IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MONTANA HEALTH CO-OP, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	No. 16-1427C Judge Victor J. Wolski

PLAINTIFF'S SUPPLEMENTAL MEMORANDUM OF LAW IN FURTHER SUPPORT OF ITS MOTION FOR PARTIAL SUMMARY JUDGMENT

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As the Court has requested, Plaintiff Montana Health CO-OP ("Plaintiff" or "Montana Health") submits this Supplemental Memorandum of Law in Further Support of its Motion for Partial Summary Judgment to brief Judge Griggsby's Opinion and Order in *Blue Cross & Blue Shield of N.C. v. United States*, No. 16-651C ("BCBSNC Order"). 2017 WL 1382976 (Fed. Cl. Apr. 18, 2017). Although the BCBSNC Order correctly recognized that the Court has subject matter jurisdiction to hear the case, the Court reached the wrong conclusion in deciding that the plaintiff had failed to state a claim. The decision on the merits in *Blue Cross & Blue Shield of N.C. v. United States* is not consistent with the governing statute or basic principles of statutory interpretation and should not be followed.

BACKGROUND

Blue Cross & Blue Shield of North Carolina ("BCBSNC") is a health insurer that made a Qualified Health Plan ("QHP") available on the North Carolina exchange and, like Montana Health, asserted a claim for money damages against the United States under the risk corridors program ("RCP") created by Section 1342 of the Affordable Care Act ("ACA"), 42 U.S.C. § 18042, and its implementing regulations. As in the case *sub judice*, the Government moved to dismiss BCBSNC's complaint, asserting that: (1) the Court lacked subject matter jurisdiction because no payments were "presently due"; (2) BCBSNC's claims were not ripe because payments were not due until, if at all, sometime in 2017 or 2018; and (3) BCBSNC failed to state a claim because the RCP does not require payment in excess of amounts collected.[1] *BCBSNC*, 2017 WL 1382976, at *11. Unlike Montana Health, Plaintiff BCBSNC did not move for summary judgment with respect to its statutory claim.

Judge Griggsby denied in part and granted in part the Government's motion to dismiss. The Court held that it had subject matter jurisdiction under the Tucker Act and that BCBSNC's

[1] We address only those aspects of Judge Griggsby's order relevant to Montana Health's claims.

claims were ripe for adjudication. It therefore denied the Government's motion to dismiss for lack of subject matter jurisdiction. On the merits, however, the Court held that BCBSNC failed to state a plausible statutory claim for relief because the RCP did not impose a specific deadline for payment (and therefore no payments were due) and that BCBSNC failed to state a plausible claim for relief based on an implied-in-fact contract because Congress had not manifested an intent to be contractually bound to make RCP payments.

As set forth in greater detail below, the BCBSNC Order supports Montana Health's opposition to the Government's motion to dismiss for lack of subject matter jurisdiction and lack of ripeness. But the Court's analysis on the merits is incorrect. Montana Health elaborates on these points below.

ARGUMENT

I. THE *BLUE CROSS* COURT CORRECTLY DENIED THE GOVERNMENT'S MOTION TO DISMISS FOR LACK OF SUBJECT MATTER JURISDICTION.

A. Jurisdiction Arises Under the Tucker Act.

Judge Griggsby concluded that this Court has subject-matter jurisdiction over Montana Health's statutory and implied-in-fact contract claims under the Tucker Act. *See BCBSNC*, 2017 WL 1382976, at **11-13;[2] *see also* 28 U.S.C. § 1491(a)(1); *Slattery v. United States*, 635 F.3d 1298, 1317-21 (Fed. Cir. 2011). For the reasons Montana Health has previously briefed, this was the correct result. Pl.'s Mot. Partial Summ. J. 18-19, ECF No. 5 ("Pl.'s Br."); Pl.'s Reply in Support of Pl.'s Mot. Partial Summ. J. and Opp. to Def.'s Cross Mot. to Dismiss 5-6, ECF No. 18 ("Pl.'s Reply"); Pl.'s Supp. Mem. In Further Support of its Mot. Partial Summ. J. 2, ECF No.

[2] *See also* Order 2, *Maine Cmty. Health Options v. United States*, No. 16-967C (EGB) (Fed. Cl. Mar. 9, 2017), ECF No. 30 ("Maine 12(b)(1) Order"); *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 449-55 (2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 769-73 (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).

26 ("Pl.'s Moda Br."). In brief, the Court has jurisdiction over the statutory count because it is brought under a money-mandating statute (Section 1342) and the Court has jurisdiction over the implied-in-fact contract count under settled Tucker Act precedent.

