APPENDIX

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Appendix A

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

No. 19-1633

COMMUNITY HEALTH CHOICE, INC.,
Plaintiff-Appellee,
v.
UNITED STATES,
Defendant-Appellant.

No. 19-2102

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellee,
v.
UNITED STATES,
Defendant-Appellant.

Decided: Aug. 14, 2020

Before DYK, BRYSON, and TARANTO, *Circuit Judges*.

OPINION

DYK, *Circuit Judge*.

Today in *Sanford Health Plan v. United States* ("*Sanford*"), No. 19-1290, we hold that the United States failed to comply with section 1402 of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119, 220-24 (2010) (codified at 42 U.S.C. § 18071)—which requires the government to reimburse insurers for "cost-sharing reductions." We hold that section 1402 "imposes an unambiguous obligation on the government to pay money and that the obligation is enforceable through a damages action in the Court of Federal Claims [('Claims Court')] under the Tucker Act." *Sanford*, No. 19-1290, slip op. at 3.

In these cases, following our decision in *Sanford*, we affirm the Claims Court's decisions as to liability. As in *Sanford*, we conclude that the government is not entitled to a reduction in damages with respect to cost-sharing reductions not paid in 2017. As to 2018, we address an issue not presented in *Sanford*: the appropriate measure of damages. We hold that the Claims Court must reduce the insurers' damages by the amount of additional premium tax credit payments that each insurer received as a result of the government's termination of cost-sharing reduction payments. We reverse and remand for further proceedings with respect to damages.

BACKGROUND

I

In 2010, Congress enacted the ACA, which includes "a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).

"[T]he Act requires the creation of an '[e]xchange' in each State—basically, a marketplace that allows people to compare and purchase insurance plans." *Id.* Insurance plans sold on the ACA exchanges must provide a minimum level of "essential health benefits" and are referred to as "qualified health plans." *See* 42 U.S.C. § 18031. The ACA defines four levels of coverage: bronze, silver, gold, and platinum, which are based on the percentage of essential health benefits that the insurer pays for under each type of plan. *Sanford*, No. 19-1290, slip op. at 4. For example, under a silver-level plan, the health insurance provider pays for 70 percent of the actuarial value of the benefits, and either the insured or the government pays the remaining 30 percent. *Id.*

Under most health insurance plans, the insured individual must bear two types of costs. First, the insured must pay a monthly premium to maintain coverage. Second, the insured must pay an additional fee—called "cost-sharing"—when medical expenses are incurred. Deductibles, coinsurance, and co-payments are examples of such fees. *See* 42 U.S.C. § 18022(c)(3)(A)(i). The ACA includes two sections, 1401 and 1402, that reduce the premiums and cost-sharing for low-income insureds by government payments to the insurers. These sections "work together: the [premium reductions] help people obtain insurance, and the cost-sharing reductions help people get treatment once they have insurance." *See Cmty. Health Choice, Inc. v. United States*, 141 Fed. Cl. 744, 750 (2019) (quoting *California v. Trump*, 267 F. Supp. 3d 1119, 1123 (N.D. Cal. 2017)). These sections apply to taxpayers with a household income of between 100 percent and 400 percent of the federal poverty line. *See*

42 U.S.C. § 18071(b)(2); 26 U.S.C. § 36B(c)(1)(A); *Sanford*, No. 19-1290, slip op. at 5, 7. The statute refers to them as "applicable taxpayer[s]" in the case of section 1401, 26 U.S.C. § 36B(c)(1)(A), and "eligible insured[s]" in the case of section 1402, 42 U.S.C. § 18071(b).

Premium reductions. Under section 1401, each "applicable taxpayer" enrolled in an ACA exchange plan at any level of coverage is entitled to a "premium assistance credit amount" ("premium tax credit") to offset part of the monthly premiums of the enrollee entitled to the premium tax credit. 26 U.S.C. § 36B. The ACA specifies a formula for determining the amount of premium tax credits, which depends on the applicable taxpayer's household income, but not on the monthly premium or the coverage level for the applicable taxpayer's plan. The premium tax credit cannot exceed the actual monthly premium for the individual's plan. *See id.* § 36B(b)(2). The government pays these premium tax credit amounts directly to insurers. *See Sanford*, No. 19-1290, slip op. at 8; 31 U.S.C. § 1324. Thus, the amount of the premiums charged by the insurers to the insured is effectively reduced.

Premium review. The ACA includes various measures for regulating insurance premiums. Section 1003 of the ACA establishes a "premium review process" that requires insurers to report their premium rate increases to the Secretary of Health and Human Services ("the Secretary") and state regulators. *See* 42 U.S.C. § 300gg-94 (codifying ACA section 1003). State authorities can review the proposed rates. However, "[t]he rate review process

does not establish federal authority to deny implementation of a proposed rate increase; it is a sunshine provision designed to publicly expose rate increases determined to be unreasonable." *See* Bernadette Fernandez, Vanessa C. Forsberg & Ryan J. Rosso, Cong. Rsch. Serv., R45146, Federal Requirements on Private Health Insurance Plans 9 (2018). If a state regulator finds that an insurer's premium rate increases are "excessive or unjustified," it is required to recommend that the Secretary "exclude[] [the insurer] from participation in the [state] [e]xchange." 42 U.S.C. § 300gg-94(b)(1)(B).

Following the enactment of the ACA, states have taken a varied approach to premium rate review programs. Some, but not all, states have reserved the express authority to approve or deny premium rate increases. *See* Mark Newsom & Bernadette Fernandez, Cong. Rsch. Serv., R41588, Private Health Insurance Premiums and Rate Reviews 15 (2011) ("There is substantive variation in state regulation of health insurance rates."). In states where there is no express approval requirement, insurers are still required to notify state regulators of premium increases above a certain threshold. *See* 42 U.S.C. § 300gg-94(a)(2); Fernandez et al., Federal Requirements on Private Health Insurance Plans at 9. The damages issue here does not turn on whether the states have required express approval of premium increases.

Cost-sharing reductions. Section 1402 of the ACA requires insurers to reduce the insured's "cost-sharing" payments and requires the Secretary to "make periodic and timely payments to the [insurer]

equal to the value of the [cost-sharing] reductions." 42 U.S.C. § 18071(c)(3)(A). The section applies to "eligible insured[s]" enrolled in silver-level plans offered on the exchanges. *Id.* § 18071(a), (b). Eligibility under section 1402 is tied to eligibility under section 1401, and the amount of cost-sharing reductions is directly tied to the household income of the eligible insured. *See Id.* § 18071(c), (f)(2); *Sanford*, No. 19-1290, slip op. at 7 n.2.

II

On October 12, 2017, the Secretary announced that the government would cease payment of cost-sharing reduction reimbursements. *Sanford*, No. 19-1290, slip op. at 11-12. The suspension of cost-sharing reduction reimbursements did not relieve the insurers of their statutory obligation to "offer plans with cost-sharing reductions to customers," meaning that "the federal government's failure to meet its [cost-sharing reduction] payment obligations meant the insurance companies would be losing that money." *California*, 267 F. Supp. 3d at 1134. The solution for the insurers was to increase premiums. These states "began working with the insurance companies to develop a plan for how to respond" "in a fashion that would avoid harm to consumers." *See id.* The resulting plan involved the tax credit provision of section 1401 of the ACA.

Under section 1401, the government is required to subsidize an amount equal to the lesser of (1) the monthly premium for the applicable taxpayer's plan and (2) the difference between the monthly premium for the "applicable second lowest cost silver plan [(the 'benchmark plan')] with respect to the taxpayer" and a

statutorily-defined percentage of the eligible taxpayer's monthly household income. 26 U.S.C. § 36B(b)(2) (codifying ACA section 1401(b)(2)). This percentage generally varies from 2% to 9.5% based on the eligible taxpayer's income relative to the federal poverty line. *Id.* § 36B(b)(3)(A). These payments are guaranteed since, unlike the cost-sharing reduction payments situation, there is a permanent appropriation for premium tax credits. *See Sanford*, No. 19-1290, slip op. at 8.

In effect, if the insurers increased the monthly premium for their benchmark silver plans, each insurer would receive an additional dollar-for-dollar increase in the amount of the premium tax credit for each applicable taxpayer under its silver plans, all while keeping the out-of-pocket premiums paid by each applicable taxpayer the same. *See California*, 267 F. Supp. 3d at 1134. But premium increases for silver-level plans would have an effect on other plans as well: the insurers would also receive additional tax credits for applicable taxpayers that were enrolled in bronze, gold, and platinum plans, whether or not the premiums for those plans were increased. *Id.* at 1135. Even if the insurers kept premiums the same for those other plans, they would receive additional tax credits. *See id.*

Because of the government's refusal to make cost-sharing reduction payments, most states agreed to allow insurers to raise premiums for silver-level health plans, but not for other plans. *Cmty.*, 141 Fed. Cl. at 755; *Me. Cmty. Health Options v. United States*, 143 Fed. Cl. 381, 390 (2019). "As a result, in these states, for everyone between 100% and 400% of the

federal poverty level who wishe[d] to purchase insurance on the exchanges, the available tax credits r[o]se substantially. Not just for people who purchase[d] the silver plans, but for people who purchase[d] other plans too." *Cmty.*, 141 Fed Cl. at 755 (quoting *California*, 267 F. Supp. 3d at 1135). And the insurers received "more money from the premium tax credit program, . . . mitigat[ing] the loss of the cost-sharing reduction payments." *Id.* This practice was referred to as "silver loading." *Id.*

This was, however, not a perfect solution. The premium tax credits could only offset premium increases for applicable taxpayers, i.e., insureds with a household income of between 100 percent and 400 percent of the federal poverty line. Thus, people having a higher household income would be paying significantly more in premiums for their silver-level plans since they did not receive premium tax credits. *See California*, 267 F. Supp. 3d at 1137. States took a varied approach to this issue. Although this does not appear to be the case in Texas or Maine, some states negotiated with insurers to offer off-exchange, silver-equivalent plans at the pre-silver-load premium rates. *Id.* Such off-exchange policies were not subject to the ACA's premium tax credits or cost-sharing reduction requirements. In other states, non-eligible individuals could still switch to bronze, gold, or platinum plans (which did not have premium rate increases). *Id.*

III

Community Health Choice, Inc. ("Community") and Maine Community Health Options ("Maine Community") are health insurance providers that sell qualified health plans in Texas and Maine, respectively.

See Cmty., 141 Fed. Cl. at 756; *Me. Cmty.*, 143 Fed. Cl. at 391.[1] Both insurers offered cost-sharing reductions, as required under section 1402, to insured individuals,[2] and "as with every other insurer offering qualified health plans on the exchanges, stopped receiving these payments effective October 12, 2017." *Cmty.*, 141 Fed. Cl. at 756.

The two insurers involved here filed separate actions in the Claims Court, asserting that they were entitled to recover the unpaid cost-sharing reduction reimbursements for 2017 and 2018.[3] The insurers asserted two theories of liability.[4] First, the insurers

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[1] Unless otherwise noted, the Claims Court's decisions in *Community* and *Maine Community* contain identical language. For convenience, we limit our citations to *Community*.

[2] For example, the record shows that "approximately 58% of [Community]'s insured population—over 80,000 individuals—received cost-sharing reductions." *Cmty.*, 141 Fed. Cl. at 756.

[3] Community's complaint also claimed damages related to unpaid payments under the ACA's risk corridors program for 2014, 2015, and 2016. *Cmty.*, 141 Fed. Cl. at 756. Those claims were addressed by the Supreme Court's decision in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020). Maine Community's complaint in this case did not assert a claim under the risk corridors program.

[4] Community asserted a third theory of liability: that the government's failure to pay cost-sharing reduction reimbursements constituted a breach of so-called "Qualified Health Plan Issuer" agreements between Community and the government, which "require[d] [the government], as part of a monthly reconciliation process, to make payments to insurers that underestimated their cost-sharing obligations and collect payments from insurers who overestimated their cost-sharing obligations." *Cmty.*, 141 Fed. Cl. at 764-65. The Claims Court held that the obligation to reconcile payments was different from the obligation to make cost-sharing reduction payments and that

alleged that "in failing to make the cost-sharing reduction payments . . . , the government violated the statutory and regulatory mandate" of the ACA. *Id.* Second, the insurers alleged that the government's nonpayment constituted a "breach[] [of] an implied-in-fact contract." *Id.*

On the insurers' motions for summary judgment, the Claims Court "conclude[d] that the government's failure to make cost-sharing reduction payments to [the insurers] violate[d] 42 U.S.C. § 18071 [(codifying ACA section 1402)] and constitute[d] a breach of an implied-in fact contract." *Id.* at 770. The Claims Court concluded that each insurer was entitled to recover as damages the full amount of unpaid cost-sharing reduction reimbursements for both 2017 and 2018. The Claims Court was "unpersuaded by the [government]'s . . . contention that [the] insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses from the government's nonpayment of cost-sharing reduction reimbursements," precluded or reduced the insurers' damages. *Id.* at 760.

The government appealed the Claims Court's decisions to this court, challenging the decisions as to both liability and damages. We have jurisdiction under 28 U.S.C. § 1295(a)(3).

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the insurers "ha[d] not established that the . . . [a]greements obligated the government to make cost-sharing reduction payments," and dismissed Community's claim for breach of an express contract. *Id.* at 765-66. Community does not cross-appeal the Claims Court's dismissal, and we need not address it.

On April 27, 2020, the Supreme Court issued its decision in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020), holding that section 1342 of the ACA ("[t]he Risk Corridors statute," *id.* at 1329), which states that the government "shall pay" money to insurers offering "unprofitable plans" on the ACA exchanges, *id.* at 1316, created a "money-mandating obligation requiring the Federal Government to make payments under [section] 1342's formula," *id.*, at 1331, and that health insurance providers were entitled to "seek to collect [such] payment through a damages action in the [Claims Court]," *id.*

Today in *Sanford*, following the Supreme Court's decision in *Maine Community,* we hold that the government violated its obligation to make cost-sharing reduction payments under section 1402; "that the cost-sharing-reduction reimbursement provision imposes an unambiguous obligation on the government to pay money[;] and that the obligation is enforceable through a damages action in the [Claims Court] under the Tucker Act." *Sanford*, No. 19-1290, slip op. at 3.

DISCUSSION

I

As noted, the government argues that section 1402 did not create a statutory obligation on the part of the government to pay cost-sharing reduction reimbursements and that its failure to make payments did not violate the statute. Our decision in *Sanford* resolves these issues in favor of the insurers here. *Sanford*, No. 19-1290, slip op. at 18. Because we affirm the Claims Court's decisions as to statutory

liability, and the damages are the same under either theory of liability (as discussed below), we need not address the insurers' implied-in-fact contract theory.

II

The government nonetheless argues that, even if section 1402 created a statutory obligation, the insurers are not entitled to recover the full amount of the unpaid 2017 and 2018 cost-sharing reduction payments as damages. We find no merit to the government's argument that the insurers' 2017 damages should be reduced. Like the insurers in *Sanford*, Community and Maine Community did not raise their silver-level plan premiums in 2017 or receive increased tax credits for that year from the elimination of the cost-sharing reduction payments. Here, as in *Sanford*, we see no basis for a 2017 damages offset and affirm the Claims Court's award of 2017 damages. *See Sanford*, No. 19-1290, slip op. at 9, 12.

III

We turn to the 2018 cost-sharing payments. Neither the Supreme Court in *Maine Community* nor our decision in *Sanford* resolves this question. The government asserts that, beginning in 2018, both insurers raised the premiums for their silver-level plans "to account for the absence of direct reimbursement for cost-sharing reductions," resulting in the receipt of increased premium tax credits. *See* Gov't Suppl. Damages Br. 12-14. It argues that the Claims Court erred when it failed to credit the government with "economic benefits" flowing from the increased tax credits when awarding damages. *Id.* at 15.

The government's theory is based on an analogy to contract law—specifically, the rule that "a non-breaching party is not entitled, through the award of damages, to achieve a position superior to the one it would reasonably have occupied had the breach not occurred." *LaSalle Talman Bank, F.S.B. v. United States*, 317 F.3d 1363, 1371 (Fed. Cir. 2003). The government argues that silver loading was a direct result of the insurers' mitigation efforts, i.e., increasing premiums for silver-level plans, and that the insurers' recovery must be reduced by the additional payments the insurers received in the form of tax credits.

The Claims Court rejected these arguments in both cases on the same ground, holding that there was no "statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation," and that "[t]he increased amount of premium tax credit payments that insurers receive[d]" was not a "substitute[]" for its "cost-sharing reduction payments." *Cmty.*, 141 Fed. Cl. at 760. At oral argument, the parties agreed that the Claims Court's decisions rejected the government's mitigation theory on the merits. On appeal, the insurers similarly argue that the "[g]overment cannot invoke deductions not set forth in the statute itself." Appellees' Suppl. Damages Br. 4-5.

A

In addressing the mitigation issue, it is important to distinguish between two different types of statutes providing for the grant of federal funds: those that impose an "affirmative obligation[]" or "condition[]" in exchange for federal funding, and those that do not.

Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17, 24 (1981). The Supreme Court has previously "characterized . . . [the former category of] Spending Clause legislation as 'much in the nature of a *contract*: in return for federal funds, the [recipients] agree to comply with federally imposed conditions." *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (third alteration in original) (quoting *Pennhurst*, 451 U.S. at 17). On the other hand, the latter category of statutes does not involve contract-like obligations. *See id.* at 186; *Pennhurst*, 451 U.S. at 17; *Sossamon v. Texas*, 563 U.S. 277, 290 (2011).

Section 1402 belongs in the first category of Spending Clause legislation because it imposes contract-like obligations: in exchange for federal funds, the insurers must "'participat[e] in the healthcare exchanges' under the statutorily specified conditions." *Sanford*, No. 19-1290, slip op. at 18 (quoting *Me. Cmty.*, 140 S. Ct. at 1320); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 576 (2012) (analyzing the Medicaid provisions of the ACA as Spending Clause legislation). Specifically, in exchange for "the [insurer] . . . reduc[ing] the cost-sharing under [silver plans] in the manner specified in [section 1402(c)]" and "notify[ing] the Secretary of such reductions," "the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. §§ 18071(a)(2), (c)(3)(A); *see also Cmty.*, 141 Fed. Cl. at 768 ("[T]he cost-sharing reduction program is less of an incentive program and more of a quid pro quo.").

Under these contract-like Spending Clause statutes—where the statute itself does not provide a

remedial framework—a contract-law "analogy applies . . . in determining the *scope* of damages remedies" in a suit by the government against the recipient of federal funds or by a third-party beneficiary standing in the government's shoes. *Barnes*, 536 U.S. at 186-87; *see also Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 287 (1998) ("Title IX's contractual nature has implications for our construction of the scope of available remedies."). In *Barnes*, the Court considered the government's damages remedies available under Title VI in a suit charging the federal funds recipient with failure to comply with its obligations. The Court explained that, when the statute "contains no express remedies, a recipient of federal funds is nevertheless subject to suit for compensatory damages . . . and injunction . . . forms of relief traditionally available in suits for breach of contract." *Barnes*, 536 U.S. at 187 (citations omitted). Thus, "[w]hen a federal-funds recipient violates conditions of Spending Clause legislation, the wrong done is the failure to provide what the contractual obligation requires; and that wrong is 'made good' when the recipient *compensates* the Federal Government or a third-party beneficiary (as in this case) for the loss caused by that failure." *Id.* at 189. On the other hand, forms of relief that are "generally not available for breach of contract," such as punitive damages, are not available in suits under such Spending Clause legislation. *Id.* at 187-89.[5]

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[5] This contract-law analogy does not apply where the statute does not impose contract-like obligations. *See, e.g.*, *Heinzelman v. Sec'y of HHS*, 681 F.3d 1374, 1379-80 (Fed. Cir. 2012) (holding that, with respect to a damages award under the National

The same, we think, is true when an action for damages is brought against the government, under this type of Spending Clause legislation. The available remedy is defined by analogy to contract law where the statute does not provide its own remedies for government breach.[6] We have indeed previously

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Childhood Vaccine Injury Act, 42 U.S.C. §§ 300aa-1-300aa-34, the government was not entitled to an offset due to Social Security Disability Insurance ("SSDI") benefits because the Vaccine Act "provides for offsets where compensation is made via one of the enumerated programs," and SSDI was not identified in the statute); *Modoc Lassen Indian Hous. Auth. v. United States HUD*, 881 F.3d 1181, 1194 (10th Cir. 2017) (noting that "rules that traditionally govern contractual relationships don't necessarily apply in the context of federal grant programs" that do not impose contract-like obligations such as the Native American Housing Assistance and Self-Determination Act, 25 U.S.C. § 4101 et seq.); *Md. Dep't of Human Res. v. Dep't of Health & Human Servs.*, 762 F.2d 406, 408-09 (4th Cir. 1985) (declining to infer a "contractual" relationship in the Aid to Families with Dependent Children program, 42 U.S.C. § 601 et seq., a "grant in aid" program); *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983) (noting that hospitals participating in the Medicare program did not receive a "contractual right" because the statute did not "obligate the [government] to provide reimbursement for any particular expenses"); *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014) (citing *Mem'l Hospital*).

[6] The amicus argues that the insurers are not seeking "compensation for the failure to pay," but are instead seeking "specific relief" under section 1402. Common Ground Healthcare Cooperative Suppl. Damages Amicus Br. 5. As the Supreme Court held in *Bowen v. Massachusetts*, 487 U.S. 879 (1988), "the Court of Claims has no [general] power to grant equitable relief." *Id.* at 905 (quoting *Richardson v. Morris*, 409 U.S. 464, 465 (1973) (per curiam)). Furthermore, the Supreme Court made clear that the type of relief that the insurers are seeking is best characterized as "specific sums, already calculated, past due, and

applied the contract-law analogy to limit damages in suits against the government under the Back Pay Act, 5 U.S.C. § 5596, another money-mandating statute.[7] Our predecessor court held that in suits brought for improper discharge for federal employment, damages had to be reduced by the amount earned by the federal employee in the private sector under a mitigation theory.[8] *See Craft v. United States*, 589 F.2d 1057, 1068 (Ct. Cl. 1978) ("Unless there is a regulation or a statute that provides otherwise, cases in this court routinely require the deduction of civilian earnings [from a back pay award] on an analogy to the principle of mitigation of damages."). *Laningham v. United States*, 5 Cl. Ct. 146, 158 (Ct. Cl. 1984) ("This rule has been utilized as an analog to the private contract law principle of mitigation of damages."); *see also Motto v. United States*, 360 F.2d 643, 645 (Ct. Cl. 1966); *Borak v. United States*, 78 F. Supp. 123, 125 (Ct. Cl. 1948).

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designed to compensate for completed labors." *Me. Cmty.*, 140 S. Ct. at 1330-31.

[7] *See Bowen*, 487 U.S. at 905 n.42 ("To construe statutes such as the Back Pay Act . . . as 'mandating compensation by the Federal Government for the damage sustained,' . . . one must imply from the language of such statutes a cause of action." (quoting *Eastport S.S. Corp. v. United States*, 372 F.2d 1002, 1009 (Ct. Cl. 1967))); *Hambsch v. United States*, 848 F.2d 1228, 1231 (Fed. Cir. 1988) ("By the Back Pay Act's own terms, a tribunal must also look for an 'applicable law, rule, regulation, or collective bargaining agreement' as the source of an employee entitlement which an 'unjustified or unwarranted personnel action' has denied or impaired.").

[8] The Back Pay Act was later amended to expressly provide for such offsets. *See* 5 U.S.C. § 5596(b)(1). That amendment to the statute, however, does not change the principles underlying the previous decisions.

Here the contract-law analogy applies because the statute "contains no express remedies" at all with respect to the government's obligation. *Barnes*, 536 U.S. at 187. While the ACA provides specific remedies for failure of the insurers or insured to comply with their obligations, *see* 42 U.S.C. §§ 300gg-22, 18081(h), "the [ACA] did not establish a [statutory] remedial scheme" for the government's noncompliance, *Me. Cmty.*, 140 S. Ct. at 1330. Section 1402's silence as to remedies in this respect suggests that "forms of relief traditionally available in suits for breach of contract" are appropriate. *Barnes*, 536 U.S. at 187; *see also Me. Cmty.*, 140 S. Ct. at 1330. We therefore look to government contract law to determine the scope of the insurers' damages remedy.

