IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MONTANA HEALTH CO-OP, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 17-1298C Judge Victor J. Wolski

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

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

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Federal Register

Regulatory Guidance

Legislative Materials

Other Authorities

INTRODUCTION

In 2010, Congress passed the Affordable Care Act ("ACA"),[1] creating a new health insurance marketplace—the health insurance "exchanges"—through which individuals and small groups could purchase health insurance. The creation of the exchanges, in combination with certain other ACA provisions, dramatically increased the number of individuals purchasing health insurance, including many individuals who had previously been uninsured. At the time of the ACA's passage, nobody—neither the Government nor the health insurers—knew how much it would cost to insure large numbers of previously uninsured and underinsured individuals. Recognizing this uncertainty, Congress created the "risk corridors program" ("RCP") as a mechanism through which both the Government and insurers would share in the risk of the substantial uncertainty of the exchanges during the first three benefit years[2] (2014, 2015, and 2016). Congress knew that without such a measure it could not achieve the ACA's twin goals of increased *and* affordable coverage because insurers would either opt not to offer plans on the exchanges or offer plans only at unaffordable premiums.

The RCP focused on a plan's costs. As designed, it facilitated risk sharing between plans and the Government by requiring plans that realized lower-than-expected allowable costs in a benefit year to pay a share of their realized savings *to* the Government ("payments in"), and, conversely, entitling plans that realized higher-than-expected allowable costs in a benefit year to a payment *from* the Government to cover a share of their losses ("payments out"). The amounts of the payments, both in and out, are calculated under a formula dictated in the statute itself.

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[1] The ACA is actually comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

[2] 45 C.F.R. § 155.20 ("*Benefit year* means a calendar year . . . ."); 45 C.F.R. § 153.20.

At issue in this case is the extent of the Government's obligation to make "payments out" to insurers like Montana Health. The RCP does not discriminate between the Government and insurers: both have payment obligations under the statutory formula. Insurers have dutifully "paid in" as the RCP requires when they realized lower-than-expected costs. Although the Government required full "payments in," it refused to make full "payments out" when Montana Health experienced "losses" triggering the Government's payment obligations. Specifically, although conceding on multiple occasions that RCP payments are an "obligation of the United States Government for which full payment is required,"[3] CMS has made no payment at all to Montana Health for benefit year 2016 and has publicly stated that none will be forthcoming anytime soon (if ever). *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016) (Add. A at 40); CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) (Add. A at 32). The Government's refusal to make full payments violates its obligation under Section 1342 of ACA.

STATEMENT OF THE ISSUE

Congress created the RCP to attract health insurers into the exchanges and help keep premiums affordable and stable for Americans by limiting the effects of adverse selection, thereby limiting the uncertainty inherent to establishing rates for new, unquantifiable health insurance risks. The RCP mandates full and annual "payments in" and "payments out," once costs from the previous benefit year have been calculated. This is how Congress wrote the law and it is how HHS originally construed, and announced it would administer, the program. But the Government later reversed course and adopted evolving positions regarding the

[3] *See infra* note 9. Attached to this Memorandum is Addendum A ("Add. A") containing public HHS statements cited in this Memorandum, of which this court may take judicial notice. *See* Fed. R. Evid. 201.

Government's obligation to pay insurers like Montana Health the full amount they are owed under the RCP.

The Government's revised rationale is that the RCP must be administered in a budget-neutral manner, *i.e.*, "payments out" cannot exceed "payments in." This novel position is not reflected in the text of the ACA; was never raised for public comment during the notice-and-comment rulemaking process on HHS's RCP implementing regulations; directly contradicts HHS's earlier positions; and has never been explained by HHS. It also violates the logical premise of the RCP: A budget neutral payment scheme places all the risk *of the federal Government's new program* on insurers and thus does nothing to "stabilize" premiums; it instead creates (as history has now proven) the very *instability* the RCP was designed to prevent.

Montana Health brought high-quality, affordable health insurance to the people of Montana and Idaho just as Congress envisioned when it crafted the ACA's system of requirements and incentives. *See* Compl. ¶¶ 25-29. Under the RCP, the Government owes Montana Health payment for the 2016 benefit year based on Montana Health's higher-than-budgeted costs for that year.

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

The answers are simple. (1) Based on the undisputed facts, the Government owes Montana Health $13,835,742 for benefit year 2016. *See infra* Argument I.A.1, I.B, II. (2) The money is presently due. *See infra* Argument I.A.2, I.B, II. And (3) the Government's payment obligation under the RCP has *not* been abrogated. *See infra* Argument I.C.

Accordingly, Montana Health is entitled to judgment.

STATEMENT OF RELEVANT BACKGROUND

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

The ACA changed the healthcare industry landscape. Its provisions require, among other things: individuals to carry health insurance; states to facilitate online exchanges for buying and selling insurance; and private health insurance companies to guarantee coverage and provide myriad essential health benefits to insured individuals at no cost. The ACA sought to prioritize the consumer by promoting affordability and competition in the marketplace. To entice insurers to enter the individual and small group markets served by the exchanges, where consumers can purchase health plans that meet certain standards established by CMS and the exchanges ("qualified health plans" or "QHPs"), Congress implemented several risk mitigation programs, including the RCP. A "QHP issuer" is any health insurer selling a QHP on the exchanges.

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

Expanding healthcare coverage came at substantial cost. For example, under the ACA, QHP issuers must cover a variety of essential health benefits, including preventive health benefits at no additional cost to enrollees. The ACA's myriad mandates, when coupled with the uncertainty of a new and untested pool of health insurance enrollees, would have led insurers under normal market conditions to set higher premiums to compensate for that uncertainty, or simply to decline entering the exchanges in the first place. Congress knew that. To mitigate the risk to insurers, while at the same time preventing unaffordable premiums for the millions of Americans that the ACA sought to bring into the health insurance marketplace, Congress included three marketplace premium-stabilization programs, commonly referred to as the "Three

Rs": (1) the RCP; (2) a transitional reinsurance program (which, like the RCP, was a temporary program for the first three benefits years under the exchanges); and (3) a permanent risk adjustment program. *See* CMS, "The Three Rs: An Overview" (Oct. 1, 2015), *available at* https://www.cms.gov/ Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html ("Three Rs Overview"). The "Three Rs" were intended to serve a specific objective within the framework of the ACA: to mitigate the risk that QHP issuers operating on the new exchanges would otherwise face in light of the ACA's many coverage requirements and their attendant costs. *See, e.g.*, 42 U.S.C. § 18021(a)(1)(B) (requiring coverage of "essential health benefits.").[4] The RCP was one of the enticements that drew insurers such as Montana Health into the marketplaces in the first place.[5]

Congress expressly modeled the ACA's RCP on the RCP created under Medicare Part D. *See* § 1342(a) ("The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 . . . [which] shall be based on [the Medicare Part D RCP]."). Medicare Part D's RCP is not budget neutral and payments (both in and out) are made annually. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year . . ."); 42

[4] 77 Fed. Reg. 17,220, 17,220 (Mar. 23, 2012) ("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.").

[5] 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-newsletter/2013/october/hsn-2013-iss73-norris.aspx.

C.F.R. § 423.336 (same); GAO, 15-447, Patient Protection and Affordable Care Act (Apr. 2015) ("GAO Rep.") at 14, *available at* http://www.gao.gov/assets/670/669942.pdf ("the payments that CMS makes to issuers [under the Medicare Part D program] are not limited to issuer contributions").

HHS implemented the RCP in the Code of Federal Regulations through notice-and-comment rulemaking as directed by ACA Section 1342, largely parroting the statute. *See* 45 C.F.R. § 153.510. HHS also required QHP issuers to submit their revenue and cost data on an annual basis, at which point QHP issuers were determined eligible to receive (or obligated to make) payment as calculated under the RCP's payment formula. *Id.* §§ 153.510, 153.530.