B. Montana Health's Claims Are Ripe.

Judge Griggsby also properly concluded that risk corridors claims are ripe because BCBSNC had met the Federal Circuit's two-prong ripeness test of "fitness" and "hardship." *BCBSNC*, 2017 WL 1382976, at **13-14; *see CBY Design Builders v. United States*, 105 Fed. Cl. 303, 331 (2012). The dispute is "fit" for adjudication because "HHS has completed the data analysis" for determining amounts owed, "has already made a portion of the payments owed," and therefore plaintiff's claims "are neither hypothetical nor in need of further factual development." *BCBSNC*, 2017 WL 1382976, at *13. Moreover, withholding consideration would cause hardship to Montana Health because "this outstanding sum certainly imposes an immediate financial hardship" to Montana Health, particularly since the 2015 and 2016 Spending Laws prohibit further payments from certain payment sources.[3] *See id.* at *14; *see also 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). Montana Health is owed funds that the Government has not, and will not, pay. As with BCBSNC, Montana Health's claims are thus fit for adjudication.

II. THE *BLUE CROSS* COURT ERRED IN DISMISSING THE LAWSUIT FOR FAILURE TO STATE A CLAIM FOR WHICH RELIEF CAN BE GRANTED.

Judge Griggsby dismissed BCBSNC's statutory count because, as she viewed it, neither Section 1342 nor HHS's implementing regulation imposed an annual deadline on the United

[3] *See* Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113); Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. No. 113-235) ("Spending Laws").

States to make payments. Although reserving judgment on whether, at some point in the future, the United States would be obligated under Section 1342 to make full payment, she concluded that, for the moment, BCBSNC had failed to state a claim because the United States had no definite deadline to make payment.

This analysis conflicts with Section 1342's statutory scheme and with the way in which HHS tried to administer the program. It is also undermined by the ripeness and jurisdictional determination in the BCBSNC Order.

On the implied-in-fact contract count, Judge Griggsby concluded that Congress did not intend to create a binding obligation with Section 1342. Alternatively, she held that the Government could not be in breach for the reason that was material to her decision on the statutory count, *i.e.*, even if Congress obligated the United States to make payments, that obligation was not fixed to any specific deadline, so BCBSNC could not demonstrate breach as of this time. On this count, Judge Griggsby erred by failing to credit the actions of the parties in forming the implied-in-fact contract. Judge Griggsby took too narrow a view in deciding there was no offer. And her conclusions as to breach fail for the reason her statutory analysis fails: not only did Congress obligate the United States, but also it did so on an annual basis for the RCP's three years.

The Government's motion to dismiss under Rule 12(b)(6) should have been denied as to both the statutory and implied-in-fact contract counts.

A. Section 1342 Required Annual and Complete RCP Payments.

The first rule of statutory interpretation is to give effect to the intent of Congress. *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). A court does this first and foremost by reference to the statutory text, but in construing the text, the court must be mindful of how the particular provision at issue fits within

the statutory scheme as a whole. *See, e.g.*, *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))).

Judge Griggsby's opinion was premised on the notion that because neither Section 1342 nor HHS's implementing regulations establish a firm date to make payment, the Government is not obligated to pay until some undetermined date in the future after the RCP has ended. But an "open-ended" risk corridors program untethered to the annual nature of the exchanges, and indeed the entire health insurance industry, would defeat the objective of having risk corridors in the first place. The RCP's purpose was to share risk between QHP issuers and the Government and thereby *stabilize* insurance premiums in each of the first three years of the exchanges' existence.[4] An open-ended payment obligation would accomplish neither.

The Court's analysis also comes up short as matter of statutory interpretation because it equates the absence of an explicit deadline with congressional silence on the issue of when payment is due. Congress was not silent.[5] Section 1342's entire scheme is annual, and RCP payments only serve their intended purpose if paid annually. *See Moda*, 130 Fed. Cl. at 451-55;

[4] *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; 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 (March 23, 2012) (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)).

[5] Even assuming *arguendo* that the absence of an explicit deadline amounts to congressional silence on when payment is due, this Court should construe Section 1342 as requiring payment within a "reasonable" time. *See Eden Isle Marina, Inc. v. United States*, 113 Fed. Cl. 372, 493 (2013) (in the absence of a specified timetable for performance in a contract, performance must occur within a reasonable time). While reasonableness fluctuates based on the circumstances, HHS itself opined that payments out should be made on the same 30-day timeline as payments in. Final RCP Rule, 77 Fed. Reg. at 17,238-17,239.

Health Republic, 129 Fed. Cl. at 776; Maine 12(b)(1) Order 2 ("We reject the notion that the statute does not mandate the payment of money on a yearly basis. 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.").