With respect to contract claims, the government is "to be held liable only within the same limits that any other defendant would be in any other court," and "its rights and duties . . . are governed generally by the law applicable to contracts between private individuals." *United States v. Winstar Corp.*, 518 U.S. 839, 892, 895 (1996) (first quoting *Horowitz v. United States*, 267 U.S. 458, 461 (1925), and then quoting *Lynch v. United States*, 292 U.S. 571, 579 (1934)).

B

The traditional damages remedy under contract law is compensatory in nature. Restatement (Second) of Contracts § 347 (1981); *Barnes v. Gorman*, 536 U.S. at 187-90.

> The fundamental principle that underlies the availability of contract damages is that of compensation. That is, the disappointed promisee is generally entitled to an award of

> money damages in an amount reasonably calculated to make him or her whole and neither more nor less; any greater sum operates to punish the breaching promisor and results in an unwarranted windfall to the promisee, while any lesser sum rewards the promisor for his or her wrongful act in breaching the contract and fails to provide the promisee with the benefit of the bargain he or she made.

24 Samuel Williston & Richard A. Lord, *Williston on Contracts* § 64:1 (4th ed. 2020); *see also* 11 Joseph M. Perillo & Helen Hadjiyannakis Bender, *Corbin on Contracts* § 55.3 (2020) ("[I]t is a basic tenet of contract law that the aggrieved party will not be placed in a better position than it would have occupied had the contract been fully performed.").

Thus, courts have uniformly held—as a matter of both state and federal law—that a plaintiff suing for breach of contract is not entitled to a windfall, i.e., the non-breaching party "[i]s not entitled to be put in a better position by the recovery than if the [breaching party] had fully performed the contract." *Miller v. Robertson*, 266 U.S. 243, 260 (1924); *Bluebonnet Sav. Bank, F.S.B. v. United States*, 339 F.3d 1341, 1345 (Fed. Cir. 2003) ("[T]he non-breaching party should not be placed in a better position through the award of damages than if there had been no breach."); *LaSalle*, 317 F.3d at 1372 ("[T]he non-breaching party is not entitled, through the award of damages, to achieve a position superior to the one it would reasonably have occupied had the breach not occurred." (citing 3 E.

Allan Farnsworth, *Farnsworth on Contracts* 193 (2d ed. 1998)).[9]

This concern to limit contract damages to compensatory amounts is embodied, in part, in the doctrine of mitigation, which ensures that the non-breaching party will not benefit from a breach. The mitigation doctrine has two aspects. First, the non-breaching party is expected to take reasonable steps to mitigate his or her damages. Restatement (Second) of Contracts § 350 cmt. b ("Once a party has reason to know that performance by the other party will not be forthcoming, . . . he is expected to take such affirmative steps as are appropriate in the circumstances to avoid loss by making substitute arrangements or otherwise."). Under common-law principles, the injured party may not recover damages for any "loss that the injured party could have avoided without undue risk, burden or humiliation." *Id.* § 350(1); 3 Dan B. Dobbs, *Law of Remedies* § 12.6(1), at 127 (2d ed. 1993) ("[T]he damage recovery is reduced to the extent that the plaintiff could reasonably have avoided damages he claims and is otherwise entitled to."); *Roehm v. Horst*, 178 U.S. 1, 11 (1900) (explaining that a plaintiff for breach of

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[9] *See, e.g.*, *John Hancock Life Ins. Co. v. Abbott Labs.*, 863 F.3d 23, 44 (1st Cir. 2017) (same under Illinois law); *VICI Racing, LLC v. T-Mobile USA, Inc.*, 763 F.3d 273, 303 (3d Cir. 2014) (same under Delaware law); *Hess Mgmt. Firm, LLC v. Bankston (In re Bankston)*, 749 F.3d 399, 403 (5th Cir. 2014) (same under Louisiana law); *Westlake Petrochemicals, L.L.C. v. United Polychem, Inc.*, 688 F.3d 232, 243-44 (5th Cir. 2012) (same under the Uniform Commercial Code); *Ed S. Michelson, Inc. v. Neb. Tire & Rubber Co.*, 63 F.2d 597, 601 (8th Cir. 1933) (treating the issue as a general matter of contract law).

contract is entitled to "damages as would have arisen from the nonperformance of the contract at the appointed time, subject, however, to abatement in respect of any circumstances which may have afforded him the means of mitigating his loss" (quoting *Frost v. Knight*, L.R. 7 Exch. 111 (1872))). We need not determine whether this first aspect of the mitigation doctrine applies here—such that the insurers were obligated to increase premiums to secure increased premium credits.

Rather, here we look to a second aspect of the mitigation doctrine, which recognizes that there must be a reduction in damages equal to the amount of benefit that resulted from the mitigation efforts that the non-breaching party in fact undertook.[10] *Kansas*

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[10] A related principle is that, when the non-breaching party indirectly benefits from the defendant's breach, "in order to avoid overcompensating the promisee, any savings realized by the plaintiff as a result of the . . . breach . . . must be deducted from the recovery." 24 *Williston on Contracts* § 64:3; 11 *Corbin on Contracts* § 57.10 ("A breach of contract may prevent a loss as well as cause one. In so far as it prevents loss, the amount will be credited in favor of the wrongdoer."); Charles T. McCormick, *Handbook on the Law of Damages* 146 (1935) ("Where the defendant's wrong or breach of contract has not only caused damage, but has also conferred a benefit upon [the] plaintiff . . . which he would not otherwise have reaped, the value of this benefit must be credited to [the] defendant in assessing the damages."); *LaSalle*, 317 F.3d at 1372 (citing McCormick); *Kansas Gas & Elec.*, 685 F.3d at 1367 (same); *Stern v. Satra Corp.*, 539 F.2d 1305, 1312 (2d Cir. 1976) (same); *see also DPJ Co. P'ship v. F.D.I.C.*, 30 F.3d 247, 250 (1st Cir. 1994) (holding that, with respect to reliance damages for breach of contract, "a 'deduction' is appropriate 'for any benefit received [by the claimant] for salvage or otherwise'" (alteration in original) (quoting A. Farnsworth, *Contracts* § 12.16 (2d ed. 1990))).

Gas & Elec. Co. v. United States, 685 F.3d 1361, 1366 (Fed. Cir. 2012) ("[M]itigation efforts may result in direct savings that reduce the damages claim."); Restatement (Second) of Contracts § 350 cmt. h (explaining that the calculation of mitigation should reflect "[a]ctual efforts to mitigate damages"); 11 *Corbin on Contracts* § 57.11 (explaining that, in the case of a buyer breaching a contract for the sale of goods, the rule "measures the seller's damages by the contract price less the market price—the price actually obtained . . . by a new sale").

For example, in *Kansas Gas and Electric*, the government breached a contract to dispose of the plaintiff utility companies' nuclear waste. *Kansas Gas & Elec.*, 685 F.3d at 1364. Anticipating that the government would breach the contract, the utility companies began a "rerack project" to increase its storage capacity and mitigate the effects of a government breach. *Id.* We held that the plaintiffs were entitled to the costs of its rerack project taken in mitigation of the government's breach. *Id.* at 1365, 1371. We also held, however, that the plaintiffs' recovery was to be reduced by the "real-world benefit" realized by the plaintiff's rerack project. *Id.* at 1367-68. Namely, "[w]hile conducting the rerack, the [plaintiffs] both . . . used racks that could support higher enrichment fuel assemblies," which "allowed [them] to achieve the same energy output from [their] reactor with fewer fuel assemblies," thereby increasing the efficiency of their plant. *Id.* at 1364.

The plaintiffs argued that the efficiency benefits of the rerack project were "too remote and not directly related to the breach because the decision to 'pursue

more highly enriched fresh nuclear fuel' was an 'independent business decision' and influenced by . . . market price[s]." *Id.* at 1367. We rejected that argument, holding that the rerack project was "part and parcel of the [plaintiffs]' mitigation efforts." *Id.* We stated that "[t]he long-term benefit of fuel cost savings [influenced by market forces] does not sever its connection to the [plaintiffs]' mitigation efforts," and that the appropriate inquiry was whether, "[b]y enhancing the racks to accommodate high-enrichment fuel assemblies, the [plaintiffs] mitigated the [g]overnment's breach in a way that produced a benefit." *Id.* at 1368. We concluded that the plaintiffs' damages were correctly reduced "by the amount of the benefit received in mitigating the [g]overnment's partial breach of the . . . [c]ontract." *Id.*

Here, each insurer mitigated the effects of the government's breach by applying for increased premiums and, as a result, received additional premium tax credits in 2018 as a direct result of the government's nonpayment of cost-sharing reduction reimbursements. Notably, the government does not argue that it is entitled to offset the premium increases in the damages calculation, but it does argue that it is entitled to offset the additional payments made by the government in the form of premium tax credits.

The insurers appear not to dispute that if the elimination of cost sharing-reduction payments directly triggered increased premium tax credits, an offset would be appropriate under a contract theory. But they argue that the premium tax credits were not "direct benefits" of the breach because they depend on

actions by the insurers—the decision to pursue increased premiums. These payments were not, in the appellees' phrasing, received in the "first step." We think the relationship is no less direct because the insured's tax credits did not automatically flow from the elimination of cost sharing reduction payments, and the insurers played a role by securing the increased premiums that in turn resulted in the increased tax credits.

There is thus a direct relationship between cost-sharing reductions and premiums, and between premiums and tax credits. The text of the ACA recognizes the relationship between premiums and cost-sharing reductions. Section 1412 of the ACA provides for the "[a]dvance determination and payment of premium tax credits and cost-sharing reductions." 42 U.S.C. § 18082 (codifying ACA section 1412). Section 1412(a)(3) states: "the Secretary of the Treasury makes advance payments of [premium tax] credits or [cost-sharing] reductions to the [insurers] . . . in order to reduce the premiums payable by individuals eligible for such credit." *Id.* § 18082(a)(3). As we noted in *Sanford*, this section may be understood to indicate that the statute recognizes that, without cost-sharing reduction reimbursements, "insurers might otherwise seek higher premiums to enable them to pay healthcare providers the amounts enrollees are not paying due to cost-sharing reductions." *Sanford*, No. 19-1290, slip op. at 22.

The Claims Court's findings show that the premium tax credits flowed directly from the insurers' mitigation efforts. As the Claims Court found, the

plaintiffs themselves recognized this connection. They negotiated for increased premiums (leading to the increased tax credits) in direct response to the cessation of cost-sharing reduction payments:

> The Trump administration's termination of cost-sharing reduction payments did not come as a surprise to insurers: "Anticipating that the Administration would terminate [cost-sharing reduction] payments, most states began working with the insurance companies to develop a plan for how to respond. . . . And the states came up with an idea: allow the insurers to make up the deficiency through premium increases . . . ." *California*, 267 F. Supp. 3d at 1134-35 . . . . In other words, by raising premiums for silver-level qualified health plans, the insurers would obtain more money from the premium tax credit program, which would help mitigate the loss of the cost-sharing reduction payments.

Cmty., 141 Fed. Cl. at 754-55 (first alteration in original); *id.* at 755 n.10 (noting that "increasing silver-level qualified health plan premiums would not harm most consumers who qualify for the premium tax credit because the credit increases as the premium increases").

The practice of silver loading—and the resulting premium tax credits received by each insurer—"was a direct consequence of the government's breach" of its obligations, and "indeed was an extreme measure forced" by the government's nonpayment. *LaSalle*, 317 F.3d at 1372. The government's payment of the

premium tax credits is directly traceable to the premium increase, and the premium increase is directly traceable to the government's breach. The insurers "received a benefit as a direct result of their mitigation activity." *Kansas Gas & Elec.*, 685 F.3d at 1368. The argument for an offset is particularly strong here because the insurers received direct payments (rather than indirect benefits, such as efficiency gains) from the government due to their mitigation efforts.

The insurers argue, however, that there are two exceptions to the mitigation principle that defeat the government's claim to an offset: (1) the prohibition on so-called "pass-through" defenses and (2) the collateral source rule. As to the "pass-through" defense, the insurers argue that the government, as a breaching party, may not claim mitigation of damages when the non-breaching party "passe[s] through" its losses to its customers. Appellees' Suppl. Damages. Br. 15 (citing *Hughes Commc'ns Galaxy, Inc. v. United States*, 271 F.3d 1060, 1072 (Fed. Cir. 2001)).[11] The insurers assert that the cases stand for the proposition that mitigation may only be considered in the "first step," and that "later-step" recoveries such as pass-through are "irrelevant" to the calculation of damages. *Id.* at 10. But this is not a case where a third-party customer pays for the insurers' losses, as was the case in *Hughes*.[12] The complexity of the process cannot

[11] In addition to *Hughes*, the appellees also rely on cases arising under antitrust law, *see Hanover Shoe, Inc. v. United Shoe Mach. Corp.*, 392 U.S. 481 (1968), RICO, *see Carter v. Berger*, 777 F.2d 1173 (7th Cir. 1985), and utility overcharges, *see S. Pac. Co. v. Darnell-Taenzer Lumber Co.*, 245 U.S. 531 (1918).

[12] The antitrust, RICO, and utility cases too are distinguishable because they concern situations where costs are passed to a third-

obscure the underlying economic reality that the government is paying at least some of the increased costs that the insurers incurred as a result of the government's failure to make cost-sharing reduction payments. *See* Gov't Suppl. Damages Br. 24 ("[T]he government is not urging that [the] plaintiffs' damages should be reduced merely because [the] plaintiffs passed on their cost-sharing reduction expenses to customers. The crucial point is that [the] plaintiffs . . . passed these expenses *on to the government itself*, which by virtue of the ACA's structure is paying the cost-sharing reduction expenses . . . in the form of higher premium tax credits.").

The government's claim is not that damages should be reduced because the insurers passed on the increased costs to their customers, but that "the insurers . . . obtain[ed] more money from the premium tax credit program, which would help mitigate the loss of the cost-sharing reduction payments." *Cmty.*, 141 Fed. Cl. at 755 & n.10. The pass-through exception, to the extent that it is applicable to contract damages, does not apply here.

Second, the insurers invoke the collateral source rule, arguing that the additional premium tax credits were collateral benefits that should not be credited against their damages. The collateral source rule is a

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party. *See, e.g.*, *S. Pac.*, 245 U.S. at 534 (explaining that the pass-through doctrine is concerned with the lack of privity between the defendant railroad company and the "consumer who . . . paid [the] increased price"); *Adams v. Mills*, 286 U.S. 397, 407 (1932) (similar); *Hanover Shoe*, 392 U.S. at 490 (similar in the antitrust context).

generally recognized principle of tort law that "bars a tortfeasor from reducing the damages it owes to a plaintiff 'by the amount of recovery the plaintiff receives from other sources of compensation that are independent of (or collateral to) the tortfeasor.'" *Johnson v. Cenac Towing, Inc.*, 544 F.3d 296, 304 (5th Cir. 2008) (quoting *Davis v. Odeco, Inc.*, 18 F.3d 1237, 1243 (5th Cir. 1994)); *see, e.g.*, *Chisholm v. UHP Projects, Inc.*, 205 F.3d 731, 737 (4th Cir. 2000); *Fitzgerald v. Expressway Sewerage Constr., Inc.*, 177 F.3d 71, 73 (1st Cir. 1999). Thus, the collateral source rule bars a reduction of damages due to "insurance policies and other forms of protection purchased by [the] plaintiff," *Johnson*, 544 F.3d at 305, or unemployment benefits in the case of a wrongful-discharge case, *Craig v. Y & Y Snacks, Inc.*, 721 F.2d 77, 83 (3d Cir. 1983).

As with the insurers' pass-through argument, their collateral source rule argument fails. We are aware of no authority, and the insurers cite none, holding that the collateral source rule applies to contract damages, and the prevailing authority rejects any such limitation. *See, e.g.*, *United States v. Twin Falls*, 806 F.2d 862, 873 (9th Cir. 1986) ("We have found no authority to support the application of the collateral source rule in the contracts field." (collecting cases rejecting the application of the collateral source rule to contract-based damages)), *overruled on other grounds as recognized by Ass'n of Flight Attendants v. Horizon Air Indus., Inc.*, 976 F.2d 541, 551-52 (9th Cir. 1992); *Star Ins. Co. v. Sunwest Metals Inc.*, 691 F. App'x 358, 361 (9th Cir. 2017) (noting that "California courts have declined to extend the collateral source rule to contract-based claims" and that contract

damages rules are "[u]nlike" those in tort damages); *LaSalle*, 317 F.3d at 1372 (declining to apply the collateral source rule to government contracts). In any event, even if that rule applied here, the "source of compensation" is the not "independent" of the government. The source is the government itself. *See Phillips v. W. Co. of N. Am.*, 953 F.2d 923, 931 (5th Cir. 1992) ("The [collateral source] rule is intended to ensure that the availability of outside sources of income does not diminish the plaintiff's recovery, not make the tortfeasor pay twice."). The collateral source rule does not bar the reduction in damages.

We conclude that additional premium tax credits were received by Community and Maine Community in 2018 as a direct consequence of their mitigation efforts following the government's nonpayment of 2018 cost-sharing reduction reimbursements, and the Claims Court was required to credit the government with such tax credit payments in determining damages.

IV

Determining the amount of premium tax credits paid to each insurer is necessarily a fact-intensive task. Because the Claims Court rejected the government's mitigation theory on a limited summary judgment record, it did not address these calculation issues. And as the insurers conceded in their briefing before the Claims Court, to the extent that the insurers' premium changes are "relevant . . . to [the] quantum," they involve "factual questions that cannot be resolved on [the existing motion for summary judgment]." Community Reply in Supp. of Mot. for Summ. J. 15, *Cmty. Health Choice, Inc. v. United*

States, No. 18-cv-00005, 141 Fed. Cl. 744, ECF No. 20 (Nov. 30, 2018); Maine Community Mot. for Summ. J. 1, *Me. Cmty Health Options v. United States*, No. 17-cv-02057, 143 Fed. Cl. 381, ECF No. 31 (Apr. 8, 2019) (adopting "all of the arguments regarding benefit year 2018 raised by . . . Community . . . in [its] brief[]"). We therefore remand to the Claims Court for a determination of the amount of premium increases (and resultant premium tax credits) attributable to the government's failure to make cost-sharing reduction payments. This will require either new summary judgment motions or a trial.

We note that three principles will govern the remand proceedings.

First, as the insurers argue, some of the silver-level premium increases (and resulting tax credits) may be caused by other factors, such as market forces or increased medical costs. To the extent that this is the case, the government's liability is not reduced by the tax credits attributable to these other factors.

Second, as previously mentioned, increasing the premium rates for silver plans resulted in an increase in premium tax credits for *all* plans on the exchange. In some states, state regulators have also allowed insurers to recoup part of their lost cost-sharing reduction reimbursements by increasing premiums for other, non-silver plans on the exchange. In these circumstances, the tax credits for these other plans (attributable to the silver plan premium increase) are still caused by the elimination of cost-sharing reduction payments and will, of course, reduce the government's liability. But we do not address whether in situations where, as here, there have been no

premium increases for other plans, the government's liability should be reduced for the increased tax credit payments with respect to other plans. We leave that issue to the Claims Court in the first instance.

Finally, the insurers will bear the burden of persuasion with respect to the amount of the tax-credit increase attributable to the loss of cost-sharing reduction reimbursements. Other circuit courts and state courts applying state law are inconsistent as to which party bears the burden of persuasion with respect to the amount of mitigation.[13] But in the federal context the rule is clear. The plaintiffs bear the burden of proof:

> [A] non-breaching plaintiff bears the burden of persuasion to establish both the costs that it incurred and the costs that it avoided as a result of a breach of contract. The breaching party may be responsible for affirmatively

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[13] *Compare VICI Racing, LLC v. T-Mobile USA, Inc.*, 763 F.3d 273, 301 (3d Cir. 2014) (holding that, under Delaware law, "[a] defendant need not provide an accounting of the costs a plaintiff should have avoided, but the burden is properly on a defendant to articulate the actions that would have been reasonable under the circumstances to mitigate loss"), *with John Morrell & Co. v. Local Union 304A of United Food & Commercial Workers, AFL-CIO*, 913 F.2d 544, 557 (8th Cir. 1990) ("[T]he breaching party[] ha[s] the burden of proving that 'the breach resulted in a direct and immediate savings to the plaintiff,' . . . . [T]he defendant must prove the amount of the offset with reasonable certainty."); *Amigo Broad., LP v. Spanish Broad. Sys., Inc.*, 521 F.3d 472, 486 (5th Cir. 2008) (holding that, under Texas law, "it is the burden of [the defendants], not [the plaintiff], to show that [the plaintiff] received a benefit from its expenditures that reduce or offset the amount of reliance damages to which [the plaintiff] claims it is entitled").

> pointing out costs that were avoided, but once such costs have been identified, the plaintiff must incorporate them into a plausible model of the damages that it would have incurred absent the breach.

Bos. Edison Co. v. United States, 658 F.3d 1361, 1369 (Fed. Cir. 2011) (citing *S. Nuclear Operating Co. v. United States*, 637 F.3d 1297, 1304 (Fed. Cir. 2011)); *see also Sys. Fuels, Inc. v. United States*, 666 F.3d 1306, 1312 (Fed. Cir. 2012) (collecting cases). Here, the government has affirmatively pointed out the insurers' avoided costs (due to increased premium tax credits). Therefore, it was the insurers burden to incorporate those benefits into their damages calculations. *Energy Nw. v. United States*, 641 F.3d 1300, 1309 (Fed. Cir. 2011) (explaining that, to establish damages, "a plaintiff [must] show what it would have done in the non-breach world, and what it did post-breach"). We think that this allocation of the burden of proof is particularly appropriate here because the insurers were already required by section 1003 of the ACA to provide "justification[s]" for premium rate increases. 42 U.S.C. § 300gg-94(a)(2). Thus, Community and Maine Community—having previously justified their silver-level premium increases—are "in the best position to adduce and establish such proof." *S. Nuclear*, 637 F.3d at 1304 (quoting 11 *Corbin on Contracts* § 57.10 n.15 (2005)).

According to the insurers, they cannot be expected to bear this burden of proof by comparing "each insurer's financial picture now in relation to what it hypothetically might have been if [the cost-sharing reduction reimbursements] had been timely paid."

Appellees' Suppl. Damages Br. 9. Specifically, the insurers argue that they cannot "submit a hypothetical model establishing what their costs would have been in the absence of breach." *Id.* at n.9 (quoting Gov't Suppl. Damages Br. 8). Given the explicit arguments that the insurers here have made for rate increases, we doubt that proof will be as difficult as the insurers' claim. In any event, as we have discussed, our cases make clear that the plaintiff seeking to recover damages must "prov[e] causation by comparing a hypothetical 'but for' world to a plaintiff's actual costs." *Energy Nw.*, 641 F.3d at 1306 (quoting *Yankee Atomic Elec. Co. v. United States*, 536 F.3d 1268, 1273-74 (Fed. Cir. 2008)). The insurers here cannot avoid their burden to prove damages.

V

Although we do not address the Claims Court's holding with respect to the insurers' implied-in-fact contract theory, the same damages analysis would apply to that claim as well, since, as the Claims Court recognized, a claim for breach of an implied-in-fact contract is subject to the same damages limitations as an ordinary contract. *See Cmty.*, 141 Fed Cl. at 767-70 (analyzing damages for breach of an implied-in-fact contract under "[t]he general rule in common law breach of contract cases" (quoting *Estate of Berg v. United States*, 687 F.2d 377, 379 (Ct. Cl. 1982)); *see, e.g.*, *Lindquist Ford, Inc. v. Middleton Motors, Inc.*, 557 F.3d 469, 481 (7th Cir. 2009), *as amended* (Mar. 18, 2009) ("[A]n implied-in-fact contract is governed by general contract principles."); *Hill v. Waxberg*, 237 F.2d 936, 939 (9th Cir. 1956) (explaining that "the general contract theory of compensatory damages

should be applied" in an action for breach of an implied-in-fact contract). There is thus no need on remand to separately address the insurers' implied-in-fact contract claim.

AFFIRMED IN PART, REVERSED AND REMANDED IN PART

COSTS

No costs.

Appendix B

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

No. 19-1633

COMMUNITY HEALTH CHOICE, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

Filed: Nov. 10, 2020

Before PROST, *Chief Judge*, NEWMAN, LOURIE, BRYSON[1], DYK, MOORE, O'MALLEY, REYNA, WALLACH, TARANTO, CHEN, HUGHES, and STOLL, *Circuit Judges*.