HHS made no mention of budget neutrality when it proposed its RCP implementing regulations. By contrast, HHS indicated in the preamble to the proposed rule that the RCP's companion program, the risk adjustment program, was, in fact, budget neutral. *See* 76 Fed. Reg. 41,930, 41,938 (July 15, 2011) (Add. A at 5). That different treatment made sense because the risk adjustment program was designed to share risk *among QHP issuers,* whereas the RCP was designed to share risk between QHP issuers *and the Government*. *See* Three Rs Overview. Accordingly, the final, codified regulations do not reflect a budget-neutral RCP. Indeed, in the preamble to that rule, HHS said just the opposite—that HHS anticipated making ***prompt*** payment to QHP issuers after making the annual determination of the amount due (or owed by the QHP issuer). *See* 77 Fed. Reg. at 17,238-39 (Add. A at 9-10). A year later, in the preamble to its first annual "Payment Rule" articulating the payment policies and requirements for marketplace participation, HHS stated:

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

78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013) (emphasis added) (Add. A at 13).

III. MONTANA HEALTH WAS ENTICED BY THE RCP TO PARTICIPATE ON THE MONTANA AND IDAHO STATE EXCHANGES.

Montana Health is a member-led non-profit QHP issuer and the only CO-OP insurer in Montana and Idaho. Montana Health participated on the ACA exchanges in Montana and Idaho during benefit years 2014, 2015, and 2016. But for its existence, there would have been only two carriers on Montana's individual marketplace in 2014. Montana Health was created specifically in response to the ACA's call for expanded and affordable health insurance and is required to participate on the exchanges. Its mission is to partner with members, employers, and healthcare providers to create affordable, high-quality benefits that promote health and well-being. Montana Health exemplifies the ACA's objectives to bring affordable coverage to more individuals, particularly those individuals who are most in need. It has actively educated the public regarding the availability of coverage under the ACA, how marketplaces work, and Montana Health's available benefit plans.

The ACA's success depended on QHP issuers participating in the marketplaces at a reasonable price point for the millions of uninsured Americans Congress intended to obtain insurance. Congress knew that a new and vastly expanded health insurance market for which there was insufficient data would make it difficult for entities like Montana Health to accurately set premiums. Like any health insurer facing an uncertain risk profile, *but for* the risk mitigation provided by the RCP, Montana Health would have had to set premiums at higher rates to account for market uncertainty or decline to enter the market altogether. Either approach would have driven up premiums, reduced competition, or both, which would have undermined the ACA's purpose and objectives. The RCP was central to Montana Health's decision to offer competitive premiums for high-quality health benefits to consumers.

IV. THE GOVERNMENT'S POSITION ON ITS RISK CORRIDORS OBLIGATIONS HAS FLUCTUATED.

In March 2013, HHS issued its first Payment Rule ("2014 Payment Rule") to set the payment parameters for the Three Rs for the 2014 benefit year.[6] In it, HHS stated unambiguously (in response to a commenter) that the RCP "is not statutorily required to be budget neutral" and HHS would make payments "regardless of the balance of payments and receipts." 78 Fed. Reg. at 15,473 (Add. A at 13). QHP issuers then submitted their rates for review and their participation in the exchanges was fixed and irrevocable no later than October 2013. Compl. ¶ 39.

Although HHS's comment in the 2014 Payment Rule was fully consistent with the ACA's text, it caused the ACA's opponents in Congress to threaten to defund the ACA entirely. Of particular note, in November 2013, legislation was introduced in the Senate seeking to strike the RCP from the ACA. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013). Citing HHS's commitment to meeting its statutory obligations, the bill's sponsor (Senator Rubio) pledged that he would refuse to agree to any forthcoming annual appropriation unless it defunded the ACA.[7]

Other members of Congress shared that sentiment and a budget impasse ensued that shut down the Government for over two weeks.[8] Subsequently, in March 2014, HHS indicated *for the first time* in the preamble to its 2015 Payment Rule that it now intended to administer the risk corridors program in a "budget-neutral" manner, and that if "payments in" were not

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[6] The "Payment Rule" is an annual CMS rule that identifies any changes CMS intends to make in the next year with respect to, among other things, the three premium stabilization programs.
[7] Rubio, Marco, The Wall Street Journal, "No Bailouts for ObamaCare" (Nov. 18, 2013), *available at* http://www.wsj.com/articles/SB10001424052702303985504579205743008770218.
[8] *See, e.g.*, Weisman, Jonathan and Jeremy W. Peters, The New York Times, "Government Shuts Down in Budget Impasse" (Sept. 30, 2013), *available at* http://www.nytimes.com/2013/10/01/us/politics/congress-shutdown-debate.html.

sufficient to cover "payments out" in a given year, it would offset current-year liabilities with future collections, directly contradicting its statement in the preamble to the 2014 Payment Rule it had issued a year earlier. 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014) (Add. A at 16). HHS's reversal occurred after Montana Health had already set premiums and enrolled members for the 2014 benefit year. HHS had never expressed its novel point of view during the notice-and-comment rulemaking on its RCP implementing regulations, and it did not even acknowledge that it was reversing course. In a follow-up guidance letter, HHS stated that it anticipated RCP "payments in" would cover "payments out," but that it would "establish in future guidance or rulemaking" what it would do if that assumption proved wrong. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf (describing how payments would be calculated) (Add. A at 18-19).

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

[9] *See, e.g.*, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 22). That acknowledgment would be repeated numerous times over the next two-and-a-half years. *See* 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 25); CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) ("HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which ***full payment is required***.") (emphasis added) (Add. A at 35); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("[T]he Affordable Care Act requires the Secretary to make ***full payments*** to issuers" and HHS will "record payments due as an obligation of the United States Government for which ***full payment*** is required") (emphases added) (Add. A at 37); Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20, 2016), *available at* https://energy commerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (quoting Acting Administrator of CMS's testimony as

despite stating in its April 11, 2014 guidance that it would announce through future rulemaking or guidance how the Government would cover RCP obligations in the event amounts collected were less than amounts owed, HHS has never done so.

Meanwhile, having failed at trying to substantively repeal the ACA, either in whole or in part, Congress took aim, through the appropriations process, at HHS's ability to administer the RCP. In the fiscal year 2015, 2016, and 2017 appropriations bills, enacted well after QHP issuers like Montana Health had begun performance of their obligations as QHP issuers, Congress prohibited CMS and HHS from using two specified funds, as well as funds transferred from other accounts funded by congressional appropriations, to make RCP payments owed to QHPs.[10] The Spending Riders did not nullify or modify the Government's RCP obligations.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. Montana Health is a non-profit corporation organized under the laws of Montana, with its principal place of business in Helena, Montana.

2. Montana Health is a CO-OP QHP issuer under the ACA.

3. Montana Health participated on the Montana exchange in benefit years 2014, 2015, and 2016 and the Idaho exchange in benefit years 2015 and 2016.

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

> (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall*** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under [the Medicare Part D program].

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part of hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight") (Add. A at 43-44).

[10] *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014) ("2015 Spending Rider"); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015) ("2016 Spending Rider"); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 135, 543 (2017) ("2017 Spending Rider") (collectively, the "Spending Riders").

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 of the target amount, the Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs ***for any plan year*** are more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.

Pub. L. No. 111-148, § 1342 (emphases added). Section 1342 also includes a provision dealing with "payments in," requiring QHP issuers to pay amounts to HHS if the plans' actual costs are less than its targeted costs. *Id.* § 1342(b)(2). For both "payments out" and "payments in," the statute defines "allowable costs" and "target amount." *Id.* § 1342(c).

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

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

(b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:

(1) When a QHP's allowable costs ***for any benefit year*** are more than 103 percent but not more than 108 percent of the target amount, ***HHS will pay the QHP issuer*** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

(2) When a QHP's allowable costs ***for any benefit year*** are more than 108 percent of the target amount, ***HHS will pay to the QHP issuer*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

7. In the preamble to that rule, HHS recognized that "QHP issuers who are owed these amounts will want ***prompt payment, and payment deadlines should be the same for HHS and QHP issuers.***" 77 Fed. Reg. at 17,238 (emphasis added) (Add. A at 9). And HHS reiterated that the RCP "serves to protect against uncertainty in rate setting by qualified health plans ***sharing risk in losses and gains with the Federal government***." *Id.* at 17,220 (emphasis added) (Add. A at 8).