Judge Griggsby appears to have felt obligated—mistakenly—to defer under *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984), to HHS's *informal* guidance issued April 11, 2014 (after Montana Health was already on the exchanges) in which the agency, the Government asserts, announced a "three-year" framework for administering the RCP, including making only partial payments in any given year in which payments in did not cover payments out.[6] *See BCBSNC*, 2017 WL 1382976, at **15-16 (citing CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("April 11 Guidance"), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf (Add. A at 18-20)). But *Chevron* deference is not warranted in a case like this where (1) the object of the agency's request for deference is informal guidance that only came into existence *after* the agency had completed its rulemaking, (2) the agency's interpretation of that guidance contradicts what the agency said during its rulemaking, and (3) the agency's interpretation would undermine the aims of the statutory program.

1. Congress Intended Annual RCP Payments.

Judge Griggsby improperly credited the Government's argument that it need not make annual payments because Section 1342 does not contain an explicit payment date. But by stopping there, Judge Griggsby ignored the ordinary tools of statutory interpretation including

[6] As Montana Health has argued, it disputes that the April 11 Guidance created any such "three-year" framework. Pl.'s Reply 18. Rather, it further supports Montana Health's argument that HHS intended annual payments. *See* April 11 Guidance (confirming partial payment on an annual basis).

the intent of the enacting Congress and how the specific program at issue fits within the larger statutory scheme. The ACA as a whole was aimed at providing affordable health insurance to tens of millions of uninsured or underinsured Americans. *See* 42 U.S.C. § 18091(2) (citing the increased costs of individuals forgoing health insurance, finding that the ACA's requirements will "add millions of new consumers to the health insurance market," and seeking to achieve "near-universal coverage"). The exchanges were created to facilitate competition and drive down premiums. *See* CMS, "Initial Guidance to States on Exchanges," *available at* https://www.cms.gov/cciio/resources/files/guidance_to_states_on_exchanges.html (highlighting importance of promoting competition among plans). And to incentivize health insurers to operate on the exchanges, Congress made a number of guarantees.

Relevant here, the so-called "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 were assuming in light of the ACA's expansion of myriad coverage requirements and their attendant costs. *See, e.g.*, 42 U.S.C. § 18021(a)(1)(B) (requiring coverage of "essential health benefits."); Final RCP Rule, 77 Fed. Reg. at 17,220 ("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."). The RCP was one of the enticements that drew insurers into the marketplaces in the first place.[7] It was designed to operate

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

annually: annual premium setting, annual enrollment, annual cost calculation, and annual payment—either in or out, depending on how an insurer's final costs compared to its anticipated budget. Congress thus intended for the Government to share in insurers' risk and mitigate (although not eliminate) their losses in each of the first three years of the RCP in order to (1) attract insurers to the exchanges and (2) make affordable coverage available to millions of previously uninsured Americans. The RCP was created to stabilize premiums by giving insurers some confidence that, if their calculations proved wrong (as they fully expected they would in light of insufficient data about a new market with which to price premiums), the Government would mitigate their losses (not guarantee profits or allow them to break even, as the Government has elsewhere asserted[8]). It afforded issuers the ability to not pass all of the risk along to their consumers in the form of unaffordable premiums that "priced in" every dollar of uncertainty. Anything other than annual payments would not provide the intended risk-sharing.

Furthermore, the RCP was expressly based on the Medicare Part D RCP—an annual, non-budget neutral program. The Government has required full and annual payments "in" from QHP issuers that owe RCP payments to the Government. And the Government itself has *made* annual "prorated" payments, which reflected only a fraction of the amounts owed. The Government's conduct in making partial payments *annually*, while conceding that full payment in a specific dollar amount is being recorded as "an obligation of the Government," is inexplicable if payment

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newsletter/2013/october/hsn-2013-iss73-norris.aspx.

[8] *See, e.g.*, Def.'s Mot. Dismiss and Opp. to Pl.'s Mot. Partial Summ. J. 32, *HPHC Ins. Co., Inc. v. United States*, No. 17-87C (LKG) (Fed. Cl. Apr. 13, 2017), ECF No. 13 ("The ACA's premium stabilization programs were designed to create a structure to mitigate insurers' risks, not to eliminate those risks by creating a government guarantee."). No one argues that the RCP was intended to eliminate all risk and any Government effort to cast plaintiffs' arguments as such should be dismissed as a straw man. Rather, the point is that, under the Government's reading, the RCP would hedge *no risk at all*, as insurers would receive no payment whatsoever if no payments in were collected in a given year. This is antithetical to the statute's structure and purpose.

is not due annually.