ON PETITION FOR PANEL REHEARING AND REHEARING EN BANC

ORDER

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[1] Circuit Judge Bryson participated only in the decisions on petitions for panel rehearing.

PER CURIAM.

Community Health Choice, Inc. filed a combined petition for panel rehearing and rehearing en banc. At the court's invitation and with leave of the court, the United States filed a response to the petition and incorporated a conditional cross-petition for rehearing en banc. The petitions were first referred to the panel that heard the appeal, and thereafter the petitions for rehearing en banc were referred to the circuit judges who are in regular active service.

Upon consideration thereof,

IT IS ORDERED THAT:

The petitions for panel rehearing are denied.

The petitions for en banc rehearing are denied.

The mandate of the court will issue on November 17, 2020.

For the Court

November 10, 2020
Date

/s/ Peter R. Marksteiner
Peter R. Marksteiner
Clerk of the Court

Appendix C

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

No. 19-2102

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellee,
v.
UNITED STATES,
Defendant-Appellant.

Filed: Nov. 10, 2020

Before PROST, *Chief Judge*, NEWMAN, LOURIE, BRYSON[1], DYK, MOORE, O'MALLEY, REYNA, WALLACH, TARANTO, CHEN, HUGHES, and STOLL, *Circuit Judges*.

ON PETITION FOR PANEL REHEARING AND REHEARING EN BANC

ORDER

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[1] Circuit Judge Bryson participated only in the decisions on petitions for panel rehearing.

PER CURIAM.

Maine Community Health Options filed a petition for rehearing en banc. Anthem, Inc., Local Initiative Health Authority for Los Angeles County, and Molina Healthcare of California, Inc. filed a brief as amici curiae in support of the petition. At the court's invitation and with leave of the court, the United States filed a response to the petition and incorporated a conditional cross-petition for rehearing en banc. The petitions were first referred as petitions for rehearing to the panel that heard the appeal, and thereafter the petitions for rehearing en banc were referred to the circuit judges who are in regular active service.

Upon consideration thereof,

IT IS ORDERED THAT:

The petitions for panel rehearing are denied.

The petitions for en banc rehearing are denied.

The mandate of the court will issue on November 17, 2020.

For the Court

November 10, 2020
Date

/s/ Peter R. Marksteiner
Peter R. Marksteiner
Clerk of the Court

Appendix D

UNITED STATES COURT OF FEDERAL CLAIMS

No. 18-5C

COMMUNITY HEALTH CHOICE, INC.,
Plaintiff,
v.
UNITED STATES,
Defendant.

Filed: Feb. 15, 2019

OPINION AND ORDER

SWEENEY, Chief Judge

Plaintiff Community Health Choice, Inc. contends that the federal government ceased making the cost-sharing reduction payments to which it and other insurers are entitled under the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010), and its implementing regulations. Currently before the court are plaintiff's motion for summary judgment and defendant's cross-motion to dismiss for failure to state a claim upon which relief can be granted. For the reasons set forth below, the court finds that plaintiff is entitled to recover the unpaid cost-sharing reduction reimbursements under two of the three

theories it advances. Therefore, it grants in part and denies in part the parties' motions.

I. BACKGROUND

A. The Affordable Care Act

Congress enacted the Affordable Care Act as part of a comprehensive scheme of health insurance reform.[1] *See generally King v. Burwell*, 135 S. Ct. 2480 (2015). Specifically, the Act includes "a series of interlocking reforms designed to expand coverage in the individual health insurance market." *Id.* at 2485. In conjunction with these reforms, the Act provided for the establishment of an American Health Benefit Exchange ("exchange") in each state by January 1, 2014, to facilitate the purchase of "qualified health plans" by individuals and small businesses. 42 U.S.C. §§ 18031, 18041 (2012); *accord King*, 135 S. Ct. at 2485 (describing an exchange as "a marketplace that allows people to compare and purchase insurance plans"). Qualified health plans can be offered at four levels (bronze, silver, gold, and platinum) that differ based on how much of a plan's benefits an insurer must cover under the plan.[2] 42 U.S.C. § 18022(d)(1).

Among the reforms included in the Affordable Care Act were two aimed at ensuring that individuals

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[1] Seven days after enacting the Affordable Care Act, Congress enacted the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, which included additional provisions related to health insurance reform.

[2] For example, for a silver-level qualified health plan, insurers are required to provide coverage for 70% of the benefits offered under the plan. 42 U.S.C. § 18022(d)(1)(B). Insurers offering qualified health plans on an exchange must offer at least one silver-level plan and one gold-level plan. *Id.* § 18021(a)(1)(C)(ii).

have access to affordable insurance coverage and health care: the premium tax credit enacted in section 1401 of the Act, 26 U.S.C. § 36B (2012), and the cost-sharing reduction program enacted in section 1402 of the Act, 42 U.S.C. § 18071. "The premium tax credits and the cost-sharing reductions work together: the tax credits help people obtain insurance, and the cost-sharing reductions help people get treatment once they have insurance." *California v. Trump*, 267 F. Supp. 3d 1119, 1123 (N.D. Cal. 2017).

1. Premium Tax Credit

The first of these two reforms, the premium tax credit, is designed to reduce the insurance premiums paid by individuals whose household income is between 100% and 400% of the poverty line. *See* 26 U.S.C. § 36B(c)(1)(A); 42 U.S.C. § 18082(c)(2)(B)(i); *accord* 26 C.F.R. § 1.36B-2(a) to (b) (2017); 45 C.F.R. § 156.460(a)(1) (2017). The Secretary of the Department of Health and Human Services ("Secretary of HHS") is required to determine whether individuals enrolling in qualified health plans on an exchange are eligible for the premium tax credit and, if so, to notify the Secretary of the United States Department of the Treasury ("Treasury Secretary") of that fact. 42 U.S.C. § 18082(c)(1). The Treasury Secretary, in turn, is required to make periodic advance payments of the premium tax credit to the insurers offering the qualified health plans in which the eligible individuals enrolled. *Id.* § 18082(c)(2)(A). The insurers are required to use these advance payments to reduce the premiums of the eligible individuals. *Id.* § 18082(c)(2)(B)(i); *see also* 26 U.S.C. § 36B(f) (describing the process for annually

reconciling an individual's actual premium tax credit with the advance payments of the credit). To fund the premium tax credit, Congress amended a preexisting permanent appropriation to allow for the payment of refunds arising from the credit. *See* 31 U.S.C. § 1324 (2012) ("Necessary amounts are appropriated . . . for refunding internal revenue collections as provided by law . . . . Disbursements may be made from the appropriation made by this section only for . . . refunds due from credit provisions of [26 U.S.C. § 36B].").

2. Cost-Sharing Reductions

The other reform, cost-sharing reductions, is designed to reduce the out-of-pocket expenses (such as deductibles, copayments, and coinsurance[3]) paid by individuals whose household income is between 100% and 250% of the poverty line. *See* 42 U.S.C. §§ 18022(c)(3), 18071(c)(2); *accord* 45 C.F.R. §§ 155.305(g), 156.410(a). Insurers offering qualified health plans are required to reduce eligible individuals' cost-sharing obligations by specified amounts,[4] 42 U.S.C. § 18071(a), and the Secretary of

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[3] "The term 'cost-sharing' includes . . . deductibles, coinsurance, copayments, or similar charges," but not "premiums, balance billing amounts for non-network providers, or spending for non-covered services." 42 U.S.C. § 18022(c)(3).

[4] To be eligible for cost-sharing reductions, an individual must enroll in a silver-level qualified health plan. 42 U.S.C. § 18071(b)(1). Under a standard silver-level plan, insurers are required to provide coverage for 70% of the benefits offered under the plan. *Id.* § 18022(d)(1)(B). However, for eligible individuals, that percentage increases to 73% (when household income is between 200% and 250% of the poverty line), 87% (when household income is between 150% and 200% of the poverty line),

HHS is required to reimburse the insurers for the cost-sharing reductions they make, *see id.* § 18071(c)(3)(A) ("[T]he Secretary [of HHS] shall make periodic and timely payments to the issuer equal to the value of the reductions.").

The Secretary of HHS is afforded some discretion in the timing of the reimbursements: once he determines which individuals are eligible for cost-sharing reductions, he must notify the Treasury Secretary "if an advance payment of the cost-sharing reductions . . . is to be made to the issuer of any qualified health plan" and, if so, the time and amount of such advance payment. *Id.* § 18082(c)(3). Pursuant to this authority, the Secretary of HHS established a reimbursement schedule by which the government "would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,486 (Mar. 11, 2013) (to be codified at 45 C.F.R. § 156.430); *see also* 45 C.F.R. § 156.430(b)(1) ("A [qualified health plan] issuer will receive periodic advance payments [for cost sharing reductions]."). The amount of the cost-sharing reduction payments owed to insurers is based on information provided to HHS by the insurers. *See* 45 C.F.R. § 156.430(c) (requiring insurers to report to HHS, "for each policy, the total allowed costs for essential health benefits charged for the policy for the

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or 94% (when household income is between 100% and 150% of the poverty line). *Id.* § 18071(c)(2).

benefit year, broken down by . . . (i) [t]he amount the [insurer] paid[,] (ii) [t]he amount the enrollee(s) paid[, and] (iii) [t]he amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions").

The Affordable Care Act did not include any language appropriating funds to make the cost-sharing reduction payments.

3. Requirements for Insurers

To offer a health insurance plan on an exchange in any given year—and become eligible to receive payments for the premium tax credit and cost-sharing reductions—an insurer must satisfy certain requirements established by the Secretary of HHS. *See, e.g.*, 42 U.S.C. § 18041(a)(1) (authorizing the Secretary of HHS to "issue regulations setting standards for meeting the requirements under [title I of the Affordable Care Act] with respect to—(A) the establishment and operation of Exchanges . . . ; (B) the offering of qualified health plans through such Exchanges; . . . and (D) such other requirements as the Secretary determines appropriate"). The requirements include (1) obtaining certification that any plan it intends to offer is a qualified health plan, *see, e.g.*, 45 C.F.R. §§ 155.1000, .1010, 156.200; (2) submitting rate and benefit information before the open enrollment period for the applicable year, *see, e.g.*, *id.* §§ 155.1020, 156.210; and (3) executing a standard Qualified Health Plan Issuer Agreement ("QHPI Agreement") with the Centers for Medicare

and Medicaid Services ("CMS"), an agency of HHS,[5] for that year,[6] *see id.* § 155.260(b) (requiring exchanges to execute agreements with entities that will gain access to personally identifiable information submitted to the exchanges that address privacy and security standards and obligations); *see also id.* § 155.20 (defining "exchange" to include exchanges established and operated by either a state or HHS).

With respect to the latter requirement, each QHPI Agreement includes the following recitals:

> WHEREAS:
>
> 1. Section 1301(a) of the Affordable Care Act . . . provides that [Qualified Health Plans] are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under

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[5] The Secretary of HHS delegated to the Administrator of CMS (1) his authority—granted in section 1301 of the Affordable Care Act—"pertaining to defining qualified health plans"; (2) his authority—granted in section 1311 of the Affordable Care Act—"pertaining to affordable choices of health benefit plans"; and (3) his authority—granted in section 1321 of the Affordable Care Act—"pertaining to the State's flexibility in operation and enforcement of [exchanges] and related requirements." Delegation of Authorities, 76 Fed. Reg. 53,903, 53,903 (Aug. 30, 2011); *see also* 42 U.S.C. §§ 18021 (codifying section 1301 of the Affordable Care Act), 18031 (codifying section 1311 of the Affordable Care Act), 18041 (codifying section 1321 of the Affordable Care Act).

[6] The QHPI Agreements for 2017 and 2018 include, as relevant in this case, identical language. *See* Decl. of Kenneth Janda ("Janda Decl."), Exs. A-B (collectively, "Agreements").

section 1321(a) and other requirements that an applicable Exchange may establish.

2. [Qualified Health Plan Issuer] is an entity licensed by an applicable State Department of Insurance . . . as an Issuer and seeks to offer through the [Federally-facilitated Exchange] in such State one or more plans that are certified to be [Qualified Health Plans].

3. It is anticipated that periodic [Advance Payments of the Premium Tax Credit], advance payments of [Cost-Sharing Reductions], and payments of [Federally-facilitated Exchange] user fees will be due between CMS and [Qualified Health Plan Issuer].

4. [Qualified Health Plan Issuer] and CMS are entering into this Agreement to memorialize the duties and obligations of the parties, including to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, [Qualified Health Plan Issuer] and CMS agree as follows . . . .

Agreements 1. Section I of each agreement is titled "Definitions." *Id.* at 1-3. Section II of each agreement, titled "Acceptance of Standard Rules of Conduct," addresses standards related to personally identifiable information (as set forth in 45 C.F.R. § 155.260) and

communications with CMS's Data Services Hub. *Id.* at 3-6. Section III of each agreement is titled "CMS Obligations" and provides, in its entirety:

> a. CMS will undertake all reasonable efforts to implement systems and processes that will support [Qualified Health Plan Issuer] functions. In the event of a major failure of CMS systems and/or processes, CMS will work with [Qualified Health Plan Issuer] in good faith to mitigate any harm caused by such failure.
>
> b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [Qualified Health Plan Issuer] against amounts owed to CMS by [Qualified Health Plan Issuer] in relation to offering of [Qualified Health Plans] or any entity operating under the same tax identification number as [Qualified Health Plan Issuer] (including overpayments previously made), including the following types of payments: [Advance Payments of the Premium Tax Credit], advance payments of [Cost- Sharing Reductions], and payment of Federally-facilitated Exchange user fees.

Id. at 6. The remaining sections of the agreements contain various boilerplate provisions, *see id.* at 6-9, including several related to the termination of the

agreements, *id.* at 6-7. One termination-related clause provides:

> [Qualified Health Plan Issuer] acknowledges that termination of this Agreement 1) may affect its ability to continue to offer [Qualified Health Plans] through the [Federally-facilitated Exchange]; 2) does not relieve [Qualified Health Plan Issuer] of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve [Qualified Health Plan Issuer] of any obligation under applicable State law to continue to offer coverage for a full plan year.

Id. at 7. Each agreement is to be executed by authorized representatives of the insurer and CMS. *Id.* at 10-11 (2017 agreement[7]), 9-10 (2018 agreement).

In addition, in most circumstances, insurers must make their qualified health plans available on the exchanges for the entire year for which the plans were certified. 45 C.F.R. § 156.272(a).

B. Termination of Cost-Sharing Reduction Payments

On April 10, 2013, before the exchanges opened for business, President Barack H. Obama submitted to Congress his budget for fiscal year 2014. *See* Office of Mgmt. & Budget, Exec. Office of the President, *Fiscal Year 2014 Budget of the United States Government to Congress* (2013). The budget included a request for a line-item appropriation for cost-sharing

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[7] The signature pages in the 2017 agreement executed by plaintiff are both numbered "10."

reduction payments. *See id.* at App. 448; *accord* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *Fiscal Year 2014 Justification of Estimates for Appropriations Committees* 184 (2013). However, Congress did not provide the requested appropriation. *See* Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5; *see also* S. Rep. No. 113-71, at 123 (2013) ("The Committee recommendation does not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the [Affordable Care Act]."). In fact, it is undisputed by the parties that Congress has never specifically appropriated funds to reimburse insurers for their cost-sharing reductions.[8] It is further undisputed that Congress has never (1) expressly prevented—in an appropriations act or otherwise—the Secretary of HHS or the Treasury Secretary from expending funds to make cost-sharing reduction payments or (2) amended the Affordable Care Act to eliminate the cost-sharing reduction payment obligation.

Although Congress did not specifically appropriate funds for cost-sharing reduction payments, the Obama administration began making advance payments to insurers for cost-sharing reductions in January 2014. *See* Ctrs. for Medicare &

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[8] Whether Congress will appropriate funds for cost-sharing reduction payments in the future is an open question. *Cf.* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227, 283 (Jan. 24, 2019) ("The Administration supports a legislative solution that would appropriate [cost-sharing reduction] payments . . . .").

Medicaid Servs., Dep't of Health & Human Servs., *Guidance Related to Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015* 27 (2016). It made the payments from "the same account from which the premium tax credit" advance payments were made—in other words, from the permanent appropriation described in 31 U.S.C. § 1324. Letter from Sylvia M. Burwell, Director of the Office of Mgmt. & Budget, to Ted Cruz and Michael S. Lee, U.S. Senators 4 (May 21, 2014), http://www.cruz.senate.gov/files/documents/Letters/20140521_ Burwell_Response.pdf.

On November 21, 2014, the United States House of Representatives ("House") sued the Obama administration in the United States District Court for the District of Columbia ("D.C. district court") to stop the payment of cost-sharing reduction reimbursements to insurers. *See generally U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC (D.D.C. filed Nov. 21, 2014). The D.C. district court ruled for the House, holding:

> The Affordable Care Act unambiguously appropriates money for Section 1401 premium tax credits but not for Section 1402 reimbursements to insurers. Such an appropriation cannot be inferred. None of Secretaries' extra-textual arguments—whether based on economics, "unintended" results, or legislative history—is persuasive. The Court will enter judgment in favor of the House of Representatives and enjoin the use of unappropriated monies to fund reimbursements due to insurers under

> Section 1402. The Court will stay its injunction, however, pending appeal by either or both parties.

U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 168 (D.D.C. 2016). The Obama administration appealed the ruling. *See generally U.S. House of Representatives v. Azar* ("*Azar*"), No. 16-5202 (D.C. Cir. filed July 6, 2016). However, the United States Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") stayed the appeal to allow President-elect Donald J. Trump and his future administration time to determine how to proceed. *See* Mot. Hold Briefing Abeyance 1-2, *Azar*, No. 16-5202 (Nov. 21, 2016); Order, *Azar*, No. 16- 5202 (Nov. 21, 2016).

The Trump administration continued the previous administration's practice of making advance cost-sharing reduction payments to insurers. However, on October 11, 2017, the United States Attorney General sent a letter to the Treasury Secretary and the Acting Secretary of HHS advising that "the best interpretation of the law is that the permanent appropriation for 'refunding internal revenue collections,' 31 U.S.C. § 1324, cannot be used to fund the [cost-sharing reduction] payments to insurers authorized by 42 U.S.C. § 18071." Letter from Jefferson B. Sessions III, U.S. Attorney General, to Steven Mnuchin, Sec'y of the Treasury, and Don Wright, M.D., M.P.H., Acting Sec'y of HHS 1 (Oct. 11, 2017), http://www.hhs.gov/sites/default/files/ csr-payment-memo.pdf. Based on this guidance, the Acting Secretary of HHS directed, the following day, that "[cost-sharing reduction] payments to issuers must stop, effective immediately," and that such

"payments are prohibited unless and until a valid appropriation exists." Memorandum from Eric Hargan, Acting Sec'y of HHS,[9] to Seema Verma, Administrator of the Ctrs. for Medicare & Medicaid Servs. (Oct. 12, 2017), http://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

C. Reaction to the Termination of Cost-Sharing Reduction Payments

The Trump administration's termination of cost-sharing reduction payments did not come as a surprise to insurers:

> Anticipating that the Administration would terminate [cost-sharing reduction] payments, most states began working with the insurance companies to develop a plan for how to respond. Because the Affordable Care Act requires insurance companies to offer plans with cost-sharing reductions to customers, the federal government's failure to meet its [cost-sharing reduction] payment obligations meant the insurance companies would be losing that money. So most of the states set out to find ways for the insurance companies to increase premiums for 2018 (with open enrollment beginning in November 2017) in a fashion that would avoid harm to consumers. And the states came up

[9] Eric Hargan was named Acting Secretary of HHS on October 10, 2017. *See* Press Release, The White House, President Donald J. Trump Announces Intent to Nominate Personnel to Key Administration Posts (Oct. 10, 2017), https://www.whitehouse.gov/presidentialactions/president-donald-j-trump-announces-intent-nominate-personnel-key-administrationposts-22/.

> with an idea: allow the insurers to make up the deficiency through premium increases for silver plans only. In other words, allow a relatively large premium increase for silver plans, but no increase for bronze, gold, or platinum plans.
>
> As a result, in these states, for everyone between 100% and 400% of the federal poverty level who wishes to purchase insurance on the exchanges, the available tax credits rise substantially. Not just for people who purchase the silver plans, but for people who purchase other plans too.

California, 267 F. Supp. 3d at 1134-35 (footnote omitted). In other words, by raising premiums for silver-level qualified health plans, the insurers would obtain more money from the premium tax credit program, which would help mitigate the loss of the cost-sharing reduction payments.[10] *Accord id.* at 1139 (agreeing with the states "that the widespread

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[10] Notably, increasing silver-level qualified health plan premiums would not harm most consumers who qualify for the premium tax credit because the credit increases as the premium increases. *See California*, 267 F. Supp. 3d at 1134 ("[T]he amount [of the premium tax credit] is based on the cost of the second-cheapest silver plan available on the exchange in your geographic area, and then adjusted based on your income (that is, based on where you fall on the spectrum between 100% and 400% of the federal poverty level). So, if premiums for the second-cheapest silver plan in your area go up, the amount of your tax credit will go up by a corresponding amount. *See* 26 U.S.C. § 36B."); *see also id.* at 1122 ("[M]ost state regulators have devised responses that give millions of lower-income people better health coverage options than they would otherwise have had.").

increase in silver plan premiums will qualify many people for higher tax credits, and that the increased federal expenditure for tax credits will be far more significant than the decreased federal expenditure for [cost-sharing reduction] payments"). This approach is commonly referred to as "silver loading," and many states appear to have endorsed it, *see id.* at 1137 ("Even before the Administration announced its decision, 38 states accounted for the possible termination of [cost-sharing reduction] payments in setting their 2018 premium rates. And now that the announcement has been made, even more states are adopting [the] strategy [of increasing silver-level plan premiums to obtain additional premium tax credit payments]." (footnote omitted)).

D. Other Litigation

While the states and insurers were working on ways to mitigate the loss of cost-sharing reduction payments, the parties in the case on appeal at the D.C. Circuit began discussing that case's disposition. Joint Status Report 1-2, *Azar*, No. 16-5202 (Nov. 30, 2017). Ultimately, at the request of the parties, the D.C. Circuit dismissed the appeal, Order, *Azar*, No. 16-5202 (May 16, 2018), and the D.C. district court vacated the portion of its ruling in which it provided that "reimbursements paid to issuers of qualified health plans for the cost-sharing reductions mandated by Section 1402 of the Affordable Care Act, Pub. L. 111-148, are ENJOINED pending an appropriation for such payments," Order, *Azar*, No. 1:14-cv-01967-RMC (May 18, 2018).

A separate lawsuit was filed by seventeen states and the District of Columbia in the United States

District Court for the Northern District of California ("California district court") to compel the Trump administration to continue making the advance cost-sharing reduction payments to insurers. *See generally California v. Trump*, No. 3:17-cv-05895-VC (N.D. Cal. filed Oct. 13, 2017). The California district court denied the states' motion for a preliminary injunction. *California*, 267 F. Supp. 3d at 1121-22, 1140. Eventually, the states requested a stay of the proceedings or, alternatively, dismissal of the suit without prejudice, explaining:

> [S]taying the proceedings is warranted to avoid disturbing the status quo given the general success of the practice commonly referred to as "silver-loading" which mostly curbed the harm caused by the federal government's unjustified cessation of cost-sharing reduction (CSR) subsidies mandated by Section 1402 of the Patient Protection and Affordable Care Act (ACA). At the same time, because of the real threat of the federal government taking action to prohibit silver-loading, the Court should retain jurisdiction, thus allowing the Plaintiff States to expeditiously seek appropriate remedies from this Court for the protection of their citizens. Alternatively, if the Court determines that a stay is not appropriate at this time, the Plaintiff States respectfully request that the Court dismiss the action without prejudice.

Mot. for Order Staying Proceedings or, in the Alternative, Dismissing Action Without Prejudice 2, *California*, No. 3:17-cv-05895-VC (July 16, 2018); *cf.*

HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. at 283 ("The Administration supports a legislative solution that would appropriate CSR payments and end silver loading. In the absence of Congressional action, we seek comment on ways in which HHS might address silver loading, for potential action in future rulemaking applicable not sooner than plan year 2021."). The California district court dismissed the case without prejudice on July 18, 2018. Order Dismissing Case Without Prejudice, *California*, No. 3:17-cv-05895-VC (July 18, 2018).

