2016 Spending Riders. This case involves a debt of the United States, created by Congress, not an HHS debt. It is immaterial to the interpretation of Section 1342 whether HHS itself was authorized to make payment; it matters only whether *Congress* bound the United States to certain obligations when insurers performed and qualified for payments by virtue of experiencing sufficient higher-than-expected costs on the exchanges.

The Government's invocations of the Anti-Deficiency Act ("ADA") and Congressional Budget Act for the proposition that HHS may not incur obligations without advance budget authority or a dedicated appropriation are also off the mark. *See* Govt. Br. at 20 (citing 2 U.S.C. § 622(2)(A)); *id.* at 27. In arguing that the ADA constrained HHS, the Government relied on the ADA provision that prohibits agency officials from making or authorizing an expenditure or obligation "exceeding an amount available in an appropriation or fund for the expenditure or

obligation." Govt. Br. at 20 (citing 31 U.S.C. § 1341(a)(1)(A)). But the ADA only imposes fiscal restraints on agency officials; *the ADA does not restrict or apply to Congress*. There is no dispute that Congress possesses Constitutional authority to make or authorize obligations. Further, "Congress may expressly state that an agency may obligate in excess of the amounts appropriated, or it may implicitly authorize an agency to do so *by virtue of a law that necessarily requires such obligations*." GAO Redbook at 6-91 (emphasis added). The ADA even makes clear that its restrictions on agencies incurring obligations evaporate where "authorized by law," *i.e.*, where Congress says otherwise. *See* 31 U.S.C. § 1341(a)(1)(B). As GAO has opined, there is:

> no legal requirement for specific appropriation authorization language, although the use of such language certainly serves to remove any doubt as to whether an authorization of appropriations is intended. ***Rather, the enactment of general legislation which clearly contemplates Federal financing is sufficient authorization for appropriations to carry out such legislation.***

Hon. George E. Danielson, B-173832 (Comp. Gen.) (Aug. 1, 1975), *available at* http://www.gao.gov/products/400005#mt=e-report (emphasis added). Here, Congress did that.

Two other cases favored by the Government are also of no help to it. In *Highland Falls-Fort Montgomery Cent. Sch. Dist. v. United States*, the substantive statute mandated that qualifying entities "shall be entitled" to payment but also expressly dictated how the Government should allocate funds in the case of insufficient annual appropriations, and Congress subsequently specifically "earmarked" the *precise* amount of funds, indicating an intent to repeal. 48 F.3d 1166, 1168, 1170 (Fed. Cir. 1995) (quoting 20 U.S.C. §§ 237(a), 240(c)). Similarly, in *Star-Glo Associates, LP v. United States*, Congress expressly limited payments under a statutory program compensating citrus growers for destroyed citrus groves—"[t]he Secretary of Agriculture shall use $58,000,000 of the funds of the Commodity Credit Corporation to carry out this section, to remain available until expended"—thereby expressly

legislating a statutory cap. 414 F.3d 1349, 1354-55 (Fed. Cir. 2005) (quotations omitted).

The ADA provision relied upon by the Government and the cases applying it are not controlling because Congress never capped in an appropriation the amount of funds available to make RCP payments. That is the point: Section 1342's "shall pay" mandate is unconditional, capped only by the inherent limitations imposed by the statutory formula. *See, e.g.*, *Moda*, 130 Fed. Cl. at 455 ("Section 1342 simply directs the Secretary of HHS to make full 'payments out.' Therefore, full payments out he must make."); *Molina*, 133 Fed. Cl. at 37 ("Section 1342 also explicitly capped the Government's liability at a certain percentage of a lossmaking insurer's allowable costs."). Judge Wheeler's decision on behalf of the insurer in *Molina* is instructive. He aptly pointed out that the Government's argument that Section 1342 could not have created an obligation on the part of the United States absent Congress *also* creating a dedicated appropriation "is completely contrary to a mountain of controlling case law . . . holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation." *Molina*, 133 Fed. Cl. at 36. Similarly, addressing Section 1342 specifically and a GAO report about how the RCP was to be funded, the federal district court for the District of Columbia observed that "not only is it possible for a statute to authorize and mandate payments without making an appropriation, but GAO has found a prime example in the ACA." *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 185 (D.D.C. 2016). The Government itself acknowledged this principle in its brief submitted in *Burwell*, contending that a plaintiff may establish liability irrespective of an appropriation, and then if 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. at 11, *U.S. House of Representatives v. Burwell*, No.