8. In the 2014 Payment Rule (published on March 11, 2013) HHS stated in the preamble: "The risk corridors program is not statutorily required to be budget neutral. ***Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.***" 78 Fed. Reg. at 15,473 (emphasis added) (Add. A at 13).

9. On May 27, 2014, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . . ." and committed to "***use other sources of funding for the risk corridors payments***, subject to the availability of appropriations" if there is a shortfall. *See* 79 Fed. Reg. at 30,260 (emphases added) (Add. A at 22).

10. On February 27, 2015, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . . ." and indicated that "***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations." *See* 80 Fed. Reg. at 10,779 (emphases added) (Add. A at 25).

11. On October 8, 2015, Montana Health executed its QHP Issuer Agreement with CMS, at which point Montana Health's participation on the Montana and Idaho exchanges for benefit year 2016 became fixed and irrevocable.

12. Consistent with CMS regulations, its policy, and the QHP Issuer Agreement, Montana Health began selling QHPs to consumers in Montana and Idaho on or around November 1, 2015, with coverage effective January 1, 2016.

13. Montana Health complied with its statutory requirements and submitted to HHS all data required by the ACA demonstrating that it experienced higher-than-expected allowable costs under the RCP for benefit year 2016, entitling Montana Health to payment by HHS in the amount of $13,835,742.00. *See* 45 C.F.R. § 153.530(d); Compl. ¶ 63.

14. The Government owes Montana Health $13,835,742.00 under Section 1342, which the Government has not paid. Compl. ¶¶ 63, 64.

15. On November 19, 2015, HHS stated that "HHS is recording those amounts that remain unpaid following [its] 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which full payment is required." *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 35). HHS stated further that it "will explore other sources of funding for the risk corridors payments, subject to the availability of appropriations. This includes ***working with Congress on the necessary funding for outstanding risk corridors payments***." *Id.* (emphasis added).

16. On September 9, 2016, in a memorandum, HHS recognized that the ACA "requires . . . ***full payments*** to issuers" and it will "record risk corridors payments due as an obligation of the United States Government for which ***full payment is required.***" *See* CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) (emphases added) (Add. A at 37).

17. On September 14, 2016, in testimony before the House Energy and Commerce Committee, regarding whether CMS must make RCP payments even in the absence of an appropriation, the Acting Administrator of CMS Andrew Slavitt testified: "Yes, ***it is an obligation*** of the federal government." *See* Energy and Commerce Committee Press Release (emphasis added) (Add. A at 43-44).

18. To insurers who were owed a payment for benefit year 2014, the Government paid approximately 12.6% of what it owed—equating to the percentage of the Government's debt to QHP issuers that the Government was able to cover using "payments in" from issuers such as Montana Health. CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 35).

19. The Government has not paid any issuers who (like Montana Health) are owed RCP payments for benefit years 2015 or 2016.

JURISDICTION

This Court has jurisdiction under the Tucker Act because the RCP is a statutory provision that: (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]," and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." 28 U.S.C. § 1491(a)(1); *see United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472-73 (2003); *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (en banc in relevant part) (citations omitted). The Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007) (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). The RCP mandates that HHS "shall pay" to QHP issuers certain statutorily dictated amounts. And since Montana Health is a QHP issuer under the ACA, it falls within "the class of plaintiffs entitled to recover under the money-mandating source [and] the Court of Federal Claims has jurisdiction." *Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008).

Tucker Act jurisdiction is also "limited to actual, presently due money damages from the United States." *See Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (citations

and quotations omitted). Montana Health is entitled to presently due money damages because it has fulfilled all statutory requirements for payment. *See Doe v. United States*, 100 F.3d 1576, 1580, 1582 (Fed. Cir. 1996) (jurisdiction existed where plaintiff had fulfilled all statutory conditions for payment). Montana Health has submitted all required information to HHS demonstrating its entitlement to payment in specific amounts under the formula contained in Section 1342 of the ACA and HHS has confirmed the total amounts due to Montana Health for benefit years 2014 and 2015. Applying the same formula it used to determine its 2014 and 2015 RCP amounts, which were validated by HHS, Montana Health has also determined the total amount it is owed for 2016.

Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded." *Fisher*, 402 F.3d at 1173. Montana Health has pled that the ACA is money-mandating, requires full and timely payment, sets forth statutory requirements for receipt of payment that Montana Health fulfilled, and requires payment the Defendant has not made. *See, e.g.*, Compl. ¶¶ 9-14, 20-22, 25, 63-66. Accordingly, this Court's jurisdiction is plain. *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).

SUMMARY OF ARGUMENT

Judgment in Montana Health's favor is appropriate because the Government has refused to pay Montana Health money that the ACA mandates it pay.

1. *Statutory Mandate to Pay*. Under Section 1342, for each benefit year, a QHP issuer's costs are to be calculated. If there is a cost overrun above a certain amount, the Government owes the issuer money, and if there is a cost savings above a certain amount, the issuer owes money to the Government. Both calculations are governed by the statutory formula. *Moda*, 130 Fed. Cl. at 451-57 (holding that the Government was liable to Moda Health as a QHP issuer because the ACA RCP requires full annual payments as evidenced by: the text of Section 1342; HHS's implementing regulations; Congress's obvious object and purpose in creating the RCP; and Congress's modeling of Section 1342 on Medicare Part D's annual RCP); *Molina*, 133 Fed. Cl. at 35-38 (same).

The plain text of the statute answers the question of "how much" money the Government owes Montana Health by stating, in mandatory terms, that *if* a QHP issuer's allowable costs are more than a specified percentage above the target amount, *then* the Government "shall" reimburse the QHP pursuant to the prescribed formula. It is a long-accepted principle of statutory interpretation that when Congress uses the term "shall," it creates a mandatory obligation that the Government cannot, in its discretion, dispense with. *See Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Not surprisingly, HHS has acknowledged on multiple occasions that full payment is due. *See supra* note 9. Because, as Judge Wheeler recognized in *Molina*, "[t]he plain language of Section 1342 leaves the Secretary of HHS with no discretion whether to make risk corridor payments and how much those payments should be," *Molina*, 133 Fed. Cl. at 40, the Court should find that, under the statutory formula, the Government owes Montana Health $13,835,742.00 for benefit year 2016.

Section 1342 also answers the question of "when" the Government's RCP obligations are due. Section 1342's express language states that if a plan's allowable costs "for any ***plan year***" exceed the target amount, the Secretary "***shall pay to the plan***" the statutorily specified amounts. Although it does not expressly state that payments must be made on an annual basis, the statute cannot logically be read to require anything other than payment at the conclusion of the "plan year."[11] *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) ("[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme." (quoting *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2441 (2014) (internal quotations omitted))).

Finally, whether the Government's obligation under Section 1342 has changed on account of subsequent legislative acts is also apparent by reference to its text, which remains in the U.S. Code unchanged.

The Government posits that it need not make the mandated RCP payments to Montana Health and other QHPs for benefit year 2016. Under the Government's current view of the statute, payment would only ever be due after the conclusion of the third year of the RCP, and even then it is obligated to pay out only to the extent of RCP collections received from issuers who realized lower-than-anticipated costs. This ignores the plain language of Section 1342. Most notably, Congress specifically modeled the ACA RCP on the Medicare Part D RCP, which requires full annual payments. *See* GAO Rep. at 14. In the ACA RCP, Congress also directed HHS to establish risk *corridors* (plural) for each "plan year" 2014, 2015, and 2016. "[P]lan year" means 12 consecutive months under the ACA[12] and Congress *intentionally* used the plural "corridors." *See Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) ("Ordinarily the

[11] HHS reiterated that when allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the specified amounts. 45 C.F.R § 153.510 (emphases added).
[12] *See* 45 C.F.R. § 155.20.

legislature by use of a plural term intends a reference to more than one thing" (quotation and citations omitted)).