The Government has repeatedly recognized outside of this litigation that the RCP was created to serve as a risk-sharing program *between* insurers *and the United States*. *See* Final RCP Rule, 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)). After Congress passed the ACA, HHS promulgated implementing regulations (after taking comments from the public and from industry) in complete alignment with the RCP's statutory text. 45 C.F.R. § 153.510(b) ("QHP issuers will receive payment from HHS . . . When a QHP's allowable costs ***for any benefit year*** are more than [specified percentages], ***HHS will pay the QHP issuer*** [a specified percentage of the losses]" (emphases added)). In the preamble, HHS recognized that prompt payment was essential. Final RCP Rule, 77 Fed. Reg. at 17,238-17,239 ("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.***" (emphasis added)).[9]

If RCP payments out were limited by payments in, the RCP effectively would hedge *no risk whatsoever* and defeat the objective the RCP was designed to address.

Indeed, it is beyond debate that the Government's failure to honor this commitment has caused the exchanges to experience exactly what Congress intended to avoid: insurers dropping

[9] 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); HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,441 (Mar. 11, 2013) (Risk Adjustment methodology provides for a "budget-neutral revenue redistribution among issuers.").

out of the program or becoming insolvent and premiums skyrocketing. The sheer number of health plans that went out of business operating on the exchanges evidences the impact of the Government's *current* interpretation.[10] If full RCP payments were due sometime after three years, *or maybe not at all*, they would not "stabilize" the market *or* "share" risk between insurers and the Government. "It is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494.

Ruling against the Government on the question of annual payment, Judge Sweeney made this very point, stating: "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,' [§ 18091(2)(I)–(J)]—would be unattainable." *Health Republic*, 129 Fed. Cl. at 776. The plaintiff in that case, Health Republic, went into receivership following the Government's refusal to make full RCP payments. *See* Compl. ¶ 19, *Health Republic Ins. Co. v. United States*, No. 16-259C (MMS) (Fed. Cl. Feb. 24, 2016), ECF No. 1; *see also* 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) (Kevin Counihan, then HHS's Director and Marketplace CEO at CMS, opining that "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.***" (emphasis added)). Indeed, in addressing the issue of ripeness, Judge Griggsby herself recognized the harm to insurers in light of the Government's failure to make complete *annual* payments. *See BCBSNC*, 2017 WL 1382976, at *14.

[10] *See supra* note 7; *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").

The ACA was imposed on an industry that operates on an annual cycle. Insurance premiums are set annually, regulatory reporting deadlines occur annually, taxes are paid annually, commercial books and records are kept annually, and *the government itself budgets annually*. An annual payment structure is 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.[11] Coupled with the unknown nature of the new and untested market that caused uncertainty with respect to premium setting, an open-ended RCP would have been tantamount to no RCP at all, as QHP issuers at the outset would have had to set higher premiums to account for the risk of non-annual payments or decline to enter the market entirely—the very thing Congress designed the RCP to avoid.

Congress legislated with these practical and obvious realities in mind, and Congress underscored its intent by making the RCP "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 the agency administers Part D and other programs. *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"). Judge Griggsby's opinion that Congress's express instruction that the RCP be "based on" the equivalent program under Medicare Part D "does not demonstrate that Congress intended for HHS to pay the Risk Corridors Payments owed to issuers in full, upon an annual basis" and statement that she was not aware of any authority requiring HHS to administer the RCP "in the same manner as the

[11] *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.

Medicare Part D risk corridors program," *BCBSNC*, 2017 WL 1382976, at *16, ignores the presumption that Congress legislated with a specific objective and template for the administration of the RCP in mind.[12]

There is no logical explanation (and the Government has never offered one) for what the phrase "based on" could possibly have meant *other than* that HHS was to administer the RCP on an annual basis, without regard to budget neutrality, like Medicare Part D. If Congress intended a different outcome—*i.e.*, for the ACA to *change* the key element of annual payments present in the Medicare Part D risk corridors program that Section 1342 was "based on"—surely it would have said so.[13]

HHS's actual administration of the RCP also undermines the Department of Justice's litigating position. In practice, HHS has made payments on an annual basis, albeit incomplete payments. *See Health Republic*, 129 Fed. Cl. at 778 (pointing out that HHS has administered the RCP as an annual program). HHS's actions are illogical unless there is an obligation to pay annually. Although Judge Griggsby recognized that HHS makes annual "pro-rata Risk Corridors Program Payments," *BCBSNC*, 2017 WL 1382976, at **5-6, 16-17, she failed to harmonize HHS's practice of making annual payments with the Government's position that payments are not actually due annually.