1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (citing *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2191-92 (2012)).

The Government also relies on the absence from Section 1342 of certain language found in Medicare Part D relating to an agency's "budget authority in advance of appropriations" as proof that Congress did not intend to give HHS equivalent authority to obligate the United States under Section 1342. *See* Govt. Br. at 23. But Medicare Part D actually illustrates the fallacy of the Government's position that this Court must identify a dedicated appropriation before it can find that Section 1342 obligated the United States: Part D no more has a dedicated appropriation than Section 1342. Its "in advance of appropriations" language illustrates one way for Congress to obligate the United States (by authorizing the agency to do so), but money still needs to be appropriated to pay that obligation. The two concepts are distinct. The Government recognizes that, despite Part D RCP payments not being appropriated for in advance, the United States is obligated to program participants. It is no different with RCP payments under Section 1342.[14]

The absurdity of what the Government is suggesting in litigation should be alarming to this Court. The Government argues that "shall pay" actually means "shall pay, *subject to appropriations*," despite Congress *not* writing the law to say that. The Government's addition of those words would alter the entire dynamic of the exchanges. Insurers like KYHC depended on the certainty of the "shall pay" mandate of Section 1342 no less than prescription drug providers depend on the "budget authority in advance of appropriations" language of Medicare Part D, and that certainty was solidified by the fact that Congress expressly intended Section

[14] That HHS has been acknowledging the Government's RCP obligations and recording them as requiring full payment shows that it understood its Section 1342 and Medicare Part D authorities to be functionally equivalent. While HHS's actions do not create the obligation (Section 1342 does), they certainly "evidence[] the obligation." GAO Redbook at 7-8; *see also id.* at 7-43 (non-discretionary expenditures "*imposed by law*" should be recorded as "obligations").

1342 to be "based on" Part D. *See Moda*, 130 Fed. Cl. at 466 ("After all, 'to say to Moda, "the joke is on you. You shouldn't have trusted us," is hardly worthy of our great government.'") (modifications omitted) (quoting *Brandt v. Hickel*, 427 F.2d 53, 57 (9th Cir. 1970)).

Finally, the Government misses the mark again in addressing the Judgment Fund, which is irrelevant to the question of the Government's *liability*. The Government makes the counterfactual assertion that there must be an appropriation in order for there to be a liability on which this Court may render judgment. *See* Govt. Br. at 44-45. As already explained, that is not correct. Where liability stems from an unqualified money-mandating statute, the existence of an appropriation is only relevant *after* this Court enters judgment against the United States. In that event, the political branches of Government—not the Court of Federal Claims—must determine how to pay the judgment, an action that requires an appropriation. That appropriation can either be specific to the judgment in question, or it can come out of the Judgment Fund, which is a permanent appropriation specifically for the purpose of paying judgments for which there was no other appropriation. *See* 31 U.S.C. § 1304(a)(1); *Slattery*, 635 F.3d at 1303. Either way, it is not the concern of this Court when considering whether to render judgment in the first instance on the Government's liability. *See* Pl.'s Br. at 51; *accord Collins*, 15 Ct. Cl. at 35 ("The officers of the Treasury have no authority to pay such compensation until appropriations therefor are made[.] . . . The liability, however, exists independently of the appropriation, and may be enforced by proceedings in this court.").

C. The Later Spending Riders Did Not Nullify or Modify the Government's RCP Obligations.

The Government places great weight on the 2015 and 2016 Spending Riders in arguing that, even if Congress obligated the United States in Section 1342, it abrogated the obligation in the Spending Riders. But in so arguing, the Government ignores the actual text of those acts.

Despite recognizing that "[t]he whole question depends on the intention of congress ***as expressed in the statutes***," Govt. Br. at 28 (citing *United States v. Mitchell*, 109 U.S. 146, 150 (1883)) (emphasis added), the Government places outsized weight on legislative history over the actual statutory text in order to divine Congress's intent. This is wrong for at least two reasons.

First, where the Government's liability does not depend on a specific appropriation, a later Congress's restriction on *HHS's ability* to make RCP payments is legally irrelevant. With respect to payments due to insurers under Section 1342, Congress's later actions did not abridge the obligation *of the United States*, nor could they have. At most, they affected only the source of payment. The Government's liability exists independently of HHS's ministerial capacity to *make* the payments. The Government's liability continues to exist, undisturbed, as an obligation of the United States—a point HHS itself acknowledged on multiple occasions.