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

Nor did Congress's subsequent appropriations negate the Government's obligation to make the required payments under a money-mandating statute. First, Congress's intent in 2010 when it passed the ACA is unambiguous: Congress said the United States "shall pay" when QHP issuers satisfied the statutory "payments out" trigger. Second, as a matter of law, that payment obligation was not dependent on Congress simultaneously specifying the source for the obligated payments. Finally, Congress's subsequent acts barring RCP payments from specific sources through the annual appropriations process merely hampered HHS's ability to make payment; they did not abridge the Government's underlying statutory obligation. *See* Add. B at 3.

2. *Breach of Implied-in-Fact Contract*. Judgment in Montana Health's favor is also appropriate because the Government breached its unilateral or bilateral implied-in-fact contract with Montana Health. All elements of an implied-in-fact contract are met.

Empowered by the ACA's authorization to contract with QHP issuers, the Government held out a unilateral offer of RCP payments to induce Montana Health and other QHP issuers to begin performance by expanding coverage for millions of Americans, and Montana Health accepted by beginning performance. Consideration flowed both ways, where the Government benefited from Montana Health's performance as a QHP issuer, and Montana Health benefited from the Government's promise of payment.

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

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

SUMMARY JUDGMENT STANDARD

This case presents a question of statutory interpretation appropriate for summary disposition, as all material facts are undisputed. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." RCFC 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-16 (2008). A fact is material if it "might affect the outcome of the suit under the governing law," *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986), and a dispute of material fact is genuine "if the evidence is such that a reasonable finder of fact could return a verdict for the nonmoving party." *Johnson*, 80 Fed. Cl. at 116 (citing *Liberty Lobby, Inc.*, 477 U.S. at 248). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Id.* at 116 (quoting *Santa Fe Pac. R. Co. v. United States*, 294

F.3d 1336, 1340 (Fed. Cir. 2002)). The existence of a contract is a mixed question of law and fact, and the court may grant summary judgment when there is no genuine issue for trial. *See La Van v. United States*, 53 Fed. Cl. 290 (2002), *aff'd*, 382 F.3d 1340 (Fed. Cir. 2004).

ARGUMENT

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

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

Montana Health is entitled to summary judgment because, based on the undisputed facts and as a matter of law, the Government owes it an unpaid balance of RCP payment for 2016. This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and quotations omitted). The RCP's text and the ACA's structure require full, annual payment.

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

The enacting Congress effectuated the RCP's risk mitigating purpose by plainly and unambiguously mandating full payment to QHP issuers as defined in its "Payment Methodology" without regard to budget neutrality. First, the text mandates that the Government "***shall pay to the plan***" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). "[T]he mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion." *Lexecon*, 523 U.S. at 35. Moreover, Congress used "shall" and "may" throughout the ACA, often within the same section of the law, underscoring Congress's deliberate intent to invoke their distinct meanings. *See, e.g.*, ACA §§ 2713, 2717(a)(2), and 1104(h); *see also Lopez v. Davis*, 531 U.S. 230, 241 (2001) ("Congress' use of the permissive 'may' . . . contrasts with the legislators' use of a mandatory 'shall' in the very same section."). The enacting Congress used "shall" to signify mandatory obligations and "may" to impose

discretionary ones. Unsurprisingly, in its public statements made prior to Montana Health and other QHP issuers finally and irrevocably committing to provide insurance on the exchanges, HHS agreed and acknowledged that the RCP "is not statutorily required to be budget neutral" and, in recognition of the statutory mandate to make payment, promised payment "[r]egardless of the balance of payments and receipts." 78 Fed. Reg. at 15,473 (Add. A at 13); *see, e.g.*, *Moda*, 130 Fed. Cl. at 456 (finding "the unambiguous language of Section 1342 dispositive" of the fact that Congress did not intend the RCP to be budget neutral).[13]

Second, Congress explicitly modeled the ACA's RCP on the Medicare Part D RCP, which is not budget neutral. *See* ACA § 1342(a); GAO Rep. at 14 ("for the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers is not limited to issuer contributions."). Government sharing in the risk is a critical design feature of the ACA's RCP no less than it is of the Medicare Part D RCP[14]: it is inherent to the incentive to QHP issuers to enter the exchanges and offer affordable premiums; it is also what differentiates the RCP from the risk adjustment program (which by design redistributes payments from plans serving healthier populations to plans serving less healthy populations). A budget-neutral program eliminates the Government's share of the risk and thus negates the central tenet of the RCP. Indeed, if "payments out" were subject to "payments in" and issuers experienced losses

[13] In *Moda*, Judge Wheeler found, as Montana Health argues here, that the RCP is unambiguously *not* budget neutral under the plain meaning of Section 1342, as HHS/CMS contemporaneously and repeatedly recognized (as did everyone in the industry). *Moda*, 130 Fed. Cl. at 455-57; *see also Molina*, 133 Fed. Cl. at 32-38. HHS's multiple and consistent statements shortly after the ACA's passage buttress Montana Health's interpretation that the statute is unambiguously not budget neutral.

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

across the board, issuers would not receive anything. The Government's position would have the Court ignore the very benefit the RCP was created to provide. *Cf. Engel v. Davenport*, 271 U.S. 33, 38-39 (1926) ("The adoption of an earlier statute by reference makes it as much a part of the later act as though it had been incorporated at full length." (citations omitted)). In modeling the ACA RCP on the Medicare Part D RCP, it is presumed that Congress legislated with awareness of how the Part D RCP is administered. *See Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978). If Congress had intended the ACA *not* to track this defining characteristic of Part D, surely Congress would have said so explicitly.

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

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

the government's liability to the amounts appropriated by Congress for the purpose." (citing *Greenlee Cty.*, 487 F.3d at 878-79)). In the RCP, however, Congress chose not to include such limiting language in any form, despite having done so elsewhere within the ACA itself. *See, e.g.*, 42 U.S.C. § 280k(a) ("The Secretary . . . shall, ***subject to the availability of appropriations***, establish a 5-year national, public education campaign . . . ." (emphasis added)). Especially when read in the context of the ACA as a whole, the lack of any language of budgetary limitation in Section 1342 confirms that Congress did not intend the RCP to be budget neutral or "subject to the availability of appropriations." *See United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) ("A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme—because the same terminology is used elsewhere in a context that makes its meaning clear, or because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." (citations omitted)); *see also Brown v. Gardner*, 513 U.S. 115, 118 (1994) ("Ambiguity is a creature not of definitional possibilities but of statutory context."). The Government cannot add words to § 1342 that Congress excluded, particularly where those very words appear *elsewhere* in the law.

The Congressional Budget Office ("CBO") did not score Section 1342 prior to the ACA's enactment. The Government has posited in other RCP litigation (and likely will again here) that Congress must have relied on that lack of scoring to mean it intended that Government payments would not exceed amounts collected under the RCP. This logic is faulty for multiple reasons. First, whatever the CBO had to say (or not say) is irrelevant to the Court's interpretation of what Congress actually said in the statutory text. *See Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009) (stating "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent"). Second, and in any event, as Judge

Wheeler pointed out in granting judgment for the insurers in *Moda* and *Molina*, the CBO's "failure to speak on Section 1342's budgetary impact" says nothing about the CBO's viewpoint on the subject. *Moda*, 130 Fed. Cl. at 455; *Molina*, 133 Fed. Cl. at 32. As Judge Wheeler went on, if anything, the opposite inference should be drawn from the CBO's failure to address the budgetary impact given that it did expressly score the reinsurance and risk-adjustment programs as budget neutral, and presumably would have done the same for the RCP had it thought the RCP would be budget neutral. *See Moda*, 130 Fed. Cl. at 455. Third, in the only report in which the CBO actually addressed the budgetary impact of the RCP, it concluded the RCP was *not* budget neutral. *See* CBO, "The Budget and Economic Outlook: 2014 to 2024" (Budget Outlook) at 9 (Feb. 2014), *available at* https://www.cbo.gov/publication/45010.