E. Effect of Cost-Sharing Reduction Payment Termination on Plaintiff

Plaintiff is a nonprofit corporation that offers qualified health plans on Texas's exchange. Janda Decl. ¶¶ 2-3. It began offering qualified health plans on the exchange in 2014, and continued to offer such plans thereafter. *Id.* ¶ 3. Indeed, for each year, plaintiff executed a Qualified Health Plan Issuer Agreement with CMS. *Id.* Of particular relevance, plaintiff and CMS executed the agreement for 2017 on September 21, 2016, *id.* ¶ 4, and the agreement for 2018 on October 2, 2017, *id.* ¶ 6. In 2017, approximately 58% of plaintiff's insured population—over 80,000 individuals—received cost-sharing reductions, and plaintiff continued to reduce the cost-sharing obligations of its eligible insured population in 2018. *Id.* ¶¶ 13, 15. Plaintiff began receiving monthly advance cost-sharing reduction payments in January 2014, *id.* ¶ 16, and, as with every other insurer offering qualified health plans on the exchanges, stopped receiving these payments effective October 12, 2017, *id.* ¶¶ 17-18. Had the government not ceased

these payments, plaintiff avers that it would have received another $11,174,299.10 in 2017, *id.* ¶ 19, and even more money in 2018, *id.* ¶ 20.

F. Procedural History

Plaintiff filed a complaint in this court on January 2, 2018, to recover unpaid risk corridors payments for 2014, 2015, and 2016.[11] It then filed an amended complaint on February 27, 2018, to add three claims aimed at recovering the cost-sharing reduction payments that the government has not made since September 2017.[12] In the latter claims, plaintiff asserts that in failing to make the cost-sharing reduction payments to insurers, the government violated the statutory and regulatory mandate, breached the QHPI Agreements, and breached an

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[11] Proceedings on the risk corridors claims are currently stayed pending final, nonappealable judgments in *Moda Health Plan, Inc. v. United States*, No. 16-649C, and *Land of Lincoln Mutual Health Insurance Co. v. United States*, No. 16-744C.

[12] A number of other insurers have filed suit in this court seeking to recover unpaid cost-sharing reduction reimbursements. *See, e.g.*, *Common Ground Healthcare Coop. v. United States*, No. 17-877C (Chief Judge Sweeney); *Local Initiative Health Auth. for L.A. Cty. v. United States*, No. 17-1542C (Judge Wheeler); *Me. Cmty. Health Options v. United States*, No. 17-2057C (Chief Judge Sweeney); *Sanford Health Plan v. United States*, No. 18-136C (Judge Kaplan); *Montana Health Co-op v. United States*, No. 18-143C (Judge Kaplan); *Molina Healthcare of Cal., Inc. v. United States*, No. 18-333C (Judge Wheeler); *Health Alliance Med. Plans, Inc. v. United States*, No. 18-334C (Judge Campbell-Smith); *Blue Cross & Blue Shield of Vt. v. United States*, No. 18-373C (Judge Horn); *Guidewell Mut. Holding Corp. v. United States*, No. 18-1791C (Judge Griggsby); *Harvard Pilgrim Health Care, Inc. v. United States*, No. 18- 1820C (Judge Smith).

implied-infact contract. Plaintiff moves for summary judgment on the issue of liability and defendant cross-moves to dismiss the complaint. The parties completed briefing, and after hearing argument on February 14, 2019, the court is prepared to rule.[13]

II. STANDARDS OF REVIEW

A. Motions for Summary Judgment

Plaintiff moves for summary judgment pursuant to Rule 56 of the Rules of the United States Court of Federal Claims ("RCFC"). Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. RCFC 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). 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). An issue is genuine if it "may reasonably be resolved in favor of either party." *Id.* at 250. Entry of summary judgment is mandated against a party who fails to establish "an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp.*, 477 U.S. at 322. Statutory construction and contract

[13] The court has had the benefit of full briefing and oral argument in three cost-sharing reduction cases: *Common Ground Healthcare Cooperative v. United States*, No. 17-877C, *Maine Community Health Options v. United States*, No. 17-2057C, and *Community Health Choice, Inc. v. United States*, No. 18-5C. The plaintiffs in all three cases allege that the government violated the cost-sharing reduction statutes and regulations, and the plaintiffs in two of the cases allege a breach of an implied-in-fact contract. Thus, in ruling on the parties' motions in this case, the court has, when applicable, considered the parties' arguments in all three cases.

interpretation "are questions of law amenable to resolution through summary judgment." *Stathis v. United States*, 120 Fed. Cl. 552, 561 (2015); *accord Varilease Tech. Group, Inc. v. United States*, 289 F.3d 795, 798 (Fed. Cir. 2002) ("Contract interpretation is a question of law generally amenable to summary judgment."); *Anderson v. United States*, 54 Fed. Cl. 620, 629 (2002) ("The plaintiff's entitlement . . . rests solely upon interpretation of the cited statute and is thus amenable to resolution by summary judgment."), *aff'd*, 70 F. App'x 572 (Fed. Cir. 2003) (unpublished opinion).

B. Motions to Dismiss for Failure to State a Claim Upon Which Relief Can Be Granted

Defendant cross-moves to dismiss plaintiff's cost-sharing reduction claims for failure to state a claim upon which relief can be granted pursuant to RCFC 12(b)(6). To survive such a motion, a plaintiff must include in its complaint "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). In other words, a plaintiff must "plead[] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atl. Corp.*, 550 U.S. at 556). Indeed, "[t]he issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974), *overruled on other grounds by Harlow v. Fitzgerald*, 457 U.S. 800, 814-19 (1982).

III. DISCUSSION

As noted above, in seeking to recover the cost-sharing reduction payments not made by the government, plaintiff asserts three claims for relief. The court addresses each in turn.

A. Violation of Statute

Plaintiff first contends that the government's failure to make the payments was a violation of the cost-sharing reduction provisions of the Affordable Care Act and its implementing regulations. Plaintiff further contends that Congress's failure to specifically appropriate funds for cost-sharing reduction payments does not suspend or terminate the government's obligation to make the payments. Defendant disagrees, arguing that Congress expressed its intent that cost-sharing reduction payments should not be made absent a specific appropriation for that purpose by not appropriating funds for cost-sharing reductions in the Affordable Care Act or thereafter. Consequently, defendant contends, monetary damages—payable from the Judgment Fund—are unavailable from this court.

1. The Government Is Obligated to Make Cost-Sharing Reduction Payments to Plaintiff Notwithstanding the Absence of a Specific Appropriation for That Purpose

To determine whether Congress intended the government to make cost-sharing reduction payments to insurers, the court first turns to the language of the Affordable Care Act. *See Lamie v. U.S. Tr.*, 540 U.S. 526, 534 (2004) ("The starting point in discerning congressional intent is the existing statutory text."); *see also Conn. Nat'l Bank v. Germain*, 503 U.S. 249,

253-54 (1992) ("[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there."). In addition to evaluating the specific provision of the Affordable Care Act establishing the cost-sharing reduction program, the court must read that provision in the context of the Affordable Care Act as a whole. *See King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (following "the cardinal rule that a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context" (citation omitted)); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."); *Kokoszka v. Belford*, 417 U.S. 642, 650 (1974) ("When 'interpreting a statute, the court will not look merely to a particular clause in which general words may be used, but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give to it such a construction as will carry into execution the will of the Legislature . . . .'" (quoting *Brown v. Duchesne*, 60 U.S. 183, 194 (1856))); *see also Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) ("If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."); *Kilpatrick v. Principi*, 327 F.3d 1375, 1384 (Fed. Cir. 2003) ("[I]n determining whether Congress has directly spoken to the point at issue, a court should attempt to discern congressional intent either from

the plain language of the statute or, if necessary, by resort to the applicable tools of statutory construction[.]"). If congressional intent regarding the obligation to make cost-sharing reduction payments can be ascertained from evaluating the text of the Affordable Care Act, then the court's inquiry on this issue is complete. *See Conn. Nat'l Bank*, 503 U.S. at 254.

The statutory provision governing cost-sharing reductions sets forth an unambiguous mandate: "the Secretary [of HHS] shall make periodic and timely payments" to insurers "equal to the value of the reductions" made by the insurers. 42 U.S.C. § 18071(c)(3)(A); *accord Montana Health Co-op v. United States*, 139 Fed. Cl. 213, 218 (2018)[14] ("[T]he statutory language clearly and unambiguously imposes an obligation on the Secretary of HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans as required by the [Affordable Care Act]."); *see also SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1354 (2018) ("The word 'shall' generally imposes a nondiscretionary duty."); *Gilda Indus., Inc. v. United States*, 622 F.3d 1358, 1364 (Fed. Cir. 2010) ("When a statute directs that a certain consequence 'shall' follow from specified contingencies, the provision is mandatory and leaves no room for discretion."); *cf. Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320 (2018) (concluding that similar language in

[14] The judge who decided *Montana Health Co-op*—the Honorable Elaine D. Kaplan—subsequently issued a substantively identical ruling in another case. *See Samford Health Plan v. United States*, 139 Fed. Cl. 701 (2018).

section 1342 of the Affordable Care Act—indicating that the Secretary of HHS "shall establish" a risk corridors program pursuant to which the Secretary of HHS "shall pay" risk corridors payments—is "unambiguously mandatory"). Moreover, the mandatory payment obligation fits logically within the statutory scheme established by Congress. The cost-sharing reduction payments were meant to reimburse insurers for paying an increased share of their insureds' cost-sharing obligations, 42 U.S.C. § 18071(a)(2), (c)(3)(A), and the reduction of insureds' cost-sharing obligations was meant to make obtaining health care more affordable, *see, e.g.*, *id.* § 18071(c)(1)(A) (describing how cost-sharing reductions would be achieved by reducing insureds' out-of-pocket limits). In short, the plain language, structure, and purpose of the Affordable Care Act reflect the intent of Congress to require the Secretary of HHS to make cost-sharing reduction payments to insurers.

Defendant does not dispute this conclusion. Rather, it contends that the cost-sharing reduction payment obligation is unenforceable because Congress never specifically appropriated funds—either in the Affordable Care Act or thereafter—to make cost-sharing reduction payments.

a. The Lack of Specific Appropriating Language in the Affordable Care Act

As defendant observes, the Affordable Care Act does not include any language specifically appropriating funds for cost-sharing reduction payments. Defendant also correctly observes that the Act's cost-sharing reduction provision lacks any

appropriating language, while its companion provision—the premium tax credit—included an explicit funding mechanism.[15] *Compare* Affordable Care Act § 1401(d) (amending the permanent appropriation set forth in 31 U.S.C. § 1324 to allow for the payment of the premium tax credit), *with id.* § 1402 (containing no appropriating language). According to defendant, the absence of any funding mechanism for cost-sharing reduction payments, and Congress's decision to provide a funding mechanism for premium tax credit payments and not cost-sharing reduction payments, reflect the intent of Congress, when enacting the Affordable Care Act, to preclude liability for cost-sharing reduction payments. Defendant is mistaken for several reasons.

First, it is well settled that the government can create a liability without providing for the means to pay for it. *See, e.g.*, *Moda Health Plan*, 892 F.3d at 1321 ("[I]t has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances."); *Collins v. United States*, 15 Ct. Cl. 22, 35 (1879) ("[T]he legal liabilities incurred by the United States under . . . the laws of Congress . . . may be created where there is no appropriation of money to meet them . . . ."). Thus, the absence of a specific appropriation for cost-sharing reduction payments in the Affordable Care Act does not, on its own, extinguish the government's obligation to make the payments.

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[15] Both provisions appear in subpart A of part I of subtitle E of the Affordable Care Act, which is titled "Premium Tax Credits and Cost-Sharing Reductions." 124 Stat. at 213-24.

Second, that Congress provided a funding mechanism for premium tax credit payments and not for cost-sharing reduction payments does not reflect congressional intent to foreclose liability for the latter. Defendant relies on the proposition that when "Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983) (quoting *United States v. Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972)); *accord Digital Realty Trust, Inc. v. Somers*, 138 S. Ct. 767, 777 (2018). Here, although Congress may have acted intentionally by treating the two related provisions differently,[16] it is difficult to discern what that intent might be. In addition to the intent inferred by defendant, there are other reasonable explanations for the disparity. One possible explanation is that it was a simple matter to add the premium tax credit to a preexisting permanent appropriation in the Internal Revenue Code for the payment of tax credits, whereas no such permanent appropriation existed that would apply to cost-sharing reduction payments. Another possible explanation is that Congress understood that other funds available to HHS could be used to make the cost-sharing reduction payments; indeed, the cost-sharing

[16] Alternatively, it is possible that the disparate treatment does not reflect any intent at all. As the United States Supreme Court ("Supreme Court") recognized in *King*, "[t]he Affordable Care Act contains more than a few examples of inartful drafting." 135 S. Ct. at 2492. Thus, Congress's failure to include any appropriating language in the cost-sharing reduction provision may simply have been an oversight.

reduction provision lacks any language, such as "subject to the availability of appropriations," reflecting Congress's recognition that appropriations were unavailable, *see Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 878 (Fed. Cir. 2007) (observing that "in some instances the statute creating the right to compensation . . . may restrict the government's liability . . . to the amount appropriated by Congress" with language such as "subject to the availability of appropriations"). A third possible explanation is that Congress intended to defer appropriating funds for cost-sharing reduction payments until 2014, when insurers began to offer qualified health plans on the exchanges and incur cost-sharing reduction liabilities. Because it is unclear which of these explanations—if any—is correct, the court declines to ascribe any particular intent to Congress based on Congress's disparate treatment of the two provisions.

Third, the court is unpersuaded by defendant's related contention that insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses from the government's nonpayment of cost-sharing reduction reimbursements, is evidence that Congress did not intend to provide a statutory damages remedy for the government's failure to make the cost-sharing reduction payments. *Accord Montana Health Co-op*, 139 Fed. Cl. at 221. Defendant does not identify any statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation (even if insurers intentionally increased premiums to obtain larger premium tax credit payments to make up for lost cost-

sharing reduction payments). Nor does defendant identify any evidence in the Affordable Care Act's legislative history suggesting that Congress intended to limit its liability to make cost-sharing reduction payments by increasing its premium tax credit payments. That insurers and states discovered a way to mitigate the insurers' losses from the government's failure to make cost-sharing reduction payments does not mean that Congress intended this result. Moreover, defendant's concern that Congress could not have intended to allow a double recovery of cost-sharing reduction payments is not well taken. The increased amount of premium tax credit payments that insurers receive from increasing silver-level plan premiums are still premium tax credit payments, not cost-sharing reduction payments. Indeed, under the statutory scheme as it exists, even if the government were making the required cost-sharing reduction payments, insurers could (to the extent permitted by their state insurance regulators) increase their silver-level plan premiums; in such circumstances, it could not credibly be argued that the insurers were obtaining a double recovery of cost-sharing reduction payments. While the premium tax credit and cost-sharing reduction provisions were enacted to reduce an individual's health-care-related costs (to obtain insurance and to obtain health care, respectively), they are not substitutes for each other.[17]

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[17] The California district court's decision in *California v. Trump* does not assist defendant. Although the court described how insurers are coping with the lost cost-sharing reduction payments by raising silver-level qualified health plan premiums to obtain larger premium tax credit payments, nowhere in its decision does the court hold that the government's liability for

Fourth, it would defy common sense to conclude that Congress obligated the Secretary of HHS to reimburse insurers for their mandatory cost-sharing reductions without intending to actually reimburse the insurers. If Congress did not intend to create such an obligation, it would not have included any provision for reimbursing cost-sharing reductions in the Act.

In sum, Congress's failure to include any appropriating language in the Affordable Care Act does not reflect congressional intent to preclude liability for cost-sharing reduction payments. This conclusion, however, does not end the court's analysis because defendant also argues that Congress's subsequent failure to appropriate funds to make cost-sharing reduction payments through annual appropriations acts or otherwise signals congressional intent to foreclose liability.

b. The Lack of Specific Appropriating Language in Subsequent Appropriations Acts

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cost-sharing reduction payments is lessened or eliminated by the government making larger premium tax credit payments to insurers. Indeed, the court very clearly emphasized that the premium tax credit program and the cost-sharing reduction program were separate and distinct. *See California*, 267 F. Supp. 3d at 1131. Moreover, the court's discussion of the approach taken by insurers to obtain increased premium tax credit payments was included within its analysis of "whether the absence of a preliminary injunction would harm the public and impede the objectives of health care reform." *Id.* at 1133. In other words, the court's focus was on how the increase in premiums would affect the public, and not on the government's obligation to make payments to insurers.

The Appropriations Clause of the United States Constitution provides that "[n]o Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law[.]" U.S. Const. art. I, § 9, cl. 7. The statute commonly referred to as the Antideficiency Act further provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation[.]" 31 U.S.C. § 1341(a)(1)(A). These directives are unambiguous: disbursements from the United States Treasury require an appropriation from Congress. However, "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." *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) (per curiam), *cited in Moda Health Plan*, 892 F.3d at 1321-22; *cf. Moda Health Plan*, 892 F.3d at 1322 (recognizing that the Supreme Court "rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government").

Defendant does not contend that any appropriations acts—or, indeed, any statutes at all—enacted after the Affordable Care Act contain language that "expressly or by clear implication" modifies or repeals the Act's cost-sharing reduction payment obligation. Rather, it relies on Congress's complete failure to appropriate funds for cost-sharing reduction payments as evidence that Congress intended to suspend the cost-sharing reduction payment obligation. Defendant's reliance is

misplaced. None of the appropriations acts enacted after the Affordable Care Act expressly or impliedly disavowed the payment obligation; they were completely silent on the issue. Thus, this case is distinguishable from those relied upon by defendant—*Mitchell v. United States*, 109 U.S. 146 (1883), *Dickerson v. United States*, 310 U.S. 554 (1940), and *United States v. Will*, 449 U.S. 200 (1980)—that concerned situations in which Congress made affirmative statements in appropriations acts that reflected an intent to suspend the underlying substantive law.

Here, Congress has had ample opportunity to modify, suspend, or eliminate the statutory obligation to make cost-sharing reduction payments but has not done so. Congress's inaction stands in stark contrast to its treatment of the Affordable Care Act's risk corridors program. Under that program, which was established in section 1342 of the Affordable Care Act, the Secretary of HHS was required to make annual payments to insurers pursuant to a statutory formula. 42 U.S.C. § 18062; *Moda Health Plan*, 892 F.3d at 1320. However, Congress included riders in two appropriations acts enacted after the Affordable Care Act that prohibited appropriated funds from being used to make risk corridors payments. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, tit. II, § 225, 129 Stat. 2242, 2624; Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, § 227, 128 Stat. 2130, 2491. These riders have been interpreted to suspend the government's obligation to make risk corridors payments from appropriated funds. *Moda Health Plan*, 892 F.3d at 1322-29.

Congress has never enacted any such appropriations riders with respect to cost-sharing reductions payments, even when cost-sharing reduction payments were being made—during both the Obama and Trump administrations—from the permanent appropriation for tax credits described in 31 U.S.C. § 1324. Thus, the congressional inaction in this case may be interpreted, contrary to defendant's contention, as a decision not to suspend or terminate the government's cost-sharing reduction payment obligation.[18]

In short, Congress's failure to appropriate funds to make cost-sharing reduction payments through annual appropriations acts or otherwise does not reflect a congressional intent to foreclose, either temporarily or permanently, the government's liability to make those payments.

2. Plaintiff Can Recover Unpaid Cost-Sharing Reduction Reimbursements in the United States Court of Federal Claims

Plaintiff asserts that because the government has breached its statutory obligation to make cost-sharing reduction payments, recovery is available in the United States Court of Federal Claims ("Court of

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[18] The court recognizes that drawing inferences from congressional inaction can be highly problematic. *See Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) ("Congressional inaction lacks 'persuasive significance' because 'several equally tenable inferences' may be drawn from such inaction . . . ." (quoting *United States v. Wise*, 370 U.S. 405, 411 (1962)); *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 306 (1988) ("This Court generally is reluctant to draw inferences from Congress' failure to act.").

Federal Claims") under the Tucker Act. The Tucker Act, the principal statute governing the jurisdiction of this court, waives sovereign immunity for claims against the United States, not sounding in tort, that are founded upon the United States Constitution, a federal statute or regulation, or an express or implied contract with the United States. 28 U.S.C. § 1491(a)(1) (2012). It is merely a jurisdictional statute and "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). Instead, the substantive right must appear in another source of law, such as a "money-mandating constitutional provision, statute or regulation that has been violated, or an express or implied contract with the United States." *Loveladies Harbor, Inc. v. United States*, 27 F.3d 1545, 1554 (Fed. Cir. 1994) (en banc). It is well accepted that a statute "is money-mandating for jurisdictional purposes if it 'can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s].'" *Fisher v. United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005) (panel portion) (quoting *United States v. Mitchell*, 463 U.S. 206, 219 (1983)). Under this rule, "[i]t is enough . . . that a statute creating a Tucker Act right be reasonably amenable to the reading that it mandates a right of recovery in damages. While the premise to a Tucker Act claim will not be 'lightly inferred,' a fair inference will do." *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 473 (2003) (citation omitted).

The cost-sharing reduction provision of the Affordable Care Act, codified at 42 U.S.C. § 18071, is a money-mandating statute for Tucker Act purposes:

the Secretary of HHS is required to reimburse insurers for their mandatory cost-sharing reductions, 42 U.S.C. § 18071(c)(3)(A), and his failure to make such payments is a violation of that duty that deprives the insurers of money to which they are statutorily entitled. *Accord Montana Health Co-op*, 139 Fed. Cl. at 217; *see also Moda Health Plan*, 892 F.3d at 1320 n.2 (holding that the statute providing for risk corridors payments "is money-mandating for jurisdictional purposes"). Consequently, an insurer that establishes that the government failed to make the cost-sharing reduction payments to which the insurer was entitled can recover the amount due in this court.[19]

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[19] Defendant appears to contend that for plaintiffs to recover under a money-mandating statute, they must separately establish that the statute authorizes a damages remedy for its violation. Defendant is incorrect. Although some money-mandating statutes include a separate provision authorizing a damages remedy, *see, e.g.*, 41 U.S.C. § 7104(b) (2012) (allowing contractors to bring claims arising under the Contract Disputes Act of 1978 in the Court of Federal Claims), other money-mandating statutes pursuant to which the Court of Federal Claims can enter judgment do not, *see, e.g.*, 5 U.S.C. § 5942 (2012) (governing federal employees' entitlement to a remote duty allowance); 37 U.S.C. § 204 (2012) (governing military service members' entitlement to basic pay). Indeed, "[t]o the extent that the Government would demand an explicit provision for money damages to support every claim that might be brought under the Tucker Act, it would substitute a plain and explicit statement standard for the less demanding requirement of fair inference that the law was meant to provide a damages remedy for breach of a duty." *White Mountain Apache Tribe*, 537 U.S. at 477; *accord Fisher*, 402 F.3d at 1173 (en banc portion) ("[T]he determination that the source is money-mandating shall be determinative both as to the question of the court's jurisdiction and thereafter as to

Moreover, the lack of a specific appropriation for cost-sharing reduction payments does not preclude such a recovery. Appropriations merely constrain government officials' ability to obligate or disburse funds. *See Moda Health Plan*, 892 F.3d at 1322 ("The Anti-Deficiency Act simply constrains government officials. . . . Budget authority is not *necessary* to create an obligation of the government; it is a means by which an officer is afforded that authority."); *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892) ("An appropriation *per se* merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties."). Thus, the lack of an appropriation, standing alone, does not constrain the court's ability to entertain a claim that the government has not discharged the underlying statutory obligation or to enter judgment for the plaintiff on that claim. *See Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) (en banc) ("[T]he jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid."); *N.Y. Airways*, 369 F.2d at 752 ("[T]he failure of Congress or an agency to appropriate or make available sufficient funds does

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the question of whether, on the merits, plaintiff has a money-mandating source on which to base his cause of action."); *Montana Health Co-op*, 139 Fed. Cl. at 217 n.5 ("Plaintiffs have never been required to make some separate showing that the money-mandating statute that establishes this court's jurisdiction over their monetary claims also grants them an express (or implied) cause of action for damages.").

not repudiate the obligation; it merely bars the accounting agents of the Government from disbursing funds and forces the carrier to a recovery in the Court of Claims."); *Collins*, 15 Ct. Cl. at 35 (remarking that a legal liability "incurred by the United States under . . . the laws of Congress," such as "[t]he compensation to which public officers are legally entitled . . . , exists independently of the appropriation, and may be enforced by proceedings in this court").