Second, as Plaintiff has extensively briefed, the Spending Riders on their face did not abrogate the RCP's clear statutory mandate to make full payments. Pl.'s Br. at 36-41. As Judge Wheeler observed in *Molina*, "Congress did not clearly or adequately express an intent to [retroactively] make the program 'budget neutral' in the appropriation riders, given the previous unequivocal mandatory obligation undertaken in Section 1342." 133 Fed. Cl. at 19. The *Molina* court focused on six cases in particular, two of which found that a later appropriation law repealed or amended a prior substantive law and four of which refused to do so.[15] The distinction in the two lines of cases was between Congress ***broadly curtailing spending*** for a program from appropriations contained in the relevant piece of legislation (thus effecting a

[15] Judge Wheeler noted four relevant cases that "have refused to find a repeal or amendment." *Moda*, 130 Fed. Cl. at 459 (citing *United States v. Langston*, 118 U.S. 389, 394 (1886); *Gibney v. United States*, 114 Ct. Cl. 38, 50 (1949); *N.Y. Airways v. United States*, 369 F.2d 743, 815, 818 (Ct. Cl. 1966); *District of Columbia v. United States*, 67 Fed. Cl. 292, 335 (2005)). In contrast, two cases found a repeal or amendment. *Molina*, 133 Fed. Cl. at 34-35 (citing *United States v. Dickerson*, 310 U.S. 554, 561-62 (1940); *United States v. Will*, 449 U.S. 200, 208 (1980)).

substantive amendment), and Congress targeting and ***blocking only a specific funding source*** (thus limiting spending but not substantively amending law). *See id.* at 33-35. Where, as here, Congress merely limited a single funding source and failed to expand the limitation to other sources of funds using Congress's typical language to do so ("this Act or any other Act"), 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. *Id.* at 34.

Although the Government concedes that "Congress neither repealed the risk corridors program nor amended section 1342's direction to HHS to establish and administer the program," it contends that Congress "definitively capped payments at amounts collected and thus superseded any such obligation." Govt. Br. at 27. In contending that the 2015 and 2016 Spending Riders affirmatively "appropriated" "payments in" as the sole funding mechanism for "payments out," the Government urges the Court to view these so-called appropriated "payments in" as a "cap" no different than the hard cap established by the appropriations in *Star-Glo*. There is no support for this theory—it is a fiction because the 2015 and 2016 Spending Riders are utterly devoid of any whiff that Congress affirmatively appropriated "payments in" as the cap to RCP payments out. All the Spending Riders did was block certain funds in certain HHS accounts for being used to *make* payments out. They did not repeal or cap the obligation that Congress itself imposed in Section 1342, which remains unchanged on the books.

Congress *could* have expressly amended Section 1342 to make it budget neutral or capped at "payments in," but it did not. It *could* have barred the use of funds from "this Act or any other Act," but it did not. In fact, Congress used this precise language in other provisions of the *same* Spending Riders and *could* have done the same with respect to Section 1342,[16] but it

[16] *See, e.g.*, Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. No. 113-

did not. Although the Government recognizes that Congress "knows how to . . . make and limit appropriations," Govt. Br. at 36 n.21, it offers no coherent explanation for why Congress expressly blocked access to *one* CMS account, if it supposedly "intended" that "no public funds" may be spent on RCP reimbursements, or if it sought to bar payment from "this Act or any other Act." Congress merely placed a temporary limitation on CMS's authority to use one particular funding account to pay its obligation—Congress did not nullify the underlying obligation.

Compounding its errors, the Government gives short shrift to the serious disruption its position would cause rights already accrued. As Plaintiff briefed, the GAO Redbook clearly notes that obligations may arise (even unmatured obligations) in earlier fiscal years than when those payment are ultimately due. Pl.'s Br. at 35-36. KYHC had a right to its RCP payments before Congress curtailed the sources of those payments because KYHC had completed all of its statutory requirements and its commitment to participate on the exchanges was fixed and irrevocable ***before Congress passed the Spending Riders.*** Months before December 16, 2014, when Congress enacted the 2015 Spending Rider (for the first time curtailing CMS's authority to fund 2014 RCP obligations), KYHC had nearly completed performance for the 2014 benefit year and submitted premiums, complied with all requisite regulatory requirements, and executed QHP agreements for the 2015 benefit year. Likewise, Congress did not enact the 2016 Spending Rider

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235), § 716 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 717 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 718 ("None of the funds appropriated by this or any other Act shall be used to pay . . . ."), § 731 ("None of the funds made available by this or any other Act may be used to write, prepare, or publish . . . ."), § 735 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."); Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113), § 714 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 715 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 716 ("None of the funds appropriated by this or any other Act shall be used to pay . . . ."), § 733(b) ("None of the funds appropriated or otherwise made available by this or any other Act shall be used . . . .").