Finally, ACA opponents in Congress have repeatedly introduced (but failed to pass) legislation intended to make the RCP budget neutral. *See infra* Section I.C.1. Obviously, if the RCP were budget neutral, such legislative efforts would have been unnecessary. *See, e.g.*, *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 22 n.6 (2011) (noting that congressional attempts to amend a law provide support for the proposition that the law in its current form does not already do what the amendment proponents are seeking). The RCP's sole purpose was to induce participation in an uncharted healthcare insurance market by mitigating the risk that would otherwise lead QHP issuers under normal market conditions to either steer clear or charge significantly higher premiums. HHS's acknowledgment of this fact on multiple occasions illustrates its awareness that the Government is liable for full payment. *See supra* note 9.

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

The ACA's text and structure unambiguously anticipate that RCP payments—both "in" and "out"—will be made on an annual basis. And this is exactly how HHS originally understood

and stated it would apply its congressional mandate. *See* 77 Fed. Reg. at 17,238-39 (stating that the same deadlines should apply to both "payments in" and "payments out") (Add. A at 9-10); 78 Fed. Reg. at 15,473 (setting a 30-day deadline from determination of charges for QHP issuers to make "payments in") (Add. A at 13).

a. *The Text and Structure of the ACA Require Annual RCP Payment.*

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

Second, the RCP's "Payment Methodology" also constructs an annual program by predicating the appropriate payment amounts on figures that are calculated annually. The RCP mandates payments to any QHP issuer that, for the applicable year, had "allowable [health care] costs" that were more than three percent greater than a "target amount." *See* ACA § 1342(b). The RCP defines "allowable costs" and the "target amount" with reference to "a plan for any year" and the "amount of a plan for any year." *See* ACA §§ 1342(c)(1)(A), 1342(c)(2), 1342(b). "Target amounts" necessary to calculating RCP payments are based on payments and receipts under the related risk adjustment and reinsurance provisions, which are annual. 45 C.F.R. § 153.510(a)-(d), (g). The scheme is annual.

Third, the enacting Congress, by referencing the plural "corridors" when it directed that HHS "shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," did so intentionally to create separate risk corridors for each of the calendar years

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

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

program—a program premised on annual payments.[15]

b. *HHS Interpreted the RCP to Require Timely Annual Payments.*

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

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

77 Fed. Reg. at 17,238 (emphasis added) (Add. A at 9).

In its first Payment Rule, HHS set a 30-day deadline for issuers to remit payment upon notification of charges. *See* 78 Fed. Reg. at 15,473 (Add. A at 13). And, as HHS stated in the preamble to its implementing regulations, it believed the same deadline should apply to both "payments in" and "payments out" of the program. Significantly, HHS requires issuers to submit their data to HHS annually to facilitate calculation of RCP payments. 45 C.F.R. § 153.530(d).

Thus, not so long ago, there was no disagreement that Congress intended both RCP payments to the Government and from the Government to be made annually. And for good reason: that is the only reading that is consistent with the overall purpose and structure of the

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

ACA. A premium rate stabilization program would not do much good if insurers could not rely on complete and timely payment. As the Supreme Court pointed out, Congress designed the ACA to prevent an economic "death spiral," in which "premiums rose higher and higher, and the number of people buying insurance sank lower and lower, [and] insurers began to leave the market entirely." *King*, 135 S. Ct. at 2486. A program by which the Government mitigated insurers' risk by sharing in that risk was necessary to incentivize health insurance companies to enter and remain on the exchanges. *See, e.g.*, *Health Republic*, 129 Fed. Cl. at 776 ("If these programs did not provide for prompt compensation to insurers upon the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges. Further, if enough insurers left the exchanges, one of the goals of the Affordable Care Act—the creation of 'effective health insurance markets,'—would be unattainable." (internal citations omitted)).

HHS's original interpretation is fully supported by the fact that the very "death spiral" the Supreme Court recognized, and that the RCP was intended to avoid, has resulted, at least in part, from Congress's failure to appropriate sufficient funds to satisfy the Government's RCP obligations.[16] To suggest, as HHS has, that QHP issuers of all sizes that sustain significant short-term losses, and report on their costs and receipts on an annual basis as the ACA requires them to do, can readily bear those losses over multiple years, all while keeping premiums affordable for enrollees in each successive year, is anathema to the structure and purpose of the ACA. "It is

[16] *See* HHS, ASPE Research Brief, "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace" at 6 (Oct. 24, 2016), *available at* https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf (predicting average premium increase of 25 percent); Kaiser Family Foundation, "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces" (Oct. 25, 2016), *available at* http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/ ("As a result of losses in this market, some insurers . . . have announced their withdrawal from the ACA marketplaces or the individual market . . . .").

implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494 (citations omitted); *Bob Jones*, 461 U.S. at 586 (statutory interpretations that frustrate the object and purpose of the statute are disfavored); *Global Computer Enters.*, 88 Fed. Cl. at 406 (same); *Fluor Enters.*, 64 Fed. Cl. at 479 (same).

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

The Government will likely contend (as it has in other RCP litigation) that, notwithstanding Section 1342's "shall pay" directive, Congress never specified an appropriation to fund the RCP in the first instance, so there can be no obligation. This position finds no support in the law.

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

It has long been understood that:

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

Collins v. United States, 15 Ct. Cl. 22, 35 (1879) (emphases added); *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 "*[t]he absence of an appropriation constitutes no bar to the recovery of a judgment in cases where the liability of the government has been established.*"). Under the Tucker Act, Montana Health may recover unpaid funds when the Government fails to meet its obligation under a money-mandating statute. *See, e.g.*, *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012); *District of Columbia v. United States*, 67 Fed. Cl. 292, 302-05 (2005). The RCP is unequivocally money-mandating because, *inter alia*, it dictates that the Government "shall pay" RCP payments. Whether, when, and how Congress appropriates the required funds are irrelevant to this Court's decision regarding the Government's legal *obligation* to make the "payments in" the first instance. There is no requirement for Congress to create a specific appropriation. *See, e.g.*, *United States v. Langston*, 118 U.S. 389, 391-94 (1886) (finding the Government liable for statutory promise of payment in absence of a specific appropriation).

The Federal Circuit's seminal decision in *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011) (*en banc*), drives home the point. *Slattery* addressed whether the Government could be sued under the Tucker Act for breaches committed by a Government entity that was not funded by appropriations ("NAFI"). The Government argued that because a NAFI is not funded by appropriations, this Court lacks jurisdiction to adjudicate claims for a NAFI breach. After canvassing the long line of cases from the Court of Claims, Federal Circuit, and Supreme Court, the Federal Circuit abrogated its own contrary precedent[17] and held that the Tucker Act's broad grant of jurisdiction for any claim "founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States . . .," 28 U.S.C. § 1491(a)(1), was *not* limited to the subset of instances where a

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

specific appropriation could be identified. It held, "the jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid." *Slattery*, 635 F.3d at 1321. Critically, the Court ruled that any resulting judgment—despite the lack of appropriations involved in creating the original obligation—*could be satisfied by the Judgment Fund*. *See id.* at 1317 (Judgment Fund's purpose "was to avoid the need for specific appropriations to pay [Court of Claims] judgments").

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

The point is this: because Congress did not condition "payments out" on "payments in," the only limitation on Montana Health's right to payment on its statutory claim is its ability to demonstrate, as a factual matter, that it performed as a QHP issuer on the exchanges and qualifies for RCP payments under the Section 1342 formula (as echoed in CMS's implementing regulation). If it can make that showing (as it has), then the Government is liable for its statutory obligation and judgment may be executed against the Judgment Fund. *See, e.g.*, *Moda*, 130 Fed. Cl. at 461 ("The Judgment Fund pays plaintiffs who prevail against the Government in this

Court, and it constitutes a separate Congressional appropriation."); *Gibney v. United States*, 114 Ct. Cl. 38, 52 (1949) ("Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether . . . Congress appropriate[s] an insufficient amount . . . or nothing at all, are questions . . . which do not enter into the consideration of case in the courts.").