In fact, judgments of this court are payable from the Judgment Fund, *see* 31 U.S.C. § 1304(a)(3)(A), which "is a permanent, indefinite appropriation . . . available to pay many judicially and administratively ordered monetary awards against the United States," 31 C.F.R. § 256.1 (2016); a*ccord Bath Iron Works Corp. v. United States*, 20 F.3d 1567, 1583 (Fed. Cir. 1994) (stating that 31 U.S.C. § 1304 "was intended to establish a central, government-wide judgment fund from which judicial tribunals administering or ordering judgments, awards, or settlements may order payments without being constrained by concerns of whether adequate funds existed at the agency level to satisfy the judgment"). Indeed, as applicable here, "funds may be paid out [of the Judgment Fund] only on the basis of a judgment based on a substantive right to compensation based on the express terms of a specific statute." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990); *accord Moda Health Plan*, 892 F.3d at 1326 ("[A]ccess to the Judgment Fund presupposes liability."); *cf.* 31 U.S.C. § 1304(a)(1) (indicating that the Judgment Fund is available when "payment is not otherwise provided for"). Because plaintiff's claim arises from a statute mandating the

payment of money damages in the event of its violation, the Judgment Fund is available to pay a judgment entered by the court on that claim.[20]

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[20] Defendant acknowledged this possibility in other litigation. *See* Defs.' Mem. Supp. Mot. Summ. J. 20, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("The [Affordable Care] Act requires the government to pay cost-sharing reductions to issuers. The absence of an appropriation would not prevent the insurers from seeking to enforce that statutory right through litigation. Under the Tucker Act, a plaintiff may bring suit against the United States in the Court of Federal Claims to obtain monetary payments based on statutes that impose certain types of payment obligations on the government. If the plaintiff is successful, it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund. The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund." (citations omitted)); Defs.' Mem. Opp'n Pl.'s Mot. Summ. J. 12-13, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("Indeed, had Congress not permanently funded the cost-sharing reductions, it would have exposed the government to litigation by insurers, who could bring damages actions under the Tucker Act premised on the government's failure to make the mandatory cost-sharing reduction payments that the Act requires."); Defs.' Reply Mem. Supp. Mot. Summ. J. 9, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("[T]he House's interpretation of the [Affordable Care Act]—under which the Act would require the government to make the cost-sharing payments but provide no appropriation for doing so directly—would invite potentially costly lawsuits under the Tucker Act. The House asserts that insurers could not prevail in such suits '[a]bsent a valid appropriation.' But courts have held that the absence of an appropriation does not necessarily preclude recovery from the Judgment Fund in a Tucker Act suit. The House does not explain how, given this precedent, the government could avoid Tucker Act litigation by insurers in the wake of a ruling that the ACA did not permanently fund the cost-

3. Plaintiff Is Entitled to Recover Unpaid Cost-Sharing Reduction Reimbursements

Plaintiff seeks to recover the cost-sharing reduction payments that it has not received since the government decided to stop making them in October 2017. As noted above, plaintiff has established that the government is obligated to reimburse it for its cost-sharing reductions pursuant to 42 U.S.C. § 18071(c)(3)(A) and that the government stopped making such reimbursements in October 2017. Accordingly, at a minimum, it is entitled to recover the cost-sharing reduction payments that the government did not make for 2017.

With respect to 2018, defendant contends—as discussed above, albeit in the course of arguing that the structure of the Affordable Care Act reflects a congressional intent to preclude cost-sharing reduction payments absent an appropriation for that purpose—that plaintiff's ability to increase the premiums for its silver-level qualified health plans to obtain greater premium tax credit payments precludes recovery under the Act's cost-sharing reduction provision. Specifically, defendant asserts that the statutory scheme enacted by Congress permits insurers to make up any lost cost-sharing reduction payments by increasing silver-level plan premiums, which would prevent monetary injury to insurers. Defendant also expresses concern that allowing insurers to both obtain greater premium tax credits and obtain a judgment for their lost cost-

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sharing reduction payments that the Act directs the government to make." (citations omitted)).

sharing reduction payments would provide an unwarranted windfall for insurers. As noted above, the court is not convinced by defendant's arguments. Accordingly, it finds that plaintiff may recover the cost-sharing reduction payments that the government did not make for 2018.

B. Breach of an Express Contract

In addition to alleging that the government violated its statutory obligation to make cost-sharing reduction payments, plaintiff asserts that the government's failure to make such payments amounts to a breach of the QHPI Agreements. Specifically, plaintiff contends that the government was obligated to make cost-sharing reduction payments pursuant to the following provision, set forth under the heading "CMS Obligations": "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [plaintiff] against amounts owed to CMS by [plaintiff] in relation to offering of [Qualified Health Plans] . . . including the . . . advance payments of [Cost-Sharing Reductions] . . . ." Agreements 6. That this provision obligates CMS to make monthly cost-sharing reduction payments is buttressed, plaintiff contends, by the agreements' recitals, which declare that "[i]t is anticipated that periodic . . . advance payments of [Cost-Sharing Reductions] . . . will be due between CMS and [plaintiff]" and that "[plaintiff] and CMS are entering into this Agreement to memorialize the duties and obligations of the parties . . . ." *Id.* at 1. Plaintiff argues that because CMS failed to make the monthly cost-sharing reduction payments after October 2017,

it breached the QHPI Agreements, causing plaintiff damages.

"To recover for breach of contract, a party must allege and establish: (1) a valid contract between the parties, (2) an obligation or duty arising out of the contract, (3) a breach of that duty, and (4) damages caused by the breach." *San Carlos Irrigation & Drainage Dist. v. United States*, 877 F.2d 957, 959 (Fed. Cir. 1989); *accord Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997) ("To prevail, [plaintiff] must allege facts showing both the formation of an express contract and its breach."). Defendant does not dispute that the QHPI Agreements are valid contracts between plaintiff and CMS. Rather, it argues that plaintiff has failed to establish that the QHPI Agreements create an obligation for CMS to make monthly cost-sharing reduction payments. Specifically, with respect to the provision set forth under the "CMS Obligations" heading, defendant asserts that the provision merely requires CMS to "recoup or net" cost-sharing reduction payments as part of a reconciliation process and does not require CMS to make monthly advance cost-sharing reduction payments to insurers. And, with respect to the recitals identified by plaintiff, defendant asserts that such recitals are merely statements of intention, not enforceable promises. Defendant is correct on both points.

Turning first to the provision set forth under the "CMS Obligations" heading, the court is guided by the principles of contract interpretation, namely: "The interpretation of a contract begins with the language of the written agreement," *Agility Pub. Warehousing*

Co. KSCP v. Mattis, 852 F.3d 1370, 1380 (Fed. Cir. 2017), and if "the contract's language is unambiguous it must be given its 'plain and ordinary' meaning," *Nw. Title Agency, Inc. v. United States*, 855 F.3d 1344, 1347 (Fed. Cir. 2017) (quoting *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1040 (Fed. Cir. 2003) (en banc)). The provision at issue, by its plain language, requires CMS, as part of a monthly reconciliation process, to make payments to insurers that underestimated their cost-sharing obligations and collect payments from insurers who overestimated their cost-sharing obligations. Indeed, CMS could not "recoup or net payments" to an insurer unless the government had already made an advance cost-sharing reduction payment to the insurer. That separate obligation to make advance cost-sharing reduction payments in the first instance is not set forth in the QHPI Agreements.

The QHPI Agreements' recitals also do not assist plaintiff. A recital is "[a] preliminary statement in a contract . . . explaining the reasons for entering into it or the background of the transaction, or showing the existence of particular facts," and often "begins with the word whereas." *Recital*, *Black's Law Dictionary* (10th ed. 2014). Recitals "generally are not considered 'contractual' and cannot be permitted to control the express provisions of the contract." *KMS Fusion, Inc. v. United States*, 36 Fed. Cl. 68, 77 (1996), *aff'd*, 108 F.3d 1393 (Fed. Cir. 1997) (unpublished table decision); *accord Barsebäck Kraft AB v. United States*, 121 F.3d 1475, 1481 (Fed. Cir. 1997) (concluding that two recital clauses in the contracts at issue—one providing that the federal agency "intends to serve" and the other providing that the federal agency

"*desires* to operate"—"facially . . . express only desires, not binding commitments"); *see also Nat'l By-Prod., Inc. v. United States*, 405 F.2d 1256, 1263 (Ct. Cl. 1969) ("Before a representation can be contractually binding, it must be in the form of a promise or undertaking. . . and not a mere statement of intention, opinion, or prediction."); Restatement (Second) of Contracts § 2 cmt. e (Am. Law Inst. 1981) ("Even if a present intention is manifested, the reservation of an option to change that intention means that there can be no promisee who is justified in an expectation of performance."). However, they can "be read in conjunction with the operative portions of a contract in order to ascertain the intention of the parties." *KMS Fusion*, 36 Fed. Cl. at 77.

The first recital relied upon by plaintiff indicates that it was "anticipated that periodic . . . advance payments of [Cost-Sharing Reductions] . . . will be due between CMS and [plaintiff]." Agreements 6. This statement is not a promise to make advanced cost-sharing reduction payments but merely an expression that such payments were expected. Indeed, it forms the factual predicate for the provision in the QHPI Agreements requiring CMS, as part of a monthly reconciliation process, to make payments to insurers that underestimated their cost-sharing obligations and collect payments from insurers who overestimated their cost-sharing obligations. The second recital relied upon by plaintiff—that plaintiff and CMS were "entering into this Agreement to memorialize the duties and obligations of the parties," *id.* at 1, merely indicates the purpose of the QHPI Agreements, which does not include obligating CMS to

make monthly advance cost-sharing reduction payments.

In sum, plaintiff has not established that the QHPI Agreements obligated the government to make cost-sharing reduction payments. Thus, its claim for breach of an express contract must be dismissed.

C. Breach of an Implied-in-Fact Contract

Finally, plaintiff alleges that the government's failure to make cost-sharing reduction payments amounts to a breach of an implied-in-fact contract. "An agreement implied in fact is 'founded upon a meeting of minds, which, although not embodied in an express contract, is inferred, as a fact, from conduct of the parties showing, in the light of the surrounding circumstances, their tacit understanding.'" *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996) (quoting *Balt. & Ohio R. Co. v. United States*, 261 U.S. 592, 597 (1923)). To establish the existence of an implied-in-fact contract with the United States, a plaintiff must demonstrate "(1) mutuality of intent to contract, (2) consideration, (3) lack of ambiguity in offer and acceptance, and (4) authority on the part of the government agent entering the contract." *Suess v. United States*, 535 F.3d 1348, 1359 (Fed. Cir. 2008); *accord Trauma Serv. Grp.*, 104 F.3d at 1326. Here, plaintiff generally alleges that the promise of cost-sharing reduction payments set forth in 42 U.S.C. § 18071(c)(3)(A) induced it to offer qualified health plans on the exchange, and that by offering such plans, it accepted the government's offer. In response, defendant argues that plaintiff has not established the existence of a valid implied-in-fact contract with the government for three reasons: the Affordable Care Act

did not create an implied-in-fact contract to make cost-sharing reduction payments, HHS lacks the authority to enter into a contract to make cost-sharing reduction payments, and the QHPI Agreements preclude the existence of an implied-in-fact contract to make cost-sharing reduction payments.

The court first addresses plaintiff's contention that 42 U.S.C. § 18071(c)(3)(A) is an offer to make cost-sharing reduction payments to insurers that offered qualified health plans on the exchanges. The Supreme Court has provided the following guidance:

> [A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that "a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." This well-established presumption is grounded in the elementary proposition that the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state. Policies, unlike contracts, are inherently subject to revision and repeal, and to construe laws as contracts when the obligation is not clearly and unequivocally expressed would be to limit drastically the essential powers of a legislative body. . . . Thus, the party asserting the creation of a contract must overcome this well-founded presumption, and we proceed cautiously both in identifying a contract within the language

> of a regulatory statute and in defining the contours of any contractual obligation.

Nat'l R.R. Passenger Corp. v. Atchison, Topeka & Santa Fe Ry. Co., 470 U.S. 451, 465-66 (1985) (citations omitted) (quoting *Dodge v. Bd. of Educ.*, 302 U.S. 74, 79 (1937)); *accord Moda Health Plan*, 892 F.3d at 1329; *Brooks v. Dunlop Mfg. Inc.*, 706 F.3d 624, 630-31 (Fed. Cir. 2012).

To determine whether 42 U.S.C. § 18071(c)(3)(A) "gives rise to a contractual obligation, 'it is of first importance to examine the language of the statute.'" *Nat'l R.R. Passenger Corp.*, 470 U.S. at 466 (quoting *Dodge*, 302 U.S. at 78); *accord Brooks*, 706 F.3d at 631. Plaintiff does not, and cannot, contend that the statute alone contains language manifesting an intent to contract. Rather, it asserts that the combination of the statute, the implementing regulations, and the government's conduct in making cost-sharing reduction payments until October 2017 reflects the parties' intent to contract. In support of its position, plaintiff relies primarily on *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). In that case, the United States Atomic Energy Commission issued a regulation titled "'Ten Year Guaranteed Minimum Price," which provided:

> To stimulate domestic production of uranium and in the interest of the common defense and security the United States Atomic Energy Commission hereby establishes the guaranteed minimum prices specified in paragraph (b) of this section, for the delivery to the Commission, in accordance with the terms of this section during the ten calendar

> years following its effective date . . . , of domestic refined uranium, high-grade uranium-bearing ores and mechanical concentrates, in not less than the quantity and grade specified in paragraph (e) of this section.

Id. at 404 (quoting 10 C.F.R. § 60.1(a) (1949)). The court rejected the defendant's contention that the regulation was "a mere invitation to the industry to make offers to the Government" and instead agreed with the plaintiff that the regulation "was an offer, which ripened into a contract when it was accepted by the plaintiff's putting itself in a position to supply the ore or the refined uranium described in it." *Id.* at 405.

The argument raised by plaintiff here is similar to the one advanced by the plaintiff in *Moda Health Plan* with respect to the risk corridors program. The risk corridors program was one of three programs established in the Affordable Care Act to mitigate the risk faced by insurers "and discourage insurers from setting higher premiums to offset that risk," *Moda Health Plan*, 892 F.3d at 1314, pursuant to which the Secretary of HHS was required to make annual payments to insurers in accordance with a statutory formula, *id.* at 1320; 42 U.S.C. § 18062. The United States Court of Appeals for the Federal Circuit concluded in *Moda Health Plan* that "the overall scheme of the risk corridors program lacks the trappings of a contractual arrangement that drove the result in *Radium Mines*," explaining:

> [In *Radium Mines*], the government made a "guarantee," it invited uranium dealers to make an "offer," and it promised to "offer a

> form of contract" setting forth "terms" of acceptance. Not so here.
>
> The risk corridors program is an incentive program designed to encourage the provision of affordable health care to third parties without a risk premium to account for the unreliability of data relating to participation of the exchanges—not the traditional quid pro quo contemplated in *Radium Mines*. Indeed, an insurer that included that risk premium, but nevertheless suffered losses for a benefit year as calculated by the statutory and regulatory formulas would still be entitled to seek risk corridors payments.

892 F.3d at 1330 (citations omitted). It further observed that the dispute in *Radium Mines* was distinguishable:

> [T]he parties in *Radium Mines*, one of which was the government, never disputed that the government intended to form some contractual relationship at some time throughout the exchange. The only question there was whether the regulations themselves constituted an offer, or merely an invitation to make offers. *Radium Mines* is only precedent for what it decided.

Id. Accordingly, it concluded that "no statement by the government evinced an intention to form a contract" to make risk corridors payments, and that "[t]he statute, its regulations, and HHS's conduct all simply worked towards crafting an incentive program." *Id.*

The risk corridors program differs from the cost-sharing reduction program in one significant manner:

in the risk corridors program, insurers receive payments as an incentive to lower their premiums, while in the cost-sharing reduction program, insurers are reimbursed by the government for cost-sharing reductions that they are statutorily required to make. In other words, the cost-sharing reduction program is less of an incentive program and more of a quid pro quo. Accordingly, that aspect of *Moda Health Plan*'s analysis is inapplicable in this case.[21]

In fact, although 42 U.S.C. § 18071(c)(3)(A) and its implementing regulation (45 C.F.R. § 156.430) do not include language traditionally associated with contracting, such as "offer," "acceptance," "consideration," or "contract," the parties' intent to enter into a contractual relationship can be implied from the quid pro quo nature of the cost-sharing reduction program, plaintiff's offering of qualified health plans on the exchange with the mandated cost-sharing reductions, and the government's reimbursement of plaintiff's cost-sharing reductions from January 2014, when the payments first became due, until October 2017. *Accord Aycock- Lindsey Corp. v. United States*, 171 F.2d 518, 521 (5th Cir. 1948) (holding that when the head of the pertinent agency "published bulletins and promulgated rules providing for the payment of subsidies to those . . . who accepted the offer by voluntarily coming under, and complying with, the [relevant] Act, there was revealed the

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[21] Nevertheless, *Moda Health Plan* precludes the court from relying on *Radium Mines* because, unlike in *Radium Mines*, the parties in this case dispute whether the government intended to form a contractual relationship for the reimbursement of insurers' cost-sharing reductions.

traditional essentials of a contract, namely, an offer and an acceptance, to the extent that we should hesitate to hold that there was not at least an implied contract to pay subsidies," and further holding that "[i]n view of the numerous requirements for the [plaintiff] to put himself in position to receive the payments, we regard the subsidies not as gratuities but as compensatory in nature"), *cited in Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 740 n.11 (1982) (identifying *Aycock-Lindsey* as a decision in which a contract was "inferred from regulations promising payment"). In other words, the government offered to reimburse insurers for their mandated cost-sharing reductions, plaintiff accepted that offer by offering the qualified health plans with reduced cost-sharing obligations, and consideration was exchanged (plaintiff supplied qualified health plans that helped the government reduce the number of uninsured individuals, and the government made cost-sharing reduction payments to plaintiff).[22]

Moreover, contrary to defendant's contention, the Secretary of HHS and his delegate, the Administrator of CMS, possessed the authority to enter into a contract with insurers to make cost-sharing reduction payments. Implied-in-fact contracts with the United States can only be made by "an authorized agent of the government." *Trauma Serv. Grp.*, 104 F.3d at 1326; *accord Kania v. United States*, 650 F.2d 264, 268 (Ct. Cl. 1981) ("The claimant for money damages for breach of an express or implied in fact contract must show that the officer who supposedly made the

[22] Defendant does not contend that there was a lack of consideration.

contract had authority to obligate appropriated funds."). Specifically, "the Government representative 'whose conduct is relied upon must have actual authority to bind the government in contract.'" *City of El Centro v. United States*, 922 F.2d 816, 820 (Fed. Cir. 1990) (quoting *Juda v. United States*, 6 Cl. Ct. 441, 452 (1984)). Actual authority may be express or implied. *See Salles v. United States*, 156 F.3d 1383, 1384 (Fed. Cir. 1998); *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). "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." *H. Landau & Co.*, 886 F.2d at 324 (quoting John Cibinic, Jr. & Ralph C. Nash, Jr., *Formation of Government Contracts* 43 (1982)) (alteration in original); *see also 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 Ralph C. Nash, Jr.& John Cibinic, Jr., *Federal Procurement Law* 5 (3d ed. 1977))).

There can be no doubt that making cost-sharing reduction payments is an integral part of the duties assigned to the Secretary of HHS because the Secretary of HHS is required to make such payments pursuant to 42 U.S.C. § 18071(c)(3)(A). Defendant contends, however, that in accordance with the Antideficiency Act, the Secretary of HHS lacks actual authority to contract for the reimbursement for cost-sharing reductions. The court is not persuaded. The Antideficiency Act provides that a government "officer or employee . . . may not . . . involve [the] government

in a contract or obligation for the payment of money before an appropriation is made unless authorized by law[.]" 31 U.S.C. § 1341(a)(1)(B). The reimbursement of cost-sharing reductions is authorized by law—42 U.S.C. § 18071(c)(3)(A). Thus, the Antideficiency Act's prohibition is inapplicable in this case. *Accord N.Y. Airways*, 369 F.2d at 752 ("Since it has been found that the [agency's] action created a 'contract or obligation (which) is authorized by law', obviously the statute [prohibiting contract obligations in excess of appropriated funds] has no application to the present situation . . . ."). In short, the Secretary of HHS possesses at least the implied actual authority to contractually bind the government to make cost-sharing reduction payments.

Defendant further contends that the QHPI Agreements executed by plaintiff and CMS preclude the existence of an implied-in-fact contract to make cost-sharing reduction payments. As defendant notes, "[t]he existence of an express contract precludes the existence of an implied contract dealing with the same subject, unless the implied contract is entirely unrelated to the express contract." *Atlas Corp. v. United States*, 895 F.2d 745, 754-55 (Fed. Cir. 1990), *cited in Schism v. United States*, 316 F.3d 1259, 1278 (Fed. Cir. 2002) (en banc); *see also Klebe v. United States*, 263 U.S. 188, 192 (1923) ("A contract implied in fact is one inferred from the circumstances or acts of the parties; but an express contract speaks for itself and leaves no place for implications."). As noted above, the QHPI Agreements only address the reconciliation of cost-sharing reduction payments, and do not create any duties or obligations to make cost-sharing reduction payments in the first instance.

Furthermore, the QHPI Agreements mostly address the privacy and security obligations set forth in 45 C.F.R. § 155.260. Accordingly, the QHPI Agreements concern a subject entirely unrelated to the purported implied-in-fact contract, and therefore do not preclude the finding of an implied-in-fact contract.

In sum, plaintiff has established the existence of an implied-in-fact contract to make cost-sharing reduction payments. Thus, the court must determine whether plaintiff also has established that the government has breached the implied-in-fact contract. As noted above, "[t]o recover for breach of contract, a party must allege and establish: (1) a valid contract between the parties, (2) an obligation or duty arising out of the contract, (3) a breach of that duty, and (4) damages caused by the breach." *San Carlos Irrigation & Drainage Dist.*, 877 F.2d at 959; *accord Trauma Serv. Grp.*, 104 F.3d at 1325. Plaintiff has established the existence of a valid contract, a government obligation to make cost-sharing reduction payments, and the government's failure to make such payments, leaving only the issue of damages.

"The general rule in common law breach of contract cases is to award damages that will place the injured party in as good a position as he or she would have been [in] had the breaching party fully performed." *Estate of Berg v. United States*, 687 F.2d 377, 379 (Ct. Cl. 1982). Thus, the injured party "must show that but for the breach, the damages alleged would not have been suffered." *San Carlos Irrigation & Drainage Dist.*, 111 F.3d at 1563; *accord Boyajian v. United States*, 423 F.2d 1231, 1235 (Ct. Cl. 1970) (per curiam) ("Recovery of damages for a breach of

contract is not allowed unless acceptable evidence demonstrates that the damages claimed resulted from and were caused by the breach."). "One way the law makes the non-breaching party whole is to give him the benefits he expected to receive had the breach not occurred." *Glendale Fed. Bank, FSB v. United States*, 239 F.3d 1374, 1380 (Fed. Cir. 2001). These expected benefits—expectancy damages—"are recoverable provided they are actually foreseen or reasonably foreseeable, are caused by the breach of the promisor, and are proved with reasonable certainty." *Bluebonnet Sav. Bank, F.S.B. v. United States*, 266 F.3d 1348, 1355 (Fed. Cir. 2001); *accord Fifth Third Bank v. United States*, 518 F.3d 1368, 1374-75 (Fed. Cir. 2008).

The injured party has the burden of proving damages caused by the breach of contract. *See Northrop Grumman Computing Sys., Inc. v. United States*, 823 F.3d 1364, 1368 (Fed. Cir. 2016); *accord Bluebonnet Sav. Bank FSB v. United States*, 67 Fed. Cl. 231, 238 (2005) (explaining that a plaintiff has the burden to prove expectancy damages by demonstrating what would have happened but for defendant's breach of contract), *aff'd*, 466 F.3d 1349 (Fed. Cir. 2006). The burden then shifts to the breaching party to establish "that plaintiff's damages claims should be reduced or denied." *Duke Energy Progress, Inc. v. United States*, 135 Fed. Cl. 279, 287 (2017). Here, plaintiff has shown that but for the government's breach, it would have received the full amount of the cost-sharing reduction payments to which it was entitled; there is no dispute that plaintiff's damages were foreseen, caused by the government's breach, and can be determined with reasonable certainty. Defendant has not attempted to

rebut plaintiff's claim of breach-of-contract damages, either through argument or evidence.[23] Accordingly, plaintiff has established its entitlement to breach-of-contract damages in the amount of the unpaid cost-sharing reduction reimbursements.