Judge Griggsby's decision to dismiss for failure to state a claim is further undermined by

[12] Moreover, Judge Griggsby's observation that "this fact, alone" does not establish annual payments ignores the fact that *several factors, together, do establish such a scheme*. *See BCBSNC*, 2017 WL 1382976, at *16. Judge Sweeney observed precisely this nuance in opining that one need not rely on a single factor alone in concluding the RCP is annual, because "when the factors are considered together, congressional intent becomes apparent: HHS is required to make annual risk corridors payments to eligible qualified health plans." *Health Republic*, 129 Fed. Cl. at 776.

[13] Tellingly, even HHS—*outside of litigation*—agrees Section 1342 was not intended to be budget neutral. *See, e.g.*, Pl.'s Br. 10, 12 n.11.

her own denial of the Government's motion to dismiss for lack of subject matter jurisdiction. In her Rule 12(b)(1) analysis, Judge Griggsby recognized that "Section 1342 and its implementing regulations . . . mandate compensation by the government." *BCBSNC*, 2017 WL 1382976, at *12. She found those claims to be both "presently due" and "ripe." But after finding that the Court has jurisdiction over BCBSNC's ripe, presently due claims brought under a *money-mandating* statute, she then inexplicably construed that very money-mandating statute to not require payment *at present*. How could the Court assume jurisdiction in the first place? Indeed, it is impossible to square Judge Griggsby's dismissal of the statutory count for failure to state a claim with her rejection of the Government's argument that the Court lacked jurisdiction because the money claimed was not "presently due."

A money-mandating statute is not merely a vehicle to allow this Court to hear a suit. It is exactly what its name says: a statute that mandates the payment of money if certain predicate facts can be shown. In the case of Section 1342, if an insurer can show—as Montana Health has here—that it (a) performed on the exchanges as required and (b) realized sufficiently higher-than-budgeted costs, then the statute mandates that the United States make payment as prescribed in the statute.

In short, Judge Griggsby failed to look at the whole picture. The statutory scheme only works if RCP payments are made in full on an annual basis. Montana Health recognizes that later Congresses made it difficult on *HHS* to execute the Government's statutory obligations, but these RCP lawsuits are against the United States, not HHS. Because Congress created a program by which payments were required to be made annually to insurers if certain circumstances could be shown; because Montana Health and other insurers that operated on the exchanges in plan years 2014, 2015, and 2016 can demonstrate that the requisite circumstances were met; and

because the Government has failed to make its required payments, the Court of Federal Claims may and must enter judgment against the Government.

The Government argued in the BCBSNC case as well as the instant case that a money-mandating statute cannot legally bind the United States absent an appropriation that funds the mandate. For this proposition, the Government has repeatedly invoked the Appropriations Clause of the Constitution, which states that "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." Def.'s Opp. to Pl.'s Mot. Partial Summ. J. 2, ECF No. 17 (quoting U.S. Const. art. I, § 9, cl. 7). On this point, the Government confuses Congress's ability to *obligate* the United States with HHS's authority to *pay* that obligation. A statutory liability (*i.e.*, obligation) may exist independently of an appropriation, and that is precisely what Congress creates when it legislates in money-mandating terms. Where Congress statutorily directs payment and leaves no discretion with the administering agency if the plaintiff can demonstrate that certain requirements have been met, the statute is money-mandating. *See Price v. Panetta*, 674 F.3d 1335, 1339 (Fed. Cir. 2012); *Fisher v. United States*, 402 F.3d 1167, 1174-75 (Fed. Cir. 2005); *see also United States v. Mitchell*, 463 U.S. 206, 218 (1983) (recognizing Tucker Act jurisdiction over "claims founded upon statutes or regulations that create substantive rights to money damages"). Once a plaintiff identifies such a money-mandating statute and establishes that it met the statutory requirements, it can secure judgment from this Court.

Courts have long recognized this fact:

> That provision of the Constitution is exclusively a direction to the officers of the Treasury, who are intrusted [sic.] with the safekeeping and payment out of the public money, and not to the courts of law; the courts and their officers can make no payment from the Treasury under any circumstances.
>
> ***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); *accord Slattery*, 635 F.3d at 1317-21 (rejecting government's contention that the United States can only be liable for financial obligations if the governmental subject of the lawsuit has been funded by an appropriation). Indeed, outside of the Court of Federal Claims, the Government acknowledges this reality:

> 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, at *2 (D.D.C. Dec. 2, 2015) (emphasis added) (citing *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2191-92 (2012)).