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*, 132 S. Ct. at 2191-92).

In short, the fact that Congress did not appropriate funds specifically for the RCP is immaterial to the question of whether, in Section 1342, it created an obligation for which the

Government can be held liable.

C. Later Appropriations Acts Did Not Nullify or Modify the Government's RCP Obligations.

The Government has argued in other RCP litigation that a subsequent Congress, through the Spending Riders, prohibited HHS from making RCP payments from certain program funds, and therefore abrogated any mandate to pay that the Government otherwise had. This argument is incorrect.

The fact that Congress curtailed HHS's ability to make RCP payments through appropriations riders, well after the exchanges were under way and after the Government's obligations to Montana Health (and other issuers) had accrued, cannot alter the Government's RCP *liability for its extant obligations*. As discussed above, the existence of a legal obligation is distinct from the means by which the Government fulfills the Government's obligation. That Congress imposed temporary restrictions on specific funding sources for HHS to fulfill those obligations did nothing to modify the obligations. Indeed, the very fact that Congress has considered legislation to modify or repeal the ACA as a whole and the RCP specifically, and declined to do so, highlights the important distinction between appropriations legislation (for annual funding of discretionary government operations) and substantive legislation (which fixes rights and obligations, including of the United States itself). *See Moda*, 130 Fed. Cl. at 455-62 (finding that Congress did not intend Section 1342 to be budget-neutral and that neither the 2015 nor 2016 Spending Riders abrogated or effectuated a repeal or amendment of the RCP).

1. *Congress Declined to Amend the RCP.*

Congress frequently amends or repeals laws. The 113th Congress, which passed the 2015 Spending Rider, directly considered two pieces of proposed legislation to amend the ACA to limit or eliminate RCP payments. *See* Obamacare Taxpayer Bailout Protection Act, S. 2214,

113th Cong. (2014) (seeking to amend the RCP to "ensur[e] budget neutrality."); Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) (seeking to eliminate the RCP). Congress declined to pass either piece of legislation. During the 2016 budget process, Congress considered an amendment expressly indicating that "Effective January 1, 2016, the Secretary shall not collect fees and shall not make payments under [the RCP]." 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015) (statement of Sen. McConnell). Senator Patty Murray spoke against the amendment, raising a point of order to strike the proposed amendment, because the RCP "is a vital program to make sure premiums are affordable and stable for our working families. Repealing it would result in increased premiums, more uninsured, and less competition in the market." *Id.* at S8354. The Senate then voted against the amendment. Congress also considered more narrow legislation that would have required the RCP to be administered on a budget-neutral basis. *See, e.g.*, S. Rep. No. 114-74, 12 (June 25, 2015); *see also id*. at 121, 126. Congress declined to pass these measures as well.[18]

In other words, Congress considered modifying or repealing the RCP—but *did not do so*. However, these repeated efforts to modify the RCP illustrate what is clear from the text of the RCP as enacted in 2010: *the Government's obligation to make "payments out" was not constrained by budget neutrality*. *See, e.g.*, *ARRA Energy*, 97 Fed. Cl. at 22 n.6. The RCP has never been substantively amended.

2. *Eliminating a Funding Source Does Not Negate the Obligation.*

Beginning with the 2015 Spending Rider, passed December 16, 2014, Congress curtailed certain funding sources available to CMS to make RCP payments. This is a critical point—Congress did not amend the RCP via the Spending Riders. Instead, Congress abridged CMS's

[18] To date, Congress has considered dozens of amendments to the ACA generally and the RCP specifically. *See* Add. B at 3.

funding authority to make RCP payments from certain accounts. But that is a mere administrative point; it does not modify the Government's underlying legal obligation. As noted *ante*, Congress considered legislation to amend the RCP, and declined to amend it. It would be farfetched, to say the least, to interpret appropriations riders to have accomplished what Congress chose not to do through substantive legislation. *See Blanchette v. Conn. Gen. Ins. Corps.*, 419 U.S. 102, 134 (1974) ("Before holding that the result of the earlier consideration has been repealed or qualified, it is reasonable for a court to insist on the legislature's using language showing that it has made a considered determination to that end . . . ." (citations and quotations omitted)).

Even without the benefit of that additional legislative history, the Spending Riders by their plain language did not nullify the Government's payment obligations. The legal standard for finding that an appropriation act negated an existing statutory right is stringent—it is presumed not to happen. In this case, three related, bedrock principles undermine any argument that the Spending Riders negated the Government's RCP obligations. *First*, even where the change would have only prospective effect, Congress is presumed not to amend preexisting substantive statutory obligations except where it signals otherwise "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted); *accord United States v. Welden*, 377 U.S. 95, 102 n.12 (1964) ("Amendments by implication, like repeals by implication, are not favored."). Nothing in the Spending Riders expresses or clearly implies an intent to abolish the obligation created by Section 1342.

Second, this general rule of statutory interpretation "applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980) (emphasis added). Because appropriations acts

"have the limited and specific purpose of providing funds for authorized programs," the statutory instructions included in them are presumed not to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). "[I]t can be strongly presumed that Congress will specifically address language on the statute books that it wishes to change." *United States v. Fausto*, 484 U.S. 439, 453 (1988); *Greenlee Cty.*, 487 F.3d at 877 ("It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." (citing *N.Y. Airways v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966))). By their terms, the Spending Riders merely restricted HHS's ability to use certain sources of money to make payments under the RCP; it did not change the law or the Government's legal obligation under Section 1342, or signal an intent to modify what Congress had previously legislated in Section 1342.

Restricting appropriations alone, without more, does not amend the underlying legislation. *See Greenlee Cty.*, 487 F.3d at 877; *Gibney*, 114 Ct. Cl. at 53 (noting that the court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation"). Nor does it absolve the Government of its obligation to make payments mandated by law. *See id.*

Third, even if the Government could overcome the presumption against implied repeal or amendment generally—which it cannot—it would run headlong into an insurmountable wall in this case given that its position, if adopted, would result in the *retroactive* negation of the Government's obligation. After all, by the time Congress said anything about appropriations for RCP payments for the respective benefit years, Montana Health had already acted in reliance on the RCP. For benefit year 2016, the Government's obligation (albeit undefinitized) accrued no

later than October 2015, when Montana Health and CMS fully executed QHP agreements. Those contracts required Montana Health to undertake myriad obligations in connection with offering QHPs on the exchanges well *before* Congress enacted any appropriation restricting RCP funding for that year. Judge Wheeler recognized this in *Molina*, where he flatly rejected—as "wholly without merit"—the Government's argument that any obligation existing under Section 1342 could not accrue until, at the earliest, the time that costs are tabulated, in the year following the applicable benefit year. *Molina*, 133 Fed. Cl. at 38. That may be when a QHP issuer's legal claim to its payment accrues, but it is bedrock fiscal law that the obligation can accrue long before the purely administrative task of tabulating the definite amount owed. *See* II GAO, *Principles of Fed. Appropriations Law*, at 7-4 - 7-5, *available at* http://www.gao.gov/legal/redbook/overview (An "obligation arises when the definite commitment is made, *even though the actual payment may not take place until a future fiscal year*. . . . [T]he term 'obligation' includes both matured and unmatured commitments . . . . An unmatured commitment is a liability which is *not yet payable* but for which a definite commitment nevertheless exists." (emphasis added)).