(curtailing CMS's authority to fund 2015 RCP obligations) until December 18, 2015, by which point KYHC had nearly completed performance for the 2015 plan year and had already committed to benefit year 2016.

Depriving KYHC of its right to RCP payments, after it had provided insurance under a statutory scheme in which such payments had been guaranteed "'would impair rights a party possessed when [it] acted . . .'" and impose new rules on a transaction already completed. *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quoting *Landgraf v. USI Film Prods*., 511 U.S. 244, 280 (1994)). Such retroactive application of statutes is "disfavored," and thus "it has become 'a rule of general application' that 'a statute shall not be given retroactive effect unless such construction is required by explicit language or by necessary implication.'" *Id.* (quotation omitted). Further, a statute "ought never to receive such a [retroactive] construction if it is susceptible of any other. It ought not to receive such a construction unless the words used ***are so clear, strong, and imperative that no other meaning can be annexed to them, or unless the intention of the legislature cannot be otherwise satisfied***." *U.S. Fid. & Guar. Co. v. United States*, 209 U.S. 306, 314 (1908) (emphasis added); *see also* Pl.'s Br. at 36-41.

III. PLAINTIFF IS ENTITLED TO SUMMARY JUDGMENT FOR BREACH OF ITS IMPLIED-IN-FACT CONTRACT WITH THE GOVERNMENT (COUNT II).

The Government's contention that Section 1342 merely establishes a "benefits program" for QHPs, and not an implied-in-fact contract, Govt. Br. at 48, ignores Plaintiff's allegations to the contrary based on the surrounding circumstances, including the Government's conduct, both at the time of statutory formation and thereafter. The Government held out a unilateral offer of RCP payments to induce QHP issuers, including KYHC, to begin performance. HHS received the benefits of the QHP issuers' expanded coverage for millions of Americans at lower premiums than would have been offered absent the RCP. HHS failed to uphold its side of the

bargain. Those RCP payments are still owed. After QHP issuers accepted by beginning performance, HHS received the benefits of expanded and affordable coverage for millions of Americans. HHS's failure to uphold its side of the bargain is a textbook contractual breach. In the alternative, the same circumstances culminating in the execution of QHP agreements gave rise to a bilateral implied-in-fact contract.

All elements of an implied contract are met here,[17] and Plaintiff is entitled to the contractually-obligated amounts as a matter of law.

A. There Was Mutuality of Intent.

The Government contracts when its conduct or language "allows a reasonable inference" that it intended to. *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011). The surrounding circumstances include the statutory purpose, context, legislative history, or any other objective indicia of actual intent.[18] Plaintiff has established that the combination of Section 1342, HHS's implementing regulations, and the Government's conduct (before and after KYHC agreed to become a QHP) support that the "conduct of the parties show[ ], in the light of the surrounding circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996); *see, e.g.*, Compl. ¶¶ 84-97.

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[17] 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. *E.g.*, *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995).

[18] *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. Assoc.-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").

The Government distorts this longstanding test by contending that this intent to contract *must be expressly stated* in the statute. DOJ asks this Court to be the first to create this narrow holding by pointing to cases that contain no such express language.[19] The Government asserts that the *Radium Mines* statute "clearly expressed" an intent to enter into a contract. Govt. Br. at 51. However, *Radium Mines* did not turn on an express reference to a possible contract but focused instead on the regulations' "promissory" nature. *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001). The Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes. *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

Further, the Government attempts to undermine Judge Wheeler's decision in *Moda* as a "sweeping new rule for inferring congressional intent to contract based on a statute's structure." Govt. Br. at 52 n.29. But the opposite is true: *Moda* fits squarely within controlling precedent while the Government would create a "new rule." It contends that considering the statute's structure—instead of the text and legislative history—is inconsistent with *Brooks v. Dunlop Mfg., Inc.*, 702 F.3d 624 (Fed. Cir. 2012). This violates the plain meaning rule. Further, *Brooks* is inapposite; unlike Section 1342, which obligated the Government to make RCP payments once insurers performed (by offering QHPs and experiencing the requisite annual losses), the statute in *Brooks* imposed no obligation—it lacked mutuality, avenue for acceptance, and consideration.