It is of course true that Congress can "cap" or limit the mandate. In *Star-Glo Associates, LP v. United States*, for example, Congress *expressly* capped 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) (quoting Pub. L. No. 106-387, 810(e) (2000)). And in *Prairie County, Montana v. United States*, the statute at issue *expressly* made the Government's obligation "subject to the availability of appropriations." 782 F.3d 685, 687-88 (Fed. Cir. 2015) ("the [statute's] plain language . . . limits the government's liability . . . to the amount appropriated by Congress."). In *BCBSNC* and the case *sub judice* (as well as the others), the Government has relied on these and similar cases for the proposition that the Court may not find there is a liability absent a correlating appropriation. *E.g.*, Def.'s Supp. Br. Regarding *Moda Health Plan, Inc. v.*

U.S. 2, 8, 13-14, ECF No. 25. These cases do not help the Government *in this case* because nothing in Section 1342 imposes a cap, expressly or implicitly, on RCP payments.

In Section 1342, Congress did not limit the money mandate to annual appropriations; it *omitted* from Section 1342 its typical words of limitation on an agency's budget authority to condition the "shall pay" command, such as "subject to appropriations" or "subject to the availability of appropriations." *See Prairie Cnty., Mont. v. United States*, 113 Fed. Cl. 194, 199 (2013), *aff'd*, 782 F.3d 685 (Fed. Cir. 2015) ("[T]he 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.") (quoting *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 878-79 (Fed. Cir. 2007)). Section 1342's omission of these words of limitation is all the more instructive where Congress included it *in at least four other sections* of the ACA. *See, e.g.*, 42 U.S.C. §§ 280k(a), 300hh-31(a), 293k-2(e), 1397m-1(b)(2)(A). Had Congress intended Section 1342's obligation to be similarly limited, it would have said so. And that is the critical point: Section 1342's "shall pay" mandate is unconditional. *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.").

As for the Government's invocation of the Appropriations Clause in *BCBSNC v. United States* and the instant case, that only relates to the mechanics of *paying* a judgment not the right to a judgment on liability in the first instance. 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—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 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.").[14]

Judge Griggsby failed to address the Government's erroneous appropriations argument because she determined (incorrectly) that the Government had no current obligation to pay. For the reasons set forth above, this Court should conclude not only that the Government's obligation to pay is an annual one, but also that the obligation requires full payment and is in no manner limited by any absence or shortfall of annual appropriations.

2. The Government's Position Does Not Merit Deference.

Judge Griggsby appears to have given *Chevron* deference to the Government's position that complete payments need not be made annually. This was erroneous for the reasons previously briefed by Montana Health. *See* Pl.'s Reply 24-34. First, deference is inappropriate because Congress spoke *directly* to the question of "when" payment was due by instructing HHS to administer the RCP on a "plan year" basis (based expressly on Medicare Part D): every year, upon calculation (no differently than when QHP issuers were required to make payments in). *See Chevron*, 467 U.S. at 842. In light of the ACA's statutory aims generally and the RCP's purpose specifically, both of which lend further support to this reading of Section 1342, the Court's analysis should end here.

[14] As Montana Health noted in its earlier supplemental brief, appropriations were, in fact, available to make RCP payments. Pl.'s Moda Br. 6-10.

But even if the statute were ambiguous when read in isolation, Judge Griggsby's analysis fails to give appropriate attention to the *only* regulation promulgated by HHS by way of notice-and-comment rulemaking, which *specifically* addressed the RCP payment scheme's annual nature with reference to costs calculated on a benefit year basis. *See* 45 C.F.R. § 153.510. It was this rule that was noticed for public comment, and of all the agency statements at issue in this case, it is the only agency pronouncement worthy of deference. *See United States v. Mead Corp.*, 533 U.S. 218, 219 (2001) (observing that "the overwhelming number of cases applying *Chevron* deference have reviewed the fruits of notice-and-comment rulemaking or formal adjudication"). Not surprisingly, the Government has avoided it, favoring instead agency statements that came in the form of guidance *after* the public comment period had closed, *after* HHS had informed insurers that they would receive prompt, annual payment, on the same terms as the Government expected payments in, and *after* Montana Health was performing for the 2014 benefit year. In the Final RCP Rule's preamble, HHS said unequivocally that deadlines for payments in and payments out should be the same and emphasized the importance of prompt payment to QHP issuers. Final RCP Rule, 77 Fed. Reg. at 17,238-17,239.