Applicable case law amplifies these principles and illustrates the Government's flawed reasoning. In *Langston*, for example, the diplomatic representative to Haiti sued when Congress failed to appropriate sufficient funds to pay his statutorily set salary. 118 U.S. at 390. Under the original statute, "[t]he representative at Ha[i]ti shall be entitled to a salary of $7,500 a year" and a subsequent appropriation set the salary "for the service of the fiscal year ending June 30, 1883, out of any money in the treasury, not otherwise appropriated, for the objects therein expressed" at $5,000. *Id.* at 390-91. The Supreme Court emphasized the importance of clear language repealing or amending a statute. For example, it distinguished the language of the appropriation

at issue from one in which Congress clearly indicated an intent to repeal previously set salaries, because the subsequent appropriation explicitly set out a new compensation system designed to replace the prior one. *Id.* at 392-93. The Court reasoned that the appropriation at issue did not contain "any language to the effect that such sum shall be 'in full compensation' for those years" or other provisions "from which it might be inferred that congress intended to repeal the act." *Id.* at 393. Reiterating that "[r]epeals by implication are not favored," the Supreme Court held that it must give effect to both provisions where possible and:

> While the case is not free from difficulty, the court is of opinion that, according to the settled rules of interpretation, a statute fixing the annual salary of a public officer at a named sum, without limitation as to time, should not be deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount for the services of that officer for particular fiscal years, and which contained no words that expressly, or by clear implication, modified or repealed the previous law.

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

Judge Wheeler analyzed the relevant cases in his decisions in *Moda* and *Molina* and observed two types of cases where courts have found a congressional intent to abridge, by way of appropriations, a substantive legal obligation. The first type involves appropriations that bar the administering agency from using funds from *any* appropriation contained in "this Act or any other Act," choking off all funding, and thus negating the obligation. *See Moda*, 130 Fed. Cl. at 459-62 (citing *United States v. Dickerson*, 310 U.S. 554, 554-55, 60-62 (1940); *Will*, 449 U.S. at 205-08, 222-24). A second type involves Congress affirmatively dedicating a specific appropriation to the obligation at issue, signaling exclusivity, and thus a newly imposed limitation on the obligation. *See Molina*, 133 Fed. Cl. at 38-40 (citing *Highland Falls–Fort Montgomery Cent. School Dist. v. United States*, 48 F.3d 1166, 1168-72 (Fed. Cir. 1995)). As

Judge Wheeler pointed out, the 2015 Spending Rider does not match either type, as it does not bar funds appropriated in "this Act or any other Act" or dedicate a specific funding source. Similarly, all Congress did in the 2017 Spending Rider was cut off specific funding sources, not "all" funding sources, and Congress was silent as to the RCP obligation itself. Indeed, Judge Wheeler pointed out that Congress used the "this Act or any other Act" limitation in *other* provisions of the 2015 Spending Rider, unrelated to the RCP, making its absence from the provision regarding the RCP all the more probative of the limited reach of the RCP funding restrictions. *See Moda*, 130 Fed. Cl. at 462. The same is true of the 2016 and 2017 Spending Riders. *See, e.g.*, 2016 Spending Rider, 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 . . ."); 2017 Spending Rider, Pub. L. No. 115-31, § 112 ("None of the funds made available in this Act or any other Act may be used to implement, administer, or enforce . . .").

* * * * *

Because Congress has not amended or repealed the RCP, and because nothing in the Spending Riders changes the obligation of the Government under Section 1342, the Government remains liable in full for its RCP obligations.

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

This Court has jurisdiction over implied contract claims, 28 U.S.C. § 1491(a)(1), and the Judgment Fund is available to pay judgments. *Slattery*, 635 F.3d at 1303, 1317-21. All elements of an implied contract are met here,[19] and Montana Health is entitled to the contractually obligated amounts. The Government held out a unilateral offer of RCP payments to induce

[19] 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).

Montana Health and other QHP issuers to begin performance by expanding coverage for millions of Americans. Montana Health accepted the Government's offer by beginning performance on the exchanges. The Government's offer became irrevocable at the point of acceptance (October 8, 2015), which occurred prior to the passage of the 2017 Spending Rider (May 5, 2017). Alternatively, the parties entered into a *bilateral* contract—culminating in the signed QHP Issuer Agreement—in which the parties agreed that Montana Health would be bound to a raft of duties and obligations in exchange for RCP payments, *inter alia*. In either scenario, HHS's failure to uphold its side of the bargain constitutes a textbook contractual breach.

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

1. *There Was Mutuality of Intent to Contract.*

The Government enters contracts when its conduct or language "allows a reasonable inference" that it intended to. *ARRA Energy*, 97 Fed. Cl. at 27. The surrounding circumstances include the statutory purpose, context, legislative history, or any other objective indicia of actual intent.[20] The combination of Section 1342, HHS's implementing regulations, and the Government's conduct (before and after Plaintiff agreed to become a QHP issuer) 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. ¶¶

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

75-90.

This longstanding test is best illustrated in *Radium Mines Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957), where the court found that a regulation establishing a guaranteed minimum Government purchase price for uranium was not "a mere invitation to the industry to make offers to the Government," and was an intent to contract, because the regulation's purpose was to "induce persons to find and mine uranium." *Id.* at 405-06. In other words, the case focused on the regulations' "promissory" nature in finding an implied-in-fact contract.[21] The Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes.[22] *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

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

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

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

performed in accordance with the RCP's requirements.

The fact that the RCP contained numerous requirements[23] that QHP issuers had to fulfill in order to receive payment further helps establish that the Government was required to make payment once those requirements were met. In *New York Airways*, this Court described the mandatory statutory payment in that case as creating an implied contract once the plaintiff had satisfied the requirements for payment. 369 F.2d at 751 (holding that the actions of the parties support the existence of a contract at least implied in fact that the agency's order was "in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer").

Similarly, when the Government includes "numerous requirements . . . to receive the payments" those payments are "compensatory in nature," and one can accept such offer for payment through satisfaction of the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F.2d 518, 521 (5th Cir. 1948). Here, the ACA contained a host of requirements for fixed payment, and when the QHP issuers met such requirements, the mutuality of intent formed an implied-in-fact contract, obligating the Government to pay QHP issuers.[24]

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

The Government *offered* RCP payments to insurers through the language of Section

[23] 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).

[24] Further, none of the countervailing factors in *Baker* are present here. *See* 50 Fed. Cl. at 491-93.

1342, regulations, and HHS's numerous publications and affirmations. Insurers then *accepted* the offer by beginning performance and providing QHP services, thus executing an enforceable unilateral contract.[25] Specifically, Montana Health 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 in benefit year 2016. Courts have found such exchanges to constitute unambiguous offer and acceptance without any explicit reference to an offer or contract.[26] The Government's offer became irrevocable at the point of acceptance—the subsequent 2017 Spending Rider neither unwound the enforceable contract nor relieved the Government of its burden to make full payment.

3. *There Was Consideration.*

Consideration at the time of contract formation flowed both ways. QHP issuers are the backbone of the Government's effort to provide affordable and comprehensive coverage through the exchanges and, *but for* the Government's promise of risk stabilization, insurers would not have offered plans with such restrictive and elaborate conditions, whose financial viability had never before been tested. When Montana Health agreed to offer a QHP, the Government and Montana Health committed to an intricate set of specific, reciprocal obligations.[27] The Government benefitted by Montana Health's servicing of formerly uninsured, high-cost enrollees at reasonable premiums (that accounted for anticipated RCP risk-sharing) in compliance with its

[25] In a unilateral contract, the offeree may only accept the offer by performing its contractual obligations. *See Contract*, Black's Law Dictionary (10th ed. 2014) (defining "unilateral contract" as "[a] contract in which only one party makes a promise or undertakes a performance."); *Lucas v. United States*, 25 Cl. Ct. 298, 304 (1992) (explaining that a prize competition is a unilateral contract because it requires participants to submit entries in return for a promise to consider those entries and award a prize).

[26] *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 816-18 (finding published "board rate" for aviation transportation services constituted an offer that plaintiff accepted through performance).

[27] *See supra* note 23.

extensive QHP standards. Indeed, the calculation of RCP payments is based on the costs incurred by QHP issuers to provide those benefits. In exchange, Montana Health received consideration because HHS committed that *only* QHP issuers would receive RCP payments (to the exclusion of other insurers), 45 C.F.R. § 153.510, and that HHS would make timely and full RCP payments. *Ace-Fed. Reporters, Inc. v. Barram*, 226 F.3d 1329, 1332 (Fed. Cir. 2000) (Government buying from "between two and five authorized sources," to the exclusion of others, was "consideration" with "substantial business value.").