The Government's other cases are also distinguishable. The *ARRA Energy* plaintiff rested its unsuccessful contract claim solely upon the statute itself, whereas Plaintiff relies upon a raft of HHS assurances.[20] *See* 97 Fed. Cl. at 27. Likewise, in *AAA Pharmacy, Inc. v. United*

[19] Moreover, *even if* they did, the longstanding legal test for inferring mutuality of intent is not tacitly modified by the mere factual vagaries of certain cases.

[20] These HHS assurances include: implementing regulations that made payments mandatory;

States, 108 Fed. Cl. 321 (2012), the plaintiff alleged an implied right to specific *procedures* for a Medicare billing appeal, which differs sharply from the mutuality of intent to actually *agree* to RCP payments in exchange for expanded coverage at low-costs. And in *Bay View, Inc. v. United States*, 278 F.3d 1259 (Fed. Cir. 2001), the bulk of the court's analysis focused on whether there was an offer and acceptance (rather than mutuality of intent to contract) and the statute at issue there did not require the Government to do anything. *See Molina*, 133 Fed. Cl. at 44.

B. There Was Offer and Acceptance.

The Government *offered* RCP payments to insurers through the language of the ACA, 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. 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 exchanges to constitute unambiguous offer and acceptance even in the absence of any explicit reference to an offer or contract.[21] The Government's reliance on *Land of Lincoln* is meritless.

C. There Was Consideration.

Consideration at the time of formation flowed both ways. QHP issuers are the backbone of the Government's effort to provide affordable and comprehensive coverage through the exchanges and, *but for* the Government's promise of risk stabilization, insurers would not have offered plans under a brand new statutory scheme at affordable premiums. When KYHC agreed

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accompanying preamble promising to pay regardless of the amounts collected; transitional policy that sharply increased the costs of health care coverage, and which led HHS to expressly reaffirm the availability of RCP payments to offset those costs; and HHS's repeated promises to pay.

[21] *Radium Mines, Inc. v. United States*, 153 F. Supp. 403, 405-06 (Ct. Cl. 1957) (risk stabilization and minimum prices constituted offer which "induced" companies to accept through performance); *N.Y. Airways*, 369 F.2d at 816-18 (finding published "board rate" for aviation transportation services constituted an offer that plaintiff accepted through performance).

to offer QHPs, the Government and KYHC committed to an intricate set of specific, reciprocal obligations.[22] The Government benefitted by KYHC's servicing of formerly uninsured, 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* QHPs 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. *See 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").

D. 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." 48 C.F.R. § 1.601(a) (contractual authority in each agency flows *from* the Agency Head to delegated officials).[23]

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

[22] 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).

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

implement the ACA,[24] give the Secretary the express (or at least implied) authority to enter into binding QHP 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 his or 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.

The Government's assertion that the ADA (31 U.S.C. § 1341(a)(1)(B)) requires otherwise is erroneous. 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*, 400 F.3d at 16; *Dep't of Health & Human Servs.-Risk Corridors Program*, B-325630 (Comp. Gen.), 2014 WL 4825237, **2-3 (Sept. 30, 2014). Second, *even if* no appropriated funds were available (they were), the resulting implied contract would not *ipso facto* violate the ADA. *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 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 *agreements* with insurers, and (2) to "establish and administer" the RCP program in which the Secretary "shall pay" RCP funds. The Secretary had actual authority (by position) and was impliedly authorized (by statute) to enter into binding agreements, regardless of

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

appropriations, and the resulting agreements were not *ultra vires*. *See id*.

Third, the Government conflates HHS's "actual authority" (to enter into agreements) with whether the QHP agreements potentially conflicted with the ADA. But "actual authority" exists as a function of position, 48 C.F.R. § 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 agreement violated the ADA (it did not), the Secretary's unauthorized commitment still *binds* the Government unless the illegality (vis-à-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) ("It would be unfair for [contractors] to suffer for every deviation [from statute] . . . [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 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. The Government's arguments that the HHS Secretary lacked actual authority are misplaced.[25]

E. In the Alternative, the Government Breached an Implied-in-Fact Bilateral Contract with KYHC.

The Government's sole response to Plaintiff's alternative argument asserting a bilateral