Judge Griggsby, however, ignored those clear statements and relied instead on an informal agency pronouncement (*BCBSNC*, 2017 WL 1382976, at **15-16) that was both inconsistent with earlier statements and not part of any public rulemaking. The fact that statements of this type are *not entitled to Chevron deference* is made clear in the Government's own principal case, *Cathedral Candle Co. v. U.S. International Trade Commission* and briefed at length as part of plaintiff's motion for partial summary judgment. *See* 400 F.3d 1352, 1362-63, 1365 (Fed. Cir. 2005); Pl.'s Reply 27-34. At most, informal agency pronouncements of the type credited with full deference by Judge Griggsby are entitled to limited "respect" to the extent that

they have the "power to persuade." *Skidmore v. Swift & Co.*, 323 U.S. 134, 139 (1944); *Mead*, 533 U.S. at 219. And as Montana Health has explained, the document cited by Judge Griggsby (along with others cited by the Government) lacks the power to persuade. Pl.'s Reply 24-34.

Not only does permitting HHS to make payments only at some later but indefinite time undermine the RCP's premise and purpose, but also the Government's policy bears none of the hallmarks of reasoned decision-making.[15] The Government's position that it is not obligated to make complete annual payments (1) was *never* raised as part of the notice-and-comment rulemaking process, and is therefore procedurally defective; (2) is inconsistent with the agency's original position that both payments out and in should be subject to the same deadline because QHP issuers would expect prompt payment (and the agency has never explained its reversal);[16] and (3) was announced only after the fact, in response to a later Congress's efforts to defund the RCP, after Montana Health set premiums.[17]

There are only two possible conclusions. Either HHS knowingly duped the industry in the rulemaking process by waiting until after the close of notice and comment on the Final Rule (and after insurers were already on the exchanges) to announce a different position, or, more plausibly, HHS knew at the time it issued the Final Rule that payments would be due annually and only changed its mind when it came under political pressure. *See* Pl.'s Br. 34. Under either conclusion, the Government's *post hoc* announcement in informal guidance of a change in position is unpersuasive and does not merit deference.

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[15] *See Encino Motorcars, LLC v. Navarro*, 579 U.S. ___, slip op. at 9 (2016) (administrative rulemaking requires that "an agency must give adequate reasons for its decisions.").
[16] *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (agency must "display awareness that it is changing position" and demonstrate "good reasons for the new policy").
[17] *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.").

* * *

In sum, Judge Griggsby's analysis of the statutory count is erroneous both because she failed to interpret Section 1342 with sufficient regard for its place in the ACA as a whole as well as the role Congress intended the RCP to play and because she deferred to agency positions that are not entitled to deference under accepted principles of statutory interpretation. Accordingly, as to her dismissal of the statutory count, Judge Griggsby's decision should not be followed.

B. The Government Breached an Implied-in-Fact Contract with Montana Health.

Judge Griggsby's dismissal of BCBSNC's implied-in-fact contract claim was in error because it creates a new, narrower test that ignores the circumstances surrounding the Government's conduct, both at the time of statutory formation *and thereafter*. Judge Griggsby impermissibly focused only on the Congress's actions prior to the ACA's passage. *BCBSNC*, 2017 WL 1382976, at **18-19. Section 1342 and its surrounding circumstances reflect, as Montana Health has alleged, that the Government held out a unilateral offer of RCP payments to induce QHP issuers, including Montana Health, to begin performance. 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. Montana Health's claim therefore survives the Government's 12(b)(6) motion.

1. The Circumstances Surrounding Section 1342's Implementation Give Rise to an Implied-in-Fact Contract By Establishing Mutuality of Intent, Offer and Acceptance, and Consideration.

Judge Griggsby erred by restricting her consideration of the "surrounding circumstances" to only those circumstances surrounding congressional intent at the time Congress passed Section 1342. *See BCBSNC*, 2017 WL 1382976, at **18-19. An implied-in-fact contract arises

based on "***conduct on the part of the government*** that allows a reasonable inference that the government intended to enter into a contract." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011) (emphasis added). The surrounding circumstances include the statutory purpose, context, legislative history, *or any other objective indicia of actual intent beyond congressional intent alone*. *See, e.g.*, *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 468 (1985) (considering the pervasive history of regulation of the industry at issue in determining whether there was an implied-in-fact contract); *Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986) (finding an implied-in-fact contract "is inferred as a matter of reason or justice from the acts ***or conduct of the parties***" (emphasis added)). Montana Health'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 circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996); *see* Compl. ¶¶ 18, 38, 50-52, 76, 92-96. Though congressional intent is certainly part of the analysis, Judge Griggsby's error was in concluding that it is the *sole* driver of the analysis, and thereby *dismissing post-enactment circumstances establishing an implied-in-fact contract.*