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

Actual authority to contract can be express or implied—either is sufficient to bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). Agency Heads have contract-making authority "by virtue of their position." FAR § 1.601(a) (contractual authority in each agency flows *from* the Agency Head to delegated officials).[28]

Moreover, Section 1342's instruction that the Secretary "shall establish" the RCP and "shall pay" RCP payments, along with the Secretary's broad obligation to administer and implement the ACA,[29] give the Secretary the express (or at least implied) authority to enter into binding agreements with QHP issuers to implement the ACA. *See Winstar Corp*., 518 U.S. at 890 n.36; *H. Landau*, 886 F.2d at 324; *California v. United States*, 271 F.3d 1377, 1383-84 (Fed. Cir. 2001) (statute granted Interior Secretary authority to enter into binding agreements). 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

[28] *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).
[29] *See* ACA §§ 1001, 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d).

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.

Even if no appropriated funds were available, the ADA expressly permits agencies to enter into contracts whenever "authorized by law." 31 U.S.C. § 1341(a)(1)(B) (officials restricted from contracting "before an appropriation is made ***unless authorized by law***." (emphasis added)). For example, in *California*, 271 F.3d at 1383-84, the 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* . . ." (emphasis added). Here, similarly, the ACA expressly (1) authorized the HHS Secretary to enter into agreements with insurers to offer QHPs, (2) authorized the HHS Secretary to develop regulations with which QHP issuers were required to comply, and (3) mandated that he or she "shall pay" RCP funds. Per precedent, the Secretary had actual authority (by position) and was impliedly authorized (by statute) to enter into binding agreements, regardless of appropriations, and the resulting agreements were not *ultra vires*. *See id*.; ACA § 1301(a)(1)(C)(iv).

Third, HHS's "actual authority" (to enter into binding agreements) is separate and distinct from whether HHS's contracts were *ultra vires*. "Actual authority" exists as a function of position, FAR 1.601(a); its existence does not flow from whether a particular action complied with all statutory and regulatory requirements in existence. *Even if* entering into agreements with QHP issuers violated the ADA (it did not), the Secretary's unauthorized commitment still *binds* the Government unless the alleged illegality (vis-à-vis the ADA) was patent and "palpably

illegal" at the time of formation. *John Reiner & Co. v. United States*, 325 F.2d 438, 440 (Ct. Cl. 1963) ("[T]he court should ordinarily impose the binding stamp of nullity only when the illegality is plain."); *Trilon Educ. Corp. v. United States*, 578 F.2d 1356, 1360 (Ct. Cl. 1978) ("[Government] officers must find their way through a maze of statutes and regulations . . . . It would be unfair for [contractors] to suffer for every deviation . . . . [T]he court has preferred to allow the contractor to recover on the ground that the contracts were not palpably illegal to the [contractor's] eyes."). Here, the ACA's requirement that QHP issuers comply with, *inter alia*, regulations developed by the Secretary coupled with its authorization that he or she "establish," "administer," and "pay" RCP amounts to insurers demonstrate clear authority. ACA § 1301(a)(1)(C)(iv). Any alleged conflict with the ADA was certainly not "palpably illegal" because Montana Health unquestionably lacked insight into the maze of arcane Government fiscal accounting procedures that existed when Montana Health "accepted" the Government's unilateral offer by beginning performance.

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

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

First, the parties' offer and acceptance was unambiguously evidenced by entering into the QHP Issuer Agreement. The agreement was signed by David J. Nelson, the Deputy Chief Operating Officer and Chief Information Officer of CMS, who is authorized to represent CMS. The agreement formally offered Montana Health participation as a QHP issuer on the exchanges in benefit year 2016. Montana Health accepted this offer through its signature on the agreement,

agreeing to offer plans as a QHP issuer on the exchanges, subjecting itself to various performance standards.

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

Third, Mr. Nelson, the CMS officer who signed the QHP Issuer Agreement, had express actual authority to contract. FAR 1.601(a). The QHP Issuer Agreement expressly memorialized his authority, stating, "The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement." *See e.g.*, CMS, "Agreement Between Qualified Health Plan Issuer and Centers for Medicare and Medicaid Services," *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/qhp-issuer-agreement.pdf. At minimum, Mr. Nelson had implied actual authority by nature of his position. *See H. Landau*, 886 F.2d at 324 ("Authority to bind the [g]overnment is generally implied when such authority is considered to be an integral part of the duties assigned to a [g]overnment employee.") (quoting Ralph C. Nash & John Cibinic, Formation of Government Contracts (1982)). Even if, *arguendo*, Mr. Nelson lacked actual authority to bind the Government, the Government continued to accept and benefit from Montana Health's performance as a QHP issuer on the exchanges, with the knowledge of—and lack of repudiation by—the HHS Secretary, thereby effecting an institutional ratification. *See Silverman v. United States*, 230 Ct. Cl. 701, 710 (1982) (finding institutional ratification where although an official did not have contracting authority, the agency accepted "the benefits flowing from" the official's "promise of payment."). HHS recognized its obligation to make full payment, and promised the same, through fall 2016.

Fourth, mutual intent to contract can be inferred from the parties' conduct and surrounding circumstances. A QHP Issuer Agreement was the culmination of the QHP certification process, where issuers such as Montana Health apply to become a QHP issuer, and then CMS—as administrator of the Federally Facilitated Marketplace—reviews the application and certifies the issuer as a QHP.[30] QHP certification is a prerequisite for issuers to participate in the exchanges under the ACA. Montana Health and CMS engaged in this QHP certification process and entered into the QHP Issuer Agreement for Montana Health's participation in the Montana and Idaho marketplaces for benefit year 2016. The QHP certification process, along with the ultimate QHP Issuer Agreement, evidences the mutual intent of Montana Health and CMS to enter into a bilateral implied-in-fact agreement, where the parties would perform their respective obligations pursuant to Section 1342 of the ACA.

* * * * *

In sum, the ACA created an implied-in-fact contract with insurers like Montana Health under which the Government owed Montana Health RCP payments if Montana Health offered QHPs on the exchanges pursuant to QHP issuer standards and suffered losses. Montana Health sold QHPs on the Montana and Idaho exchanges in benefit year 2016 as a QHP issuer and suffered losses. The Government breached its reciprocal contractual duty by failing to make full risk corridors payment as promised. Therefore, there is no genuine dispute that the Government is liable to Montana Health under the implied-in-fact contract, and Montana Health is entitled to summary judgment on that basis.

III. THIS COURT CAN GRANT MONTANA HEALTH THE RELIEF SOUGHT.

This Court can enter judgment for Montana Health irrespective of how such a judgment will be satisfied by the political branches. "This court . . . does not deal with questions of

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

appropriations, but with the legal liabilities incurred by the United States . . . ." *Collins*, 15 Ct. Cl. at 35. As noted, "[t]he judgment of a court has nothing to do with the means—with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them." *Gibney*, 114 Ct. Cl. at 52; *see Slattery*, 635 F.3d at 1317 ("The purpose of the Judgment Fund was to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims."); *N.Y. Airways*, 369 F.2d at 748 ("The failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in [this Court]."). If this Court determines that Montana Health is owed funds under the RCP, it will be for the Government to determine how to fulfill that obligation.

CONCLUSION

Montana Health respectfully requests that its motion for summary judgment be granted because, based on the undisputed facts, the Government owes Montana Health timely annual and complete RCP payments as a matter of law. Specifically, Montana Health requests monetary relief in the amounts to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b), *i.e.*, $13,835,742.00 for benefit year 2016.

Dated: November 8, 2017

Respectfully submitted,

/s/ Stephen McBrady

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CERTIFICATE OF SERVICE

I certify that on November 8, 2017, a copy of the forgoing "Plaintiff's Motion for Summary Judgment and Memorandum of Law in Support," along with (1) Addendum A, and (2) Addendum B, was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

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