IV. CONCLUSION

For the reasons set forth above, the court concludes that the government's failure to make cost-sharing reduction payments to plaintiff violates 42 U.S.C. § 18071 and constitutes a breach of an implied-in-fact contract, but does not constitute a breach of an express contract. Therefore, it **GRANTS IN PART** and **DENIES IN PART** plaintiff's motion for summary judgment and **GRANTS IN PART** and **DENIES IN PART** defendant's motion to dismiss. By **no later than Thursday, February 28, 2019**, the parties shall file a joint status report indicating the amount due to plaintiff for its unpaid cost-sharing reduction reimbursements, taking care to separately indicate the amount due for 2017 and the amount due for 2018. If the parties are unable to provide the amount due for 2018, they shall (1) suggest a deadline for providing the court with that information and (2) indicate whether an RCFC 54(b) judgment limited

[23] In arguing that the government did not violate 42 U.S.C. § 18071(c)(3)(A), defendant asserts that insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses resulting from the nonpayment of cost-sharing reduction reimbursements, is evidence that Congress did not intend to provide a statutory damages remedy for the government's failure to make the cost-sharing reduction payments. However, defendant did not advance a similar argument in responding to plaintiff's breach-of-contract claim.

to the cost-sharing reduction claim for 2017 would be appropriate. If the parties are able to provide the amount due for 2018, the court will direct the entry of judgment on plaintiff's cost-sharing reduction claim for 2017 and 2018 pursuant to RCFC 54(b).

IT IS SO ORDERED.

s/ Margaret M. Sweeny
MARGARET M. SWEENY
Chief Judge

Appendix E

UNITED STATES COURT OF FEDERAL CLAIMS

No. 17-2057C

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff,
v.
UNITED STATES,
Defendant.

Filed: June 10, 2019

OPINION AND ORDER

SWEENEY, Chief Judge

Plaintiff Maine Community Health Options contends that the federal government ceased making the cost-sharing reduction payments to which it and other insurers are entitled under the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010), and its implementing regulations. In its February 15, 2019 Opinion and Order, the court determined that plaintiff was entitled to recover the cost-sharing reduction payments that the government did not make for 2017. Plaintiff subsequently amended its complaint to add claims for the payments that the government did not make for 2018 and moved for summary judgment on

those claims. For the reasons set forth below, the court grants plaintiff's motion.[1]

I. BACKGROUND

A. The Affordable Care Act

Congress enacted the Affordable Care Act as part of a comprehensive scheme of health insurance reform.[2] *See generally King v. Burwell*, 135 S. Ct. 2480 (2015). Specifically, the Act includes "a series of interlocking reforms designed to expand coverage in the individual health insurance market." *Id.* at 2485. In conjunction with these reforms, the Act provided for the establishment of an American Health Benefit Exchange ("exchange") in each state by January 1, 2014, to facilitate the purchase of "qualified health plans" by individuals and small businesses. 42 U.S.C. §§ 18031, 18041 (2012); *accord King*, 135 S. Ct. at 2485 (describing an exchange as "a marketplace that allows people to compare and purchase insurance plans"). Qualified health plans can be offered at four levels (bronze, silver, gold, and platinum) that differ based on how much of a plan's benefits an insurer must cover under the plan.[3] 42 U.S.C. § 18022(d)(1).

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[1] For simplicity, and to facilitate any appellate review, this decision includes the background and analysis previously set forth in the court's February 15, 2019 Opinion and Order.

[2] Seven days after enacting the Affordable Care Act, Congress enacted the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, which included additional provisions related to health insurance reform.

[3] For example, for a silver-level qualified health plan, insurers are required to provide coverage for 70% of the benefits offered under the plan. 42 U.S.C. § 18022(d)(1)(B). Insurers offering

Among the reforms included in the Affordable Care Act were two aimed at ensuring that individuals have access to affordable insurance coverage and health care: the premium tax credit enacted in section 1401 of the Act, 26 U.S.C. § 36B (2012), and the cost-sharing reduction program enacted in section 1402 of the Act, 42 U.S.C. § 18071. "The premium tax credits and the cost-sharing reductions work together: the tax credits help people obtain insurance, and the cost-sharing reductions help people get treatment once they have insurance." *California v. Trump*, 267 F. Supp. 3d 1119, 1123 (N.D. Cal. 2017).

1. Premium Tax Credit

The first of these two reforms, the premium tax credit, is designed to reduce the insurance premiums paid by individuals whose household income is between 100% and 400% of the poverty line. *See* 26 U.S.C. § 36B(c)(1)(A); 42 U.S.C. § 18082(c)(2)(B)(i); *accord* 26 C.F.R. § 1.36B-2(a) to (b) (2017); 45 C.F.R. § 156.460(a)(1) (2017). The Secretary of the Department of Health and Human Services ("Secretary of HHS") is required to determine whether individuals enrolling in qualified health plans on an exchange are eligible for the premium tax credit and, if so, to notify the Secretary of the United States Department of the Treasury ("Treasury Secretary") of that fact. 42 U.S.C. § 18082(c)(1). The Treasury Secretary, in turn, is required to make periodic advance payments of the premium tax credit to the insurers offering the qualified health plans in which

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qualified health plans on an exchange must offer at least one silver-level plan and one gold-level plan. *Id.* § 18021(a)(1)(C)(ii).

the eligible individuals enrolled. *Id.* § 18082(c)(2)(A). The insurers are required to use these advance payments to reduce the premiums of the eligible individuals. *Id.* § 18082(c)(2)(B)(i); *see also* 26 U.S.C. § 36B(f) (describing the process for annually reconciling an individual's actual premium tax credit with the advance payments of the credit). To fund the premium tax credit, Congress amended a preexisting permanent appropriation to allow for the payment of refunds arising from the credit. *See* 31 U.S.C. § 1324 (2012) ("Necessary amounts are appropriated . . . for refunding internal revenue collections as provided by law . . . . Disbursements may be made from the appropriation made by this section only for . . . refunds due from credit provisions of [26 U.S.C. § 36B].").

2. Cost-Sharing Reductions

The other reform, cost-sharing reductions, is designed to reduce the out-of-pocket expenses (such as deductibles, copayments, and coinsurance[4]) paid by individuals whose household income is between 100% and 250% of the poverty line. *See* 42 U.S.C. §§ 18022(c)(3), 18071(c)(2); *accord* 45 C.F.R. §§ 155.305(g), 156.410(a). Insurers offering qualified health plans are required to reduce eligible individuals' cost-sharing obligations by specified amounts,[5] 42 U.S.C. § 18071(a), and the Secretary of

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[4] "The term 'cost-sharing' includes . . . deductibles, coinsurance, copayments, or similar charges," but not "premiums, balance billing amounts for non-network providers, or spending for non-covered services." 42 U.S.C. § 18022(c)(3).

[5] To be eligible for cost-sharing reductions, an individual must enroll in a silver-level qualified health plan. 42 U.S.C.

HHS is required to reimburse the insurers for the cost-sharing reductions they make, *see id.* § 18071(c)(3)(A) ("[T]he Secretary [of HHS] shall make periodic and timely payments to the issuer equal to the value of the reductions.").

The Secretary of HHS is afforded some discretion in the timing of the reimbursements: once he determines which individuals are eligible for cost-sharing reductions, he must notify the Treasury Secretary "if an advance payment of the cost-sharing reductions . . . is to be made to the issuer of any qualified health plan" and, if so, the time and amount of such advance payment. *Id.* § 18082(c)(3). Pursuant to this authority, the Secretary of HHS established a reimbursement schedule by which the government "would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,486 (Mar. 11, 2013) (to be codified at 45 C.F.R. § 156.430); *see also* 45 C.F.R. § 156.430(b)(1) ("A [qualified health plan] issuer will receive periodic advance payments [for cost sharing reductions]."). The amount of the cost-sharing

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§ 18071(b)(1). Under a standard silver-level plan, insurers are required to provide coverage for 70% of the benefits offered under the plan. *Id.* § 18022(d)(1)(B). However, for eligible individuals, that percentage increases to 73% (when household income is between 200% and 250% of the poverty line), 87% (when household income is between 150% and 200% of the poverty line), or 94% (when household income is between 100% and 150% of the poverty line). *Id.* § 18071(c)(2).

reduction payments owed to insurers is based on information provided to HHS by the insurers. *See* 45 C.F.R. § 156.430(c) (requiring insurers to report to HHS, "for each policy, the total allowed costs for essential health benefits charged for the policy for the benefit year, broken down by . . . (i) [t]he amount the [insurer] paid[,] (ii) [t]he amount the enrollee(s) paid[, and] (iii) [t]he amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions").

The Affordable Care Act did not include any language appropriating funds to make the cost-sharing reduction payments.

3. Requirements for Insurers

To offer a health insurance plan on an exchange in any given year—and become eligible to receive payments for the premium tax credit and cost-sharing reductions—an insurer must satisfy certain requirements established by the Secretary of HHS. *See, e.g.*, 42 U.S.C. § 18041(a)(1) (authorizing the Secretary of HHS to "issue regulations setting standards for meeting the requirements under [title I of the Affordable Care Act] with respect to—(A) the establishment and operation of Exchanges . . . ; (B) the offering of qualified health plans through such Exchanges; . . . and (D) such other requirements as the Secretary determines appropriate"). The requirements include (1) obtaining certification that any plan it intends to offer is a qualified health plan, *see, e.g.*, 45 C.F.R. §§ 155.1000, .1010, 156.200; (2) submitting rate and benefit information before the open enrollment period for the applicable year, *see, e.g.*, *id.* §§ 155.1020, 156.210; and (3) executing a

standard Qualified Health Plan Issuer Agreement ("QHPI Agreement") with the Centers for Medicare and Medicaid Services ("CMS"), an agency of HHS,[6] for that year,[7] *see id.* § 155.260(b) (requiring exchanges to execute agreements with entities that will gain access to personally identifiable information submitted to the exchanges that address privacy and security standards and obligations); *see also id.* § 155.20 (defining "exchange" to include exchanges established and operated by either a state or HHS).

With respect to the latter requirement, each QHPI Agreement includes the following recitals:

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[6] The Secretary of HHS delegated to the Administrator of CMS (1) his authority—granted in section 1301 of the Affordable Care Act—"pertaining to defining qualified health plans"; (2) his authority—granted in section 1311 of the Affordable Care Act—"pertaining to affordable choices of health benefit plans"; and (3) his authority—granted in section 1321 of the Affordable Care Act—"pertaining to the State's flexibility in operation and enforcement of [exchanges] and related requirements." Delegation of Authorities, 76 Fed. Reg. 53,903, 53,903 (Aug. 30, 2011); *see also* 42 U.S.C. §§ 18021 (codifying section 1301 of the Affordable Care Act), 18031 (codifying section 1311 of the Affordable Care Act), 18041 (codifying section 1321 of the Affordable Care Act).

[7] The QHPI Agreements for 2017 and 2018 include, as relevant in this case, identical language. *See* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., Plan Year 2017 QHP Issuer Agreement, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Plan-Year-2017-QHP-Issuer-Agreement.pdf (last visited Feb. 1, 2019); Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., Plan Year 2018 QHP Issuer Agreement, https://www.qhpcertification.cms.gov/s/PlanYear2018_QHPIssuerAgreement_FFMSPM.pdf (last visited Feb. 1, 2019) (collectively, "Agreements").

WHEREAS:

1. Section 1301(a) of the Affordable Care Act . . . provides that [Qualified Health Plans] are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1321(a) and other requirements that an applicable Exchange may establish.
2. [Qualified Health Plan Issuer] is an entity licensed by an applicable State Department of Insurance . . . as an Issuer and seeks to offer through the [Federally-facilitated Exchange] in such State one or more plans that are certified to be [Qualified Health Plans].
3. It is anticipated that periodic [Advance Payments of the Premium Tax Credit], advance payments of [Cost-Sharing Reductions], and payments of [Federally-facilitated Exchange] user fees will be due between CMS and [Qualified Health Plan Issuer].
4. [Qualified Health Plan Issuer] and CMS are entering into this Agreement to memorialize the duties and obligations of the parties, including to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the

> adequacy of which the Parties acknowledge, [Qualified Health Plan Issuer] and CMS agree as follows . . . .

Agreements 1. Section I of each agreement is titled "Definitions." *Id.* at 1-3. Section II of each agreement, titled "Acceptance of Standard Rules of Conduct," addresses standards related to personally identifiable information (as set forth in 45 C.F.R. § 155.260) and communications with CMS's Data Services Hub. *Id.* at 3-6. Section III of each agreement is titled "CMS Obligations" and provides, in its entirety:

> a. CMS will undertake all reasonable efforts to implement systems and processes that will support [Qualified Health Plan Issuer] functions. In the event of a major failure of CMS systems and/or processes, CMS will work with [Qualified Health Plan Issuer] in good faith to mitigate any harm caused by such failure.
>
> b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [Qualified Health Plan Issuer] against amounts owed to CMS by [Qualified Health Plan Issuer] in relation to offering of [Qualified Health Plans] or any entity operating under the same tax identification number as [Qualified Health Plan Issuer] (including overpayments previously made), including the following types of payments: [Advance Payments of the

> Premium Tax Credit], advance payments of [Cost-Sharing Reductions], and payment of Federally-facilitated Exchange user fees.

Id. at 6. The remaining sections of the agreements contain various boilerplate provisions, *see id.* at 6-9, including several related to the termination of the agreements, *id.* at 6-7. One termination-related clause provides:

> [Qualified Health Plan Issuer] acknowledges that termination of this Agreement 1) may affect its ability to continue to offer [Qualified Health Plans] through the [Federally-facilitated Exchange]; 2) does not relieve [Qualified Health Plan Issuer] of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve [Qualified Health Plan Issuer] of any obligation under applicable State law to continue to offer coverage for a full plan year.

Id. at 7. Each agreement is to be executed by authorized representatives of the insurer and CMS. *Id.* at 10-11 (2017 agreement), 9-10 (2018 agreement).

In addition, in most circumstances, insurers must make their qualified health plans available on the exchanges for the entire year for which the plans were certified. 45 C.F.R. § 156.272(a).

B. Termination of Cost-Sharing Reduction Payments

On April 10, 2013, before the exchanges opened for business, President Barack H. Obama submitted to Congress his budget for fiscal year 2014. *See* Office

of Mgmt. & Budget, Exec. Office of the President, *Fiscal Year 2014 Budget of the United States Government to Congress* (2013). The budget included a request for a line-item appropriation for cost-sharing reduction payments. *See id.* at App. 448; *accord* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *Fiscal Year 2014 Justification of Estimates for Appropriations Committees* 184 (2013). However, Congress did not provide the requested appropriation. *See* Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5; *see also* S. Rep. No. 113-71, at 123 (2013) ("The Committee recommendation does not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the [Affordable Care Act]."). In fact, it is undisputed by the parties that Congress has never specifically appropriated funds to reimburse insurers for their cost-sharing reductions.[8] It is further undisputed that Congress has never (1) expressly prevented—in an appropriations act or otherwise—the Secretary of HHS or the Treasury Secretary from expending funds to make cost-sharing reduction payments or (2) amended the Affordable Care Act to eliminate the cost-sharing reduction payment obligation.

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[8] Whether Congress will appropriate funds for cost-sharing reduction payments in the future is an open question. *Cf.* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227, 283 (Jan. 24, 2019) ("The Administration supports a legislative solution that would appropriate [cost-sharing reduction] payments . . . .").

Although Congress did not specifically appropriate funds for cost-sharing reduction payments, the Obama administration began making advance payments to insurers for cost-sharing reductions in January 2014. *See* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *Guidance Related to Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015* 27 (2016). It made the payments from "the same account from which the premium tax credit" advance payments were made—in other words, from the permanent appropriation described in 31 U.S.C. § 1324. Letter from Sylvia M. Burwell, Director of the Office of Mgmt. & Budget, to Ted Cruz and Michael S. Lee, U.S. Senators 4 (May 21, 2014), http://www.cruz.senate.gov/files/documents/Letters/20140521_ Burwell_Response.pdf.

On November 21, 2014, the United States House of Representatives ("House") sued the Obama administration in the United States District Court for the District of Columbia ("D.C. district court") to stop the payment of cost-sharing reduction reimbursements to insurers. *See generally U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC (D.D.C. filed Nov. 21, 2014). The D.C. district court ruled for the House, holding:

> The Affordable Care Act unambiguously appropriates money for Section 1401 premium tax credits but not for Section 1402 reimbursements to insurers. Such an appropriation cannot be inferred. None of Secretaries' extra-textual arguments—whether based on economics, "unintended"

> results, or legislative history—is persuasive. The Court will enter judgment in favor of the House of Representatives and enjoin the use of unappropriated monies to fund reimbursements due to insurers under Section 1402. The Court will stay its injunction, however, pending appeal by either or both parties.

U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 168 (D.D.C. 2016). The Obama administration appealed the ruling. *See generally U.S. House of Representatives v. Azar* ("*Azar*"), No. 16-5202 (D.C. Cir. filed July 6, 2016). However, the United States Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") stayed the appeal to allow President-elect Donald J. Trump and his future administration time to determine how to proceed. *See* Mot. Hold Briefing Abeyance 1-2, *Azar*, No. 16-5202 (Nov. 21, 2016); Order, *Azar*, No. 16- 5202 (Nov. 21, 2016).

The Trump administration continued the previous administration's practice of making advance cost-sharing reduction payments to insurers. However, on October 11, 2017, the United States Attorney General sent a letter to the Treasury Secretary and the Acting Secretary of HHS advising that "the best interpretation of the law is that the permanent appropriation for 'refunding internal revenue collections,' 31 U.S.C. § 1324, cannot be used to fund the [cost-sharing reduction] payments to insurers authorized by 42 U.S.C. § 18071." Letter from Jefferson B. Sessions III, U.S. Attorney General, to Steven Mnuchin, Sec'y of the Treasury, and Don Wright, M.D., M.P.H., Acting Sec'y of HHS 1 (Oct. 11,

2017), http://www.hhs.gov/sites/default/files/ csr-payment-memo.pdf. Based on this guidance, the Acting Secretary of HHS directed, the following day, that "[cost-sharing reduction] payments to issuers must stop, effective immediately," and that such "payments are prohibited unless and until a valid appropriation exists." Memorandum from Eric Hargan, Acting Sec'y of HHS,[9] to Seema Verma, Administrator of the Ctrs. for Medicare & Medicaid Servs. (Oct. 12, 2017), http://www.hhs.gov/ sites/default/files/csr-payment-memo.pdf.

C. Reaction to the Termination of Cost-Sharing Reduction Payments

The Trump administration's termination of cost-sharing reduction payments did not come as a surprise to insurers:

> Anticipating that the Administration would terminate [cost-sharing reduction] payments, most states began working with the insurance companies to develop a plan for how to respond. Because the Affordable Care Act requires insurance companies to offer plans with cost-sharing reductions to customers, the federal government's failure to meet its [cost-sharing reduction] payment obligations meant the insurance companies would be losing that money. So most of the

[9] Eric Hargan was named Acting Secretary of HHS on October 10, 2017. *See* Press Release, The White House, President Donald J. Trump Announces Intent to Nominate Personnel to Key Administration Posts (Oct. 10, 2017), https://www.whitehouse .gov/presidentialactions/president-donald-j-trump-announces-intent-nominate-personnel-key-administrationposts-22/.

> states set out to find ways for the insurance companies to increase premiums for 2018 (with open enrollment beginning in November 2017) in a fashion that would avoid harm to consumers. And the states came up with an idea: allow the insurers to make up the deficiency through premium increases for silver plans only. In other words, allow a relatively large premium increase for silver plans, but no increase for bronze, gold, or platinum plans.
>
> As a result, in these states, for everyone between 100% and 400% of the federal poverty level who wishes to purchase insurance on the exchanges, the available tax credits rise substantially. Not just for people who purchase the silver plans, but for people who purchase other plans too.

California, 267 F. Supp. 3d at 1134-35 (footnote omitted). In other words, by raising premiums for silver-level qualified health plans, the insurers would obtain more money from the premium tax credit program, which would help mitigate the loss of the cost-sharing reduction payments.[10] *Accord id.* at 1139

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[10] Notably, increasing silver-level qualified health plan premiums would not harm most consumers who qualify for the premium tax credit because the credit increases as the premium increases. *See California*, 267 F. Supp. 3d at 1134 ("[T]he amount [of the premium tax credit] is based on the cost of the second-cheapest silver plan available on the exchange in your geographic area, and then adjusted based on your income (that is, based on where you fall on the spectrum between 100% and 400% of the federal poverty level). So, if premiums for the second-cheapest silver plan in your area go up, the amount of your tax credit will

(agreeing with the states "that the widespread increase in silver plan premiums will qualify many people for higher tax credits, and that the increased federal expenditure for tax credits will be far more significant than the decreased federal expenditure for [cost-sharing reduction] payments"). This approach is commonly referred to as "silver loading," and many states appear to have endorsed it, *see id.* at 1137 ("Even before the Administration announced its decision, 38 states accounted for the possible termination of [cost-sharing reduction] payments in setting their 2018 premium rates. And now that the announcement has been made, even more states are adopting [the] strategy [of increasing silver-level plan premiums to obtain additional premium tax credit payments]." (footnote omitted)).

D. Other Litigation

While the states and insurers were working on ways to mitigate the loss of cost-sharing reduction payments, the parties in the case on appeal at the D.C. Circuit began discussing that case's disposition. Joint Status Report 1-2, *Azar*, No. 16-5202 (Nov. 30, 2017). Ultimately, at the request of the parties, the D.C. Circuit dismissed the appeal, Order, *Azar*, No. 16-5202 (May 16, 2018), and the D.C. district court vacated the portion of its ruling in which it provided that "reimbursements paid to issuers of qualified health plans for the cost-sharing reductions mandated by Section 1402 of the Affordable Care Act, Pub. L.

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go up by a corresponding amount. *See* 26 U.S.C. § 36B."); *see also id.* at 1122 ("[M]ost state regulators have devised responses that give millions of lower-income people better health coverage options than they would otherwise have had.").

111-148, are ENJOINED pending an appropriation for such payments," Order, *Azar*, No. 1:14-cv-01967-RMC (May 18, 2018).

A separate lawsuit was filed by seventeen states and the District of Columbia in the United States District Court for the Northern District of California ("California district court") to compel the Trump administration to continue making the advance cost-sharing reduction payments to insurers. *See generally California v. Trump*, No. 3:17-cv-05895-VC (N.D. Cal. filed Oct. 13, 2017). The California district court denied the states' motion for a preliminary injunction. *California*, 267 F. Supp. 3d at 1121-22, 1140. Eventually, the states requested a stay of the proceedings or, alternatively, dismissal of the suit without prejudice, explaining:

> [S]taying the proceedings is warranted to avoid disturbing the status quo given the general success of the practice commonly referred to as "silver-loading" which mostly curbed the harm caused by the federal government's unjustified cessation of cost-sharing reduction (CSR) subsidies mandated by Section 1402 of the Patient Protection and Affordable Care Act (ACA). At the same time, because of the real threat of the federal government taking action to prohibit silver-loading, the Court should retain jurisdiction, thus allowing the Plaintiff States to expeditiously seek appropriate remedies from this Court for the protection of their citizens. Alternatively, if the Court determines that a stay is not appropriate at this time, the

> Plaintiff States respectfully request that the Court dismiss the action without prejudice.

Mot. for Order Staying Proceedings or, in the Alternative, Dismissing Action Without Prejudice 2, *California*, No. 3:17-cv-05895-VC (July 16, 2018); *cf.* HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. at 283 ("The Administration supports a legislative solution that would appropriate CSR payments and end silver loading. In the absence of Congressional action, we seek comment on ways in which HHS might address silver loading, for potential action in future rulemaking applicable not sooner than plan year 2021."). The California district court dismissed the case without prejudice on July 18, 2018. Order Dismissing Case Without Prejudice, *California*, No. 3:17-cv-05895-VC (July 18, 2018).