[25] Even accepting an ADA violation, *arguendo*, Plaintiff is *still* entitled to payment because the implied contract would be void, the Court would retain jurisdiction, and KYHC would be entitled to *quantum valebant* for the value of the QHP services conferred. *See Yosemite Park & Curry Co. v. United States*, 582 F.2d 552, 561 (Ct. Cl. 1978); *Aero Union Corp. v. United States*, 47 Fed. Cl. 677, 680-81 (2000). This entitlement, even if different than the pled amount, still warrants rejection of the Government's 12(b)(6) motion.

implied-in-fact contract is premised upon a mischaracterization of the QHP agreements and Plaintiff's reference to them. First and foremost, QHP agreements are not and do not purport to be express contracts, nor has Plaintiff alleged that they are. Rather, the parties' conduct, representations, pricing, and the statutory requirements formed the "relevant contractual parameters" of the parties' implied-in-fact bargain. *See* Govt. Br. at 56. The parties' implied-in-fact bargain culminated in the bilateral signing, by authorized officials of each party, of the QHP agreement—a sufficiently clear manifestation of bilateral offer and acceptance to the implied contract. *See, e.g.*, *Kam-Almaz v. United States*, 682 F.3d 1364, 1368 (Fed. Cir. 2012) (implied contracts are "inferred" from "conduct" showing "tacit understanding."); *Zacharin v. United States*, No. 96-5076, 1997 WL 63177, at *5 (Fed. Cir. Feb. 14, 1997) (the terms of a "single agreement" may be drawn from multiple sources and documents, taken together).

As the Government acknowledges, Plaintiff asserted that an implied-in-fact contract "is evidenced by the QHP Agreement," Govt. Br. at 56, which is part of the surrounding circumstances giving rise to the bilateral implied-in-fact contract. *See* Compl. ¶ 89. Thus, it is incorrect to indicate that "[t]he QHP Agreements established the relevant contractual parameters of KYHC's offering of QHPs on an Exchange . . .," Govt. Br. at 56, because the terms of KYHC's offering of QHPs on the exchange were governed by the parties' course of dealing culminating in the agreements, not the QHP agreements themselves. Pl.'s Br. at 49-51. Indeed, the Government's contrary position is inconsistent with its own characterization of the QHP agreements 51 pages earlier as a part of the certification that requires QHP issuers to "adhere to privacy and security standards." Govt. Br. at 5. Plaintiff agrees. The QHP agreements are part of the certification process and they, coupled with the full certification process, give rise to a

bilateral implied-in-fact contract.[26] Since they are not express contracts precluding an implied contract claim, the Court should reject the Government's arguments out of hand.

F. Congress Cannot Abrogate Contractual Liability through Appropriations.

Congress cannot curtail the Government's contractual liability through the appropriations process. *Salazar*, 132 S. Ct. at 2189; *Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 646 (2005). This applies "even if an agency's total lump-sum appropriation is insufficient to pay all the contracts the agency has made." *Cherokee Nation*, 543 U.S. at 637. When an agency lacks appropriations, "the Government's 'valid obligations will remain enforceable in the courts.'" *Salazar*, 132 S. Ct. at 2189 (citing II GAO Redbook at 6-17 (2d ed. 1992)).

Plaintiff's implied contract claim falls neatly within this line of cases. As in *Salazar*, Congress provided some funding to meet contractual obligations, but not enough to fully satisfy those obligations. The Government does not argue otherwise. Plaintiff seeks payment for contractually-obligated amounts, and the Judgment Fund is available to pay this judgment.

IV. CONCLUSION

For the reasons set forth above, Plaintiff respectfully requests that the Court (i) GRANT its Motion for Summary Judgment, and (ii) DENY the Government's Motion to Dismiss.

[26] While Plaintiff agrees that the QHP agreement is part of the certification process, it does not agree with the balance of the Government's description that the QHP agreement does not commit insurers to participating on the exchanges. Govt. Br. at 5. It does not "merely reflect[] a business decision by the insurer that is accompanied by regulatory consequences"; the terms explicitly state that termination of the Agreement "does not relieve QHPI of applicable obligations to continue providing coverage to enrollees" and "specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year." *See, e.g.*, QHP Agreement 2017 at 7, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Plan-Year-2017-QHP-Issuer-Agreement.pdf.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on November 7, 2017, a copy of the forgoing "Plaintiff's Reply in Support of Its Motion for Summary Judgment and Opposition to Defendant's Cross Motion to Dismiss" 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, Terrance A. Mebane, via the Court's ECF system.

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