Judge Griggsby's principal cases for her narrower construction of this longstanding test are inapposite. *BCBSNC*, 2017 WL 1382976, at *18. The *ARRA Energy* plaintiff rested its unsuccessful contract claim solely upon the statute itself, resulting in the Court's analysis focusing on the statute alone, whereas Montana Health relies upon a raft of HHS assurances following Section 1342's enactment.[18] *See* 97 Fed. Cl. at 27; *see also Moda*, 130 Fed. Cl. at 464

[18] These HHS assurances include: implementing regulations that made payments mandatory; the accompanying preamble promising to pay regardless of the amounts collected; a transitional policy that sharply increased the costs of health care coverage, and which led HHS to expressly

(disagreeing with *ARRA Energy*'*s* narrow focus on the statute alone and concluding that the court should examine "the *structure* of a statutory program and determined whether the Government had expressed its intent to contract by using that structure" (citing *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957); *N.Y. Airways, Inc. v. United States*, 369 F.2d 743 (Ct. Cl. 1966))). Similarly, the statute at issue in *Brooks v. Dunlop Manufacturing Inc.*, unlike Section 1342, imposed no obligation—it lacked mutuality, avenue for acceptance, and consideration, and so the analysis did not extend any further than the statute. 702 F.3d 624, 631 (Fed. Cir. 2012). By contrast, Section 1342 obligated the Government to make RCP payments once insurers performed (by offering QHPs and experiencing the requisite annual losses), and the parties' conduct based on that language (after passage of Section 1342) is necessarily part of the analysis in the instant case.

As Montana Health has briefed, the Government *offered* RCP payments to insurers through the language of the ACA, regulations and HHS's numerous publications and affirmations,[19] which Montana Health accepted by complying with the ACA's extensive requirements for QHP issuers. Pl.'s Reply 37.[20] Consideration at the time of formation flowed both ways. QHP issuers, central to the ACA's scheme, would not have entered the exchanges and agreed to comply with its intricate requirements[21] *but for* the Government's promise of risk

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reaffirm the availability of RCP payments to offset those costs; and HHS's repeated promises to pay.

[19] HHS also had authority to enter into contracts with QHP issuers, since Agency Heads have contract-making authority "by virtue of their position," 48 C.F.R. § 1.601(a), and Section 1342's instruction on the Secretary's broad obligation to administer and implement the ACA under Section 1342 gives him the express (or at least implied) authority to enter into such contracts.

[20] *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*, 369 F.2d at 816 (finding published "board rate" for aviation transportation services constituted an offer that plaintiff accepted through performance).

[21] These include submission of, or compliance with, Government standards regarding: (1)

stabilization, and the Government benefited from expanded health insurance coverage. In addition, Montana Health 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. *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."). The Government may not now evade liability by arguing it never intended to enter into a contract at the outset. *See Thomson v. United States*, 174 Ct. Cl. 780, 791 (1966) (observing that assent "may be overtly manifested by a course of action" and, once the Government exhibits such conduct, it "may not assert that it is not bound on the ground that it did not intend to contract").

In short, the circumstances surrounding Section 1342's passage and implementation unequivocally give rise to an implied-in-fact contract.

2. The Government Breached Its Obligations.

For the same reasons discussed *supra* Part II.A, Judge Griggsby's determination that, even if an implied-in-fact contract existed, BCBSNC "cannot show that the government breached [any] such contracts," *BCBSNC*, 2017 WL 1382976, at *19, is misplaced because it is based on the same incorrect conclusion that payment was not due annually. *See* discussion *supra* Section II.A.1.

3. Montana Health's Claims Survive the Government's Motion to Dismiss.

The sole issue at this current stage is the Motion to Dismiss pursuant to Rule 12(b)(6).

"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).

The Court must take Montana Health's well-pled allegations as true with all reasonable inferences in its favor for purposes of deciding the Government's Motion. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Erickson v. Pardus*, 551 U.S. 89, 94 (2007) ("a judge must accept as true all of the factual allegations contained in the complaint."). Judge Griggsby appears to have elevated this standard in concluding that BCBSNC "has not—and cannot—establish" that the Government breached. *BCBSNC*, 2017 WL 1382976, at *19. At this stage of the proceedings, plaintiff need not prove or "establish" anything; rather, plaintiff must only set forth sufficient well-pled allegations. By any rational measure, drawing all reasonable inferences in Montana Health's favor and accepting all allegations as true, Montana Health has stated a claim on which relief can be granted.

CONCLUSION

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

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on May 12, 2017, a copy of the forgoing "Plaintiff's Supplemental Brief in Further Support of Its Motion for Partial 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, Marcus Sacks, via the Court's ECF system.

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