E. Effect of Cost-Sharing Reduction Payment Termination on Plaintiff

Plaintiff is a nonprofit corporation, organized as a Consumer Operated and Oriented Plan under section 1332 of the Affordable Care Act, that offers qualified health plans on Maine's exchange.[11] It began offering qualified health plans on the exchange in 2014, and continued to offer such plans in 2015, 2016, 2017, and 2018. As of the end of 2017, plaintiff had the largest number of exchange-insured individuals in Maine. Plaintiff began receiving monthly advance cost-sharing reduction payments in January 2014 and, as with every other insurer offering qualified health plans on the exchanges, stopped receiving these

[11] It appears that the facts in this subsection, which are derived from the allegations in plaintiff's complaint, are undisputed.

payments effective October 12, 2017. Plaintiff asserts that this cessation of payments has caused it to suffer large financial losses.

F. Procedural History

Plaintiff filed a complaint in this court on December 28, 2017, to recover the cost-sharing reduction payments that the government has not made for 2017.[12] It asserted two claims for relief, contending that in failing to make the cost-sharing reduction payments to insurers, the government violated the statutory and regulatory mandate and breached an implied-in-fact contract. Plaintiff moved for summary judgment and defendant cross-moved to dismiss the complaint. In its February 15, 2019 Opinion and Order, the court determined that plaintiff was entitled to recover the unpaid cost-sharing reduction reimbursements for 2017 under both the violation-of-statute and breach-of-an-implied-in-fact-

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[12] A number of other insurers have filed suit in this court seeking to recover unpaid cost-sharing reduction reimbursements. *See, e.g.*, *Common Ground Healthcare Coop. v. United States*, No. 17-877C (Chief Judge Sweeney); *Local Initiative Health Auth. for L.A. Cty. v. United States*, No. 17-1542C (Judge Wheeler); *Cmty. Health Choice, Inc. v. United States*, No. 18-5C (Chief Judge Sweeney); *Sanford Health Plan v. United States*, Nos. 18-136C and 19-569C (Judge Kaplan); *Mont. Health Co-op v. United States*, Nos. 18-143C and 19-568C (Judge Kaplan); *Molina Healthcare of Cal., Inc. v. United States*, No. 18-333C (Judge Wheeler); *Health Alliance Med. Plans, Inc. v. United States*, No. 18-334C (Judge Campbell-Smith); *Blue Cross & Blue Shield of Vt. v. United States*, No. 18-373C (Judge Horn); *Guidewell Mut. Holding Corp. v. United States*, No. 18-1791C (Judge Griggsby); *Harvard Pilgrim Health Care, Inc. v. United States*, No. 18-1820C (Judge Smith); *Blue Cross & Blue Shield of N.D. v. United States*, No. 18- 1983C (Judge Horn).

contract claims, and directed the parties to file a joint status report indicating the amount due to plaintiff.[13] *See generally Me. Cmty. Health Options v. United States*, 142 Fed. Cl. 53 (2019).

The court also issued decisions in two other cost-sharing reduction cases on February 15, 2019. *See generally Common Ground Healthcare Coop. v. United States*, 142 Fed. Cl. 38 (2019); *Cmty. Health Choice, Inc. v. United States*, 141 Fed. Cl. 744 (2019), *appeal docketed*, No. 19-1633 (Fed. Cir. Mar. 8, 2019). In both of those decisions, the court determined that the plaintiffs were entitled to recover unpaid cost-sharing reduction reimbursements for 2018. *See Common Ground*, 142 Fed. Cl. at 53; *Cmty. Health Choice*, 141 Fed. Cl. at 770. Consequently, with the court's approval, plaintiff filed an amended complaint in which it alleges that in failing to make the cost-sharing reduction payments to insurers for 2018, the government violated the statutory and regulatory mandate and breached an implied-in-fact contract. Plaintiff then filed a motion for summary judgment in which it adopts all of the arguments it advanced in support of its claims for 2017 and all of the arguments

[13] The court had the benefit of full briefing and oral argument in three cost-sharing reduction cases: *Common Ground Healthcare Cooperative v. United States*, No. 17-877C, *Maine Community Health Options v. United States*, No. 17-2057C, and *Community Health Choice, Inc. v. United States*, No. 18-5C. The plaintiffs in all three cases alleged that the government violated the cost-sharing reduction statutes and regulations, and the plaintiffs in two of the cases alleged a breach of an implied-in-fact contract. Thus, in ruling on the parties' motions in this case, the court, when applicable, considered the parties' arguments in all three cases.

advanced by the plaintiffs in *Common Ground* and *Community Health Choice*. Similarly, in its response in opposition to plaintiff's motion, defendant adopts all of the arguments it advanced in opposition to plaintiff's claims for 2017 and the claims for 2018 asserted by the plaintiffs in *Common Ground* and *Community Health Choice*. Finally, in a joint status report filed on June 7, 2019, the parties represented that the amount due to plaintiff for 2017—in accordance with the court's February 15, 2019 Opinion and Order—is $846,493.02, and the amount due to plaintiff for 2018—in the event that the court rules in plaintiff's favor on its claim for 2018—is $18,384,382.25. The court is now prepared to rule.

II. STANDARD OF REVIEW

Plaintiff moves for summary judgment pursuant to Rule 56 of the Rules of the United States Court of Federal Claims ("RCFC"). Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. RCFC 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). 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). An issue is genuine if it "may reasonably be resolved in favor of either party." *Id.* at 250. Entry of summary judgment is mandated against a party who fails to establish "an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp.*, 477 U.S. at 322. Statutory construction and contract interpretation "are questions of law amenable to resolution through summary judgment." *Stathis v.*

United States, 120 Fed. Cl. 552, 561 (2015); *accord Varilease Tech. Group, Inc. v. United States*, 289 F.3d 795, 798 (Fed. Cir. 2002) ("Contract interpretation is a question of law generally amenable to summary judgment."); *Anderson v. United States*, 54 Fed. Cl. 620, 629 (2002) ("The plaintiff's entitlement . . . rests solely upon interpretation of the cited statute and is thus amenable to resolution by summary judgment."), *aff'd*, 70 F. App'x 572 (Fed. Cir. 2003) (unpublished opinion).

III. DISCUSSION

As noted above, in seeking to recover the cost-sharing reduction payments not made by the government, plaintiff asserts two claims for relief. The court addresses each in turn.

A. Violation of Statute

Plaintiff first contends that the government's failure to make the payments was a violation of the cost-sharing reduction provisions of the Affordable Care Act and its implementing regulations. Plaintiff further contends that Congress's failure to specifically appropriate funds for cost-sharing reduction payments does not suspend or terminate the government's obligation to make the payments. Defendant disagrees, arguing that Congress expressed its intent that cost-sharing reduction payments should not be made absent a specific appropriation for that purpose by not appropriating funds for cost-sharing reductions in the Affordable Care Act or thereafter. Consequently, defendant contends, monetary damages—payable from the Judgment Fund—are unavailable from this court.

1. The Government Is Obligated to Make Cost-Sharing Reduction Payments to Plaintiff Notwithstanding the Absence of a Specific Appropriation for That Purpose

To determine whether Congress intended the government to make cost-sharing reduction payments to insurers, the court first turns to the language of the Affordable Care Act. *See Lamie v. U.S. Tr.*, 540 U.S. 526, 534 (2004) ("The starting point in discerning congressional intent is the existing statutory text."); *see also Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) ("[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there."). In addition to evaluating the specific provision of the Affordable Care Act establishing the cost-sharing reduction program, the court must read that provision in the context of the Affordable Care Act as a whole. *See King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (following "the cardinal rule that a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context" (citation omitted)); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."); *Kokoszka v. Belford*, 417 U.S. 642, 650 (1974) ("When 'interpreting a statute, the court will not look merely to a particular clause in which general words may be used, but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give to it such a construction as will carry into execution the will of the

Legislature . . . .'" (quoting *Brown v. Duchesne*, 60 U.S. 183, 194 (1856))); *see also Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) ("If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."); *Kilpatrick v. Principi*, 327 F.3d 1375, 1384 (Fed. Cir. 2003) ("[I]n determining whether Congress has directly spoken to the point at issue, a court should attempt to discern congressional intent either from the plain language of the statute or, if necessary, by resort to the applicable tools of statutory construction[.]"). If congressional intent regarding the obligation to make cost-sharing reduction payments can be ascertained from evaluating the text of the Affordable Care Act, then the court's inquiry on this issue is complete. *See Conn. Nat'l Bank*, 503 U.S. at 254.

The statutory provision governing cost-sharing reductions sets forth an unambiguous mandate: "the Secretary [of HHS] shall make periodic and timely payments" to insurers "equal to the value of the reductions" made by the insurers. 42 U.S.C. § 18071(c)(3)(A); *accord Local Initiative Health Auth. for L.A. Cty. v. United States*, 142 Fed. Cl. 1, 11 (2019) ("That provision can only mean one thing: the Government must repay [Qualified Health Plans] for their [cost-sharing reduction] expenses. The unambiguous 'shall make' language indicates a binding obligation to pay that the Court is powerless to construe any differently."); *Mont. Health Co-op v. United States*, 139 Fed. Cl. 213, 218 (2018) ("[T]he statutory language clearly and unambiguously

imposes an obligation on the Secretary of HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans as required by the [Affordable Care Act]."),[14] *appeal docketed*, No. 19-1302 (Fed. Cir. Dec. 12, 2018); *see also SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1354 (2018) ("The word 'shall' generally imposes a nondiscretionary duty."); *Gilda Indus., Inc. v. United States*, 622 F.3d 1358, 1364 (Fed. Cir. 2010) ("When a statute directs that a certain consequence 'shall' follow from specified contingencies, the provision is mandatory and leaves no room for discretion."); *cf. Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320 (2018) (concluding that similar language in section 1342 of the Affordable Care Act—indicating that the Secretary of HHS "shall establish" a risk corridors program pursuant to which the Secretary of HHS "shall pay" risk corridors payments—is "unambiguously mandatory"), *petition for cert. filed*, 87 U.S.L.W. 3330 (U.S. Feb. 4, 2019). Moreover, the mandatory payment obligation fits logically within the statutory scheme established by Congress. The cost-sharing reduction payments were meant to reimburse insurers for paying an increased share of their insureds' cost-sharing obligations, 42 U.S.C. § 18071(a)(2), (c)(3)(A), and the reduction of insureds' cost-sharing obligations was meant to make obtaining health care more affordable, *see, e.g.*, *id.*

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[14] The judge who decided *Montana Health Co-op*—the Honorable Elaine D. Kaplan—subsequently issued a substantively identical ruling in another case. *See Sanford Health Plan v. United States*, 139 Fed. Cl. 701 (2018), *appeal docketed*, No. 19-1290 (Fed. Cir. Dec. 11, 2018).

§ 18071(c)(1)(A) (describing how cost-sharing reductions would be achieved by reducing insureds' out-of-pocket limits). In short, the plain language, structure, and purpose of the Affordable Care Act reflect the intent of Congress to require the Secretary of HHS to make cost-sharing reduction payments to insurers.

Defendant does not dispute this conclusion. Rather, it contends that the cost-sharing reduction payment obligation is unenforceable because Congress never specifically appropriated funds—either in the Affordable Care Act or thereafter—to make cost-sharing reduction payments.

a. The Lack of Specific Appropriating Language in the Affordable Care Act

As defendant observes, the Affordable Care Act does not include any language specifically appropriating funds for cost-sharing reduction payments. Defendant also correctly observes that the Act's cost-sharing reduction provision lacks any appropriating language, while its companion provision—the premium tax credit—included an explicit funding mechanism.[15] *Compare* Affordable Care Act § 1401(d) (amending the permanent appropriation set forth in 31 U.S.C. § 1324 to allow for the payment of the premium tax credit), *with id.* § 1402 (containing no appropriating language). According to defendant, the absence of any funding mechanism for cost-sharing reduction payments, and

[15] Both provisions appear in subpart A of part I of subtitle E of the Affordable Care Act, which is titled "Premium Tax Credits and Cost-Sharing Reductions." 124 Stat. at 213-24.

Congress's decision to provide a funding mechanism for premium tax credit payments and not cost-sharing reduction payments, reflect the intent of Congress, when enacting the Affordable Care Act, to preclude liability for cost-sharing reduction payments. Defendant is mistaken for several reasons.

First, it is well settled that the government can create a liability without providing for the means to pay for it. *See, e.g.*, *Moda Health Plan*, 892 F.3d at 1321 ("[I]t has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances."); *Collins v. United States*, 15 Ct. Cl. 22, 35 (1879) ("[T]he legal liabilities incurred by the United States under . . . the laws of Congress . . . may be created where there is no appropriation of money to meet them . . . ."). Thus, the absence of a specific appropriation for cost-sharing reduction payments in the Affordable Care Act does not, on its own, extinguish the government's obligation to make the payments.

Second, that Congress provided a funding mechanism for premium tax credit payments and not for cost-sharing reduction payments does not reflect congressional intent to foreclose liability for the latter. Defendant relies on the proposition that when "Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983) (quoting *United States v. Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972)); *accord Digital Realty*

Trust, Inc. v. Somers, 138 S. Ct. 767, 777 (2018). Here, although Congress may have acted intentionally by treating the two related provisions differently,[16] it is difficult to discern what that intent might be. In addition to the intent inferred by defendant, there are other reasonable explanations for the disparity. One possible explanation is that it was a simple matter to add the premium tax credit to a preexisting permanent appropriation in the Internal Revenue Code for the payment of tax credits, whereas no such permanent appropriation existed that would apply to cost-sharing reduction payments. Another possible explanation is that Congress understood that other funds available to HHS could be used to make the cost-sharing reduction payments; indeed, the cost-sharing reduction provision lacks any language, such as "subject to the availability of appropriations," reflecting Congress's recognition that appropriations were unavailable, *see Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 878 (Fed. Cir. 2007) (observing that "in some instances the statute creating the right to compensation . . . may restrict the government's liability . . . to the amount appropriated by Congress" with language such as "subject to the availability of appropriations"). A third possible explanation is that Congress intended to defer appropriating funds for cost-sharing reduction payments until 2014, when

[16] Alternatively, it is possible that the disparate treatment does not reflect any intent at all. As the United States Supreme Court ("Supreme Court") recognized in *King*, "[t]he Affordable Care Act contains more than a few examples of inartful drafting." 135 S. Ct. at 2492. Thus, Congress's failure to include any appropriating language in the cost-sharing reduction provision may simply have been an oversight.

insurers began to offer qualified health plans on the exchanges and incur cost-sharing reduction liabilities. Because it is unclear which of these explanations—if any—is correct, the court declines to ascribe any particular intent to Congress based on Congress's disparate treatment of the two provisions.

Third, the court is unpersuaded by defendant's related contention that insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses from the government's nonpayment of cost-sharing reduction reimbursements, is evidence that Congress did not intend to provide a statutory damages remedy for the government's failure to make the cost-sharing reduction payments. *Accord Local Initiative*, 142 Fed. Cl. at 15; *Mont. Health Co-op*, 139 Fed. Cl. at 221. Defendant does not identify any statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation (even if insurers intentionally increased premiums to obtain larger premium tax credit payments to make up for lost cost-sharing reduction payments). Nor does defendant identify any evidence in the Affordable Care Act's legislative history suggesting that Congress intended to limit its liability to make cost-sharing reduction payments by increasing its premium tax credit payments. That insurers and states discovered a way to mitigate the insurers' losses from the government's failure to make cost-sharing reduction payments does not mean that Congress intended this result. Moreover, defendant's concern that Congress could not have intended to allow a double recovery of cost-sharing reduction

payments is not well taken. The increased amount of premium tax credit payments that insurers receive from increasing silver-level plan premiums are still premium tax credit payments, not cost-sharing reduction payments. Indeed, under the statutory scheme as it exists, even if the government were making the required cost-sharing reduction payments, insurers could (to the extent permitted by their state insurance regulators) increase their silver-level plan premiums; in such circumstances, it could not credibly be argued that the insurers were obtaining a double recovery of cost-sharing reduction payments. While the premium tax credit and cost-sharing reduction provisions were enacted to reduce an individual's health-care-related costs (to obtain insurance and to obtain health care, respectively), they are not substitutes for each other.[17]

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[17] The California district court's decision in *California v. Trump* does not assist defendant. Although the court described how insurers are coping with the lost cost-sharing reduction payments by raising silver-level qualified health plan premiums to obtain larger premium tax credit payments, nowhere in its decision does the court hold that the government's liability for cost-sharing reduction payments is lessened or eliminated by the government making larger premium tax credit payments to insurers. Indeed, the court very clearly emphasized that the premium tax credit program and the cost-sharing reduction program were separate and distinct. *See California*, 267 F. Supp. 3d at 1131. Moreover, the court's discussion of the approach taken by insurers to obtain increased premium tax credit payments was included within its analysis of "whether the absence of a preliminary injunction would harm the public and impede the objectives of health care reform." *Id.* at 1133. In other words, the court's focus was on how the increase in premiums would affect the public, and not on the government's obligation to make payments to insurers.

Fourth, it would defy common sense to conclude that Congress obligated the Secretary of HHS to reimburse insurers for their mandatory cost-sharing reductions without intending to actually reimburse the insurers. If Congress did not intend to create such an obligation, it would not have included any provision for reimbursing cost-sharing reductions in the Act.

In sum, Congress's failure to include any appropriating language in the Affordable Care Act does not reflect congressional intent to preclude liability for cost-sharing reduction payments. This conclusion, however, does not end the court's analysis because defendant also argues that Congress's subsequent failure to appropriate funds to make cost-sharing reduction payments through annual appropriations acts or otherwise signals congressional intent to foreclose liability.

b. The Lack of Specific Appropriating Language in Subsequent Appropriations Acts

The Appropriations Clause of the United States Constitution provides that "[n]o Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law[.]" U.S. Const. art. I, § 9, cl. 7. The statute commonly referred to as the Antideficiency Act further provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation[.]" 31 U.S.C. § 1341(a)(1)(A). These directives are unambiguous: disbursements from the United States Treasury require an appropriation from

Congress. However, "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." *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) (per curiam), *cited in Moda Health Plan*, 892 F.3d at 1321-22; *cf. Moda Health Plan*, 892 F.3d at 1322 (recognizing that the Supreme Court "rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government").

Defendant does not contend that any appropriations acts—or, indeed, any statutes at all—enacted after the Affordable Care Act contain language that "expressly or by clear implication" modifies or repeals the Act's cost-sharing reduction payment obligation. Rather, it relies on Congress's complete failure to appropriate funds for cost-sharing reduction payments as evidence that Congress intended to suspend the cost-sharing reduction payment obligation. Defendant's reliance is misplaced. None of the appropriations acts enacted after the Affordable Care Act expressly or impliedly disavowed the payment obligation; they were completely silent on the issue. Thus, this case is distinguishable from those relied upon by defendant—*Mitchell v. United States*, 109 U.S. 146 (1883), *Dickerson v. United States*, 310 U.S. 554 (1940), and *United States v. Will*, 449 U.S. 200 (1980)—that concerned situations in which Congress made affirmative statements in appropriations acts that reflected an intent to suspend the underlying substantive law. *Accord Local Initiative*, 142 Fed. Cl. at 14.

Here, Congress has had ample opportunity to modify, suspend, or eliminate the statutory obligation to make cost-sharing reduction payments but has not done so. Congress's inaction stands in stark contrast to its treatment of the Affordable Care Act's risk corridors program. Under that program, which was established in section 1342 of the Affordable Care Act, the Secretary of HHS was required to make annual payments to insurers pursuant to a statutory formula. 42 U.S.C. § 18062; *Moda Health Plan*, 892 F.3d at 1320. However, Congress included riders in two appropriations acts enacted after the Affordable Care Act that prohibited appropriated funds from being used to make risk corridors payments. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, tit. II, § 225, 129 Stat. 2242, 2624; Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, § 227, 128 Stat. 2130, 2491. These riders have been interpreted to suspend the government's obligation to make risk corridors payments from appropriated funds. *Moda Health Plan*, 892 F.3d at 1322-29. Congress has never enacted any such appropriations riders with respect to cost-sharing reductions payments, even when cost-sharing reduction payments were being made—during both the Obama and Trump administrations—from the permanent appropriation for tax credits described in 31 U.S.C. § 1324. Thus, the congressional inaction in this case may be interpreted, contrary to defendant's contention, as a decision not to suspend or terminate

the government's cost-sharing reduction payment obligation.[18]

In short, Congress's failure to appropriate funds to make cost-sharing reduction payments through annual appropriations acts or otherwise does not reflect a congressional intent to foreclose, either temporarily or permanently, the government's liability to make those payments.

2. Plaintiff Can Recover Unpaid Cost-Sharing Reduction Reimbursements in the United States Court of Federal Claims

Plaintiff asserts that because the government has breached its statutory obligation to make cost-sharing reduction payments, recovery is available in the United States Court of Federal Claims ("Court of Federal Claims") under the Tucker Act. The Tucker Act, the principal statute governing the jurisdiction of this court, waives sovereign immunity for claims against the United States, not sounding in tort, that are founded upon the United States Constitution, a federal statute or regulation, or an express or implied contract with the United States. 28 U.S.C. § 1491(a)(1) (2012). It is merely a jurisdictional statute and "does not create any substantive right enforceable against

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[18] The court recognizes that drawing inferences from congressional inaction can be highly problematic. *See Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) ("Congressional inaction lacks 'persuasive significance' because 'several equally tenable inferences' may be drawn from such inaction . . . ." (quoting *United States v. Wise*, 370 U.S. 405, 411 (1962)); *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 306 (1988) ("This Court generally is reluctant to draw inferences from Congress' failure to act.").

the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). Instead, the substantive right must appear in another source of law, such as a "money-mandating constitutional provision, statute or regulation that has been violated, or an express or implied contract with the United States." *Loveladies Harbor, Inc. v. United States*, 27 F.3d 1545, 1554 (Fed. Cir. 1994) (en banc). It is well accepted that a statute "is money-mandating for jurisdictional purposes if it 'can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s].'" *Fisher v. United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005) (panel portion) (quoting *United States v. Mitchell*, 463 U.S. 206, 219 (1983)). Under this rule, "[i]t is enough . . . that a statute creating a Tucker Act right be reasonably amenable to the reading that it mandates a right of recovery in damages. While the premise to a Tucker Act claim will not be 'lightly inferred,' a fair inference will do." *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 473 (2003) (citation omitted).

The cost-sharing reduction provision of the Affordable Care Act, codified at 42 U.S.C. § 18071, is a money-mandating statute for Tucker Act purposes: the Secretary of HHS is required to reimburse insurers for their mandatory cost-sharing reductions, 42 U.S.C. § 18071(c)(3)(A), and his failure to make such payments is a violation of that duty that deprives the insurers of money to which they are statutorily entitled. *Accord Local Initiative*, 142 Fed. Cl. at 10; *Mont. Health Co-op*, 139 Fed. Cl. at 217; *see also Moda Health Plan*, 892 F.3d at 1320 n.2 (holding that the statute providing for risk corridors payments "is

money-mandating for jurisdictional purposes"). Consequently, an insurer that establishes that the government failed to make the cost-sharing reduction payments to which the insurer was entitled can recover the amount due in this court.[19]

Moreover, the lack of a specific appropriation for cost-sharing reduction payments does not preclude such a recovery. Appropriations merely constrain

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[19] Defendant appears to contend that for plaintiffs to recover under a money-mandating statute, they must separately establish that the statute authorizes a damages remedy for its violation. Defendant is incorrect. Although some money-mandating statutes include a separate provision authorizing a damages remedy, *see, e.g.*, 41 U.S.C. § 7104(b) (2012) (allowing contractors to bring claims arising under the Contract Disputes Act of 1978 in the Court of Federal Claims), other money-mandating statutes pursuant to which the Court of Federal Claims can enter judgment do not, *see, e.g.*, 5 U.S.C. § 5942 (2012) (governing federal employees' entitlement to a remote duty allowance); 37 U.S.C. § 204 (2012) (governing military service members' entitlement to basic pay). Indeed, "[t]o the extent that the Government would demand an explicit provision for money damages to support every claim that might be brought under the Tucker Act, it would substitute a plain and explicit statement standard for the less demanding requirement of fair inference that the law was meant to provide a damages remedy for breach of a duty." *White Mountain Apache Tribe*, 537 U.S. at 477; *accord Fisher*, 402 F.3d at 1173 (en banc portion) ("[T]he determination that the source is money-mandating shall be determinative both as to the question of the court's jurisdiction and thereafter as to the question of whether, on the merits, plaintiff has a money-mandating source on which to base his cause of action."); *Mont. Health Co-op*, 139 Fed. Cl. at 217 n.5 ("Plaintiffs have never been required to make some separate showing that the money-mandating statute that establishes this court's jurisdiction over their monetary claims also grants them an express (or implied) cause of action for damages.").

government officials' ability to obligate or disburse funds. *See Moda Health Plan*, 892 F.3d at 1322 ("The Anti-Deficiency Act simply constrains government officials. . . . Budget authority is not *necessary* to create an obligation of the government; it is a means by which an officer is afforded that authority."); *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892) ("An appropriation *per se* merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties."). Thus, the lack of an appropriation, standing alone, does not constrain the court's ability to entertain a claim that the government has not discharged the underlying statutory obligation or to enter judgment for the plaintiff on that claim. *See Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) (en banc) ("[T]he jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid."); *N.Y. Airways*, 369 F.2d at 752 ("[T]he failure of Congress or an agency to appropriate or make available sufficient funds does not repudiate the obligation; it merely bars the accounting agents of the Government from disbursing funds and forces the carrier to a recovery in the Court of Claims."); *Collins*, 15 Ct. Cl. at 35 (remarking that a legal liability "incurred by the United States under . . . the laws of Congress," such as "[t]he compensation to which public officers are legally entitled . . . , exists independently of the appropriation, and may be enforced by proceedings in this court").

In fact, judgments of this court are payable from the Judgment Fund, *see* 31 U.S.C. § 1304(a)(3)(A), which "is a permanent, indefinite appropriation . . . available to pay many judicially and administratively ordered monetary awards against the United States," 31 C.F.R. § 256.1 (2016); *accord Bath Iron Works Corp. v. United States*, 20 F.3d 1567, 1583 (Fed. Cir. 1994) (stating that 31 U.S.C. § 1304 "was intended to establish a central, government-wide judgment fund from which judicial tribunals administering or ordering judgments, awards, or settlements may order payments without being constrained by concerns of whether adequate funds existed at the agency level to satisfy the judgment"). Indeed, as applicable here, "funds may be paid out [of the Judgment Fund] only on the basis of a judgment based on a substantive right to compensation based on the express terms of a specific statute." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990); *accord Moda Health Plan*, 892 F.3d at 1326 ("[A]ccess to the Judgment Fund presupposes liability."); *cf.* 31 U.S.C. § 1304(a)(1) (indicating that the Judgment Fund is available when "payment is not otherwise provided for"). Because plaintiff's claim arises from a statute mandating the payment of money damages in the event of its violation, the Judgment Fund is available to pay a judgment entered by the court on that claim.[20]

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[20] Defendant acknowledged this possibility in other litigation. *See* Defs.' Mem. Supp. Mot. Summ. J. 20, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("The [Affordable Care] Act requires the government to pay cost-sharing reductions to issuers. The absence of an appropriation would not prevent the insurers from seeking to enforce that statutory right through litigation. Under the Tucker Act, a plaintiff may bring suit

3. Plaintiff Is Entitled to Recover Unpaid Cost-Sharing Reduction Reimbursements

Plaintiff seeks to recover the cost-sharing reduction payments it did not receive for 2017 and 2018. As noted above, plaintiff has established that the government is obligated to reimburse it for its cost-sharing reductions pursuant to 42 U.S.C. § 18071(c)(3)(A) and that the government stopped

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against the United States in the Court of Federal Claims to obtain monetary payments based on statutes that impose certain types of payment obligations on the government. If the plaintiff is successful, it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund. The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund." (citations omitted)); Defs.' Mem. Opp'n Pl.'s Mot. Summ. J. 12-13, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("Indeed, had Congress not permanently funded the cost-sharing reductions, it would have exposed the government to litigation by insurers, who could bring damages actions under the Tucker Act premised on the government's failure to make the mandatory cost-sharing reduction payments that the Act requires."); Defs.' Reply Mem. Supp. Mot. Summ. J. 9, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("[T]he House's interpretation of the [Affordable Care Act]—under which the Act would require the government to make the cost-sharing payments but provide no appropriation for doing so directly—would invite potentially costly lawsuits under the Tucker Act. The House asserts that insurers could not prevail in such suits '[a]bsent a valid appropriation.' But courts have held that the absence of an appropriation does not necessarily preclude recovery from the Judgment Fund in a Tucker Act suit. The House does not explain how, given this precedent, the government could avoid Tucker Act litigation by insurers in the wake of a ruling that the ACA did not permanently fund the cost-sharing reduction payments that the Act directs the government to make." (citations omitted)).

making such reimbursements in October 2017. Accordingly, as the court determined in its February 15, 2019 Opinion and Order, plaintiff is entitled to recover the cost-sharing reduction payments that the government did not make for 2017.

With respect to 2018, defendant contends—as discussed above, albeit in the course of arguing that the structure of the Affordable Care Act reflects a congressional intent to preclude cost-sharing reduction payments absent an appropriation for that purpose—that plaintiff's ability to increase the premiums for its silver-level qualified health plans to obtain greater premium tax credit payments precludes recovery under the Act's cost-sharing reduction provision. Specifically, defendant asserts that the statutory scheme enacted by Congress permits insurers to make up any lost cost-sharing reduction payments by increasing silver-level plan premiums, which would prevent monetary injury to insurers. Defendant also expresses concern that allowing insurers to both obtain greater premium tax credits and obtain a judgment for their lost cost-sharing reduction payments would provide an unwarranted windfall for insurers. As noted above, the court is not convinced by defendant's arguments. Accordingly, it finds that plaintiff may recover the cost-sharing reduction payments that the government did not make for 2018.

B. Breach of an Implied-in-Fact Contract

In addition to alleging that the government violated its statutory obligation to make cost-sharing reduction payments, plaintiff contends that the government's failure to make such payments amounts

to a breach of an implied-in-fact contract. "An agreement implied in fact is 'founded upon a meeting of minds, which, although not embodied in an express contract, is inferred, as a fact, from conduct of the parties showing, in the light of the surrounding circumstances, their tacit understanding.'" *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996) (quoting *Balt. & Ohio R. Co. v. United States*, 261 U.S. 592, 597 (1923)). To establish the existence of an implied-in-fact contract with the United States, a plaintiff must demonstrate "(1) mutuality of intent to contract, (2) consideration, (3) lack of ambiguity in offer and acceptance, and (4) authority on the part of the government agent entering the contract." *Suess v. United States*, 535 F.3d 1348, 1359 (Fed. Cir. 2008); *accord Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1326 (Fed. Cir. 1997). Here, plaintiff generally alleges that the promise of cost-sharing reduction payments set forth in 42 U.S.C. § 18071(c)(3)(A) induced it to offer qualified health plans on the exchange, and that by offering such plans, it accepted the government's offer and entered into unilateral contract. Alternatively, plaintiff contends that it entered into bilateral contracts with the government, culminating in the execution of the QHPI Agreements, in which the parties agreed that plaintiff was required to offer cost-sharing reductions to its eligible insureds.[21] In response, defendant argues that

[21] The difference between unilateral and bilateral contracts was explained in the Restatement (First) of Contracts: "A unilateral contract is one in which no promisor receives a promise as consideration for his promise. A bilateral contract is one in which there are mutual promises between two parties to the contract; each party being both a promisor and a promisee."

plaintiff has not established the existence of a valid implied-in-fact contract with the government for three reasons: the Affordable Care Act did not create an implied-in-fact contract to make cost-sharing reduction payments, HHS lacks the authority to enter into a contract to make cost-sharing reduction payments, and the QHPI Agreements preclude the existence of an implied-in-fact contract to make cost-sharing reduction payments.

The court first addresses plaintiff's contention that 42 U.S.C. § 18071(c)(3)(A) is an offer to make cost-sharing reduction payments to insurers that offered qualified health plans on the exchanges. The Supreme Court has provided the following guidance:

> [A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that "a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." This well-established presumption is grounded in the elementary proposition that the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the

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Restatement (First) of Contracts § 12 (Am. Law Inst. 1931). However, that terminology was removed from the Restatement (Second) of Contracts. *See* Restatement (Second) of Contracts § 1 cmt. f (Am. Law Inst. 1981) ("Section 12 of the original Restatement defined unilateral and bilateral contracts. It has not been carried forward because of doubt as to the utility of the distinction, often treated as fundamental, between the two types."). Given the court's resolution of plaintiff's claim, the distinction is not relevant in this case.

> state. Policies, unlike contracts, are inherently subject to revision and repeal, and to construe laws as contracts when the obligation is not clearly and unequivocally expressed would be to limit drastically the essential powers of a legislative body. . . . Thus, the party asserting the creation of a contract must overcome this well-founded presumption, and we proceed cautiously both in identifying a contract within the language of a regulatory statute and in defining the contours of any contractual obligation.

Nat'l R.R. Passenger Corp. v. Atchison, Topeka & Santa Fe Ry. Co., 470 U.S. 451, 465-66 (1985) (citations omitted) (quoting *Dodge v. Bd. of Educ.*, 302 U.S. 74, 79 (1937)); *accord Moda Health Plan*, 892 F.3d at 1329; *Brooks v. Dunlop Mfg. Inc.*, 706 F.3d 624, 630-31 (Fed. Cir. 2012).

To determine whether 42 U.S.C. § 18071(c)(3)(A) "gives rise to a contractual obligation, 'it is of first importance to examine the language of the statute.'" *Nat'l R.R. Passenger Corp.*, 470 U.S. at 466 (quoting *Dodge*, 302 U.S. at 78); *accord Brooks*, 706 F.3d at 631. Plaintiff does not, and cannot, contend that the statute alone contains language manifesting an intent to contract. Rather, it asserts that the combination of the statute, the implementing regulations, and the government's conduct in making cost-sharing reduction payments until October 2017 reflects the parties' intent to contract. In support of its position, plaintiff relies primarily on *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). In that case, the United States Atomic Energy Commission

issued a regulation titled "Ten Year Guaranteed Minimum Price," which provided:

> To stimulate domestic production of uranium and in the interest of the common defense and security the United States Atomic Energy Commission hereby establishes the guaranteed minimum prices specified in paragraph (b) of this section, for the delivery to the Commission, in accordance with the terms of this section during the ten calendar years following its effective date . . . , of domestic refined uranium, high-grade uranium-bearing ores and mechanical concentrates, in not less than the quantity and grade specified in paragraph (e) of this section.

Id. at 404 (quoting 10 C.F.R. § 60.1(a) (1949)). The court rejected the defendant's contention that the regulation was "a mere invitation to the industry to make offers to the Government" and instead agreed with the plaintiff that the regulation "was an offer, which ripened into a contract when it was accepted by the plaintiff's putting itself in a position to supply the ore or the refined uranium described in it." *Id.* at 405.

The argument raised by plaintiff here is similar to the one advanced by the plaintiff in *Moda Health Plan* with respect to the risk corridors program. The risk corridors program was one of three programs established in the Affordable Care Act to mitigate the risk faced by insurers "and discourage insurers from setting higher premiums to offset that risk," *Moda Health Plan*, 892 F.3d at 1314, pursuant to which the Secretary of HHS was required to make annual

payments to insurers in accordance with a statutory formula, *id.* at 1320; 42 U.S.C. § 18062. The United States Court of Appeals for the Federal Circuit concluded in *Moda Health Plan* that "the overall scheme of the risk corridors program lacks the trappings of a contractual arrangement that drove the result in *Radium Mines*," explaining:

> [In *Radium Mines*], the government made a "guarantee," it invited uranium dealers to make an "offer," and it promised to "offer a form of contract" setting forth "terms" of acceptance. Not so here.
>
> The risk corridors program is an incentive program designed to encourage the provision of affordable health care to third parties without a risk premium to account for the unreliability of data relating to participation of the exchanges—not the traditional quid pro quo contemplated in *Radium Mines*. Indeed, an insurer that included that risk premium, but nevertheless suffered losses for a benefit year as calculated by the statutory and regulatory formulas would still be entitled to seek risk corridors payments.

892 F.3d at 1330 (citations omitted). It further observed that the dispute in *Radium Mines* was distinguishable:

> [T]he parties in *Radium Mines*, one of which was the government, never disputed that the government intended to form some contractual relationship at some time throughout the exchange. The only question there was whether the regulations

> themselves constituted an offer, or merely an invitation to make offers. *Radium Mines* is only precedent for what it decided.

Id. Accordingly, it concluded that "no statement by the government evinced an intention to form a contract" to make risk corridors payments, and that "[t]he statute, its regulations, and HHS's conduct all simply worked towards crafting an incentive program." *Id.*

The risk corridors program differs from the cost-sharing reduction program in one significant manner: in the risk corridors program, insurers receive payments as an incentive to lower their premiums, while in the cost-sharing reduction program, insurers are reimbursed by the government for cost-sharing reductions that they are statutorily required to make. In other words, the cost-sharing reduction program is less of an incentive program and more of a quid pro quo. Accordingly, that aspect of *Moda Health Plan*'s analysis is inapplicable in this case.[22] *Accord Local Initiative*, 142 Fed. Cl. at 17.

In fact, although 42 U.S.C. § 18071(c)(3)(A) and its implementing regulation (45 C.F.R. § 156.430) do not include language traditionally associated with contracting, such as "offer," "acceptance," "consideration," or "contract," the parties' intent to enter into a contractual relationship can be implied from the quid pro quo nature of the cost-sharing reduction program, plaintiff's offering of qualified

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[22] Nevertheless, *Moda Health Plan* precludes the court from relying on *Radium Mines* because, unlike in *Radium Mines*, the parties in this case dispute whether the government intended to form a contractual relationship for the reimbursement of insurers' cost-sharing reductions.

health plans on the exchange with the mandated cost-sharing reductions, and the government's reimbursement of plaintiff's cost-sharing reductions from January 2014, when the payments first became due, until October 2017. *Accord Aycock- Lindsey Corp. v. United States*, 171 F.2d 518, 521 (5th Cir. 1948) (holding that when the head of the pertinent agency "published bulletins and promulgated rules providing for the payment of subsidies to those . . . who accepted the offer by voluntarily coming under, and complying with, the [relevant] Act, there was revealed the traditional essentials of a contract, namely, an offer and an acceptance, to the extent that we should hesitate to hold that there was not at least an implied contract to pay subsidies," and further holding that "[i]n view of the numerous requirements for the [plaintiff] to put himself in position to receive the payments, we regard the subsidies not as gratuities but as compensatory in nature"), *cited in Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 740 n.11 (1982) (identifying *Aycock-Lindsey* as a decision in which a contract was "inferred from regulations promising payment"). In other words, the government offered to reimburse insurers for their mandated cost-sharing reductions, plaintiff accepted that offer by offering the qualified health plans with reduced cost-sharing obligations, and consideration was exchanged (plaintiff supplied qualified health plans that helped the government reduce the number of uninsured individuals, and the government made cost-sharing reduction payments to plaintiff).[23]

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[23] Defendant does not contend that there was a lack of consideration.

Moreover, contrary to defendant's contention, the Secretary of HHS and his delegate, the Administrator of CMS, possessed the authority to enter into a contract with insurers to make cost-sharing reduction payments. Implied-in-fact contracts with the United States can only be made by "an authorized agent of the government." *Trauma Serv. Grp.*, 104 F.3d at 1326; *accord Kania v. United States*, 650 F.2d 264, 268 (Ct. Cl. 1981) ("The claimant for money damages for breach of an express or implied in fact contract must show that the officer who supposedly made the contract had authority to obligate appropriated funds."). Specifically, "the Government representative 'whose conduct is relied upon must have actual authority to bind the government in contract.'" *City of El Centro v. United States*, 922 F.2d 816, 820 (Fed. Cir. 1990) (quoting *Juda v. United States*, 6 Cl. Ct. 441, 452 (1984)). Actual authority may be express or implied. *See Salles v. United States*, 156 F.3d 1383, 1384 (Fed. Cir. 1998); *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). "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." *H. Landau & Co.*, 886 F.2d at 324 (quoting John Cibinic, Jr. & Ralph C. Nash, Jr., *Formation of Government Contracts* 43 (1982)) (alteration in original); *see also 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 Ralph C. Nash, Jr.& John Cibinic, Jr., *Federal Procurement Law* 5 (3d ed. 1977))).

There can be no doubt that making cost-sharing reduction payments is an integral part of the duties assigned to the Secretary of HHS because the Secretary of HHS is required to make such payments pursuant to 42 U.S.C. § 18071(c)(3)(A). Defendant contends, however, that in accordance with the Antideficiency Act, the Secretary of HHS lacks actual authority to contract for the reimbursement for cost-sharing reductions. The court is not persuaded. The Antideficiency Act provides that a government "officer or employee . . . may not . . . involve [the] government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law[.]" 31 U.S.C. § 1341(a)(1)(B). The reimbursement of cost-sharing reductions is authorized by law—42 U.S.C. § 18071(c)(3)(A). Thus, the Antideficiency Act's prohibition is inapplicable in this case. *Accord N.Y. Airways*, 369 F.2d at 752 ("Since it has been found that the [agency's] action created a 'contract or obligation (which) is authorized by law', obviously the statute [prohibiting contract obligations in excess of appropriated funds] has no application to the present situation . . . ."); *Local Initiative*, 142 Fed. Cl. at 18-19. In short, the Secretary of HHS possesses at least the implied actual authority to contractually bind the government to make cost-sharing reduction payments.

Defendant further contends that the QHPI Agreements executed by plaintiff and CMS preclude the existence of an implied-in-fact contract to make cost-sharing reduction payments. As defendant notes, "[t]he existence of an express contract precludes the existence of an implied contract dealing with the same subject, unless the implied contract is entirely unrelated to the express contract." *Atlas Corp. v.*

United States, 895 F.2d 745, 754-55 (Fed. Cir. 1990), *cited in Schism v. United States*, 316 F.3d 1259, 1278 (Fed. Cir. 2002) (en banc); *see also Klebe v. United States*, 263 U.S. 188, 192 (1923) ("A contract implied in fact is one inferred from the circumstances or acts of the parties; but an express contract speaks for itself and leaves no place for implications."). However, the QHPI Agreements only address the reconciliation of cost-sharing reduction payments, and do not create any duties or obligations to make cost-sharing reduction payments in the first instance.[24] The relevant provision set forth under the "CMS Obligations" heading—"As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [plaintiff] against amounts owed to CMS by [plaintiff] in relation to offering of [Qualified Health Plans] . . . including . . . advance payments of [Cost-Sharing Reductions]," Agreements 6—merely requires CMS, as part of a monthly reconciliation process, to make payments to insurers that underestimated their cost-sharing obligations and collect payments from insurers that overestimated their cost-sharing obligations. *See Nw. Title Agency, Inc. v. United States*, 855 F.3d 1344, 1347 (Fed. Cir. 2017) ("When the contract's language is unambiguous it must be given its 'plain and ordinary' meaning . . . ." (quoting *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1040 (Fed. Cir. 2003) (en banc))). Indeed, CMS could not "recoup or net

[24] Defendant ultimately concedes this point in its reply brief. *See* Def.'s Reply 10 ("The Government agrees with plaintiff that the QHP[I] Agreements do not establish a contract for the payment of [cost-sharing reductions].").

payments" to an insurer unless the government had already made an advance cost-sharing reduction payment to the insurer.

Moreover, the relevant provision in the QHPI Agreements' recitals—"[i]t is anticipated that periodic . . . advance payments of [Cost-Sharing Reductions] . . . will be due between CMS and [plaintiff]," Agreements 1— is not a promise to make advanced cost-sharing reduction payments but is merely an expression that such payments were expected. *See Nat'l By-Prod., Inc. v. United States*, 405 F.2d 1256, 1263 (Ct. Cl. 1969) ("Before a representation can be contractually binding, it must be in the form of a promise or undertaking . . . and not a mere statement of intention, opinion, or prediction."). In fact, it forms the factual predicate for the provision describing CMS's reconciliation obligations.

Furthermore, the QHPI Agreements mostly address the privacy and security obligations set forth in 45 C.F.R. § 155.260. Accordingly, the QHPI Agreements concern a subject entirely unrelated to the purported implied-in-fact contract, and therefore do not preclude the finding of an implied-in-fact contract.

In sum, plaintiff has established the existence of an implied-in-fact contract to make cost-sharing reduction payments. Thus, the court also must determine whether plaintiff has established that the government has breached the implied-in-fact contract. "To recover for breach of contract, a party must allege and establish: (1) a valid contract between the parties, (2) an obligation or duty arising out of the contract,

(3) a breach of that duty, and (4) damages caused by the breach." *San Carlos Irrigation & Drainage Dist. v. United States*, 877 F.2d 957, 959 (Fed. Cir. 1989); *accord Trauma Serv. Grp.*, 104 F.3d at 1325 ("To prevail, [plaintiff] must allege facts showing both the formation of an express contract and its breach."). Plaintiff has established the existence of a valid contract, a government obligation to make cost-sharing reduction payments, and the government's failure to make such payments, leaving only the issue of damages.

"The general rule in common law breach of contract cases is to award damages that will place the injured party in as good a position as he or she would have been [in] had the breaching party fully performed." *Estate of Berg v. United States*, 687 F.2d 377, 379 (Ct. Cl. 1982). Thus, the injured party "must show that but for the breach, the damages alleged would not have been suffered." *San Carlos Irrigation & Drainage Dist.*, 111 F.3d at 1563; *accord Boyajian v. United States*, 423 F.2d 1231, 1235 (Ct. Cl. 1970) (per curiam) ("Recovery of damages for a breach of contract is not allowed unless acceptable evidence demonstrates that the damages claimed resulted from and were caused by the breach."). "One way the law makes the non-breaching party whole is to give him the benefits he expected to receive had the breach not occurred." *Glendale Fed. Bank, FSB v. United States*, 239 F.3d 1374, 1380 (Fed. Cir. 2001). These expected benefits—expectancy damages—"are recoverable provided they are actually foreseen or reasonably foreseeable, are caused by the breach of the promisor, and are proved with reasonable certainty." *Bluebonnet Sav. Bank, F.S.B. v. United States*, 266 F.3d 1348,

1355 (Fed. Cir. 2001); *accord Fifth Third Bank v. United States*, 518 F.3d 1368, 1374-75 (Fed. Cir. 2008).

The injured party has the burden of proving damages caused by the breach of contract. *See Northrop Grumman Computing Sys., Inc. v. United States*, 823 F.3d 1364, 1368 (Fed. Cir. 2016); *accord Bluebonnet Sav. Bank FSB v. United States*, 67 Fed. Cl. 231, 238 (2005) (explaining that a plaintiff has the burden to prove expectancy damages by demonstrating what would have happened but for defendant's breach of contract), *aff'd*, 466 F.3d 1349 (Fed. Cir. 2006). The burden then shifts to the breaching party to establish "that plaintiff's damages claims should be reduced or denied." *Duke Energy Progress, Inc. v. United States*, 135 Fed. Cl. 279, 287 (2017). Here, plaintiff has shown that but for the government's breach, it would have received the full amount of the cost-sharing reduction payments to which it was entitled; there is no dispute that plaintiff's damages were foreseen, caused by the government's breach, and can be determined with reasonable certainty. Defendant has not attempted to rebut plaintiff's claim of breach-of-contract damages, either through argument or evidence.[25] Accordingly,

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[25] In arguing that the government did not violate 42 U.S.C. § 18071(c)(3)(A), defendant asserts that insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses resulting from the nonpayment of cost-sharing reduction reimbursements, is evidence that Congress did not intend to provide a statutory damages remedy for the government's failure to make the cost-sharing reduction payments. However, defendant did not advance a similar argument in responding to plaintiff's breach-of-contract claim.

plaintiff has established its entitlement to breach-of-contract damages in the amount of the unpaid cost-sharing reduction reimbursements.

IV. CONCLUSION

For the reasons set forth above, the court concludes that the government's failure to make cost-sharing reduction payments to plaintiff violates 42 U.S.C. § 18071 and constitutes a breach of an implied-in-fact contract. Therefore, it **GRANTS** plaintiff's motion for summary judgment with respect to the cost-sharing reduction payments it did not receive for 2018. Based on this ruling and the ruling set forth in the court's February 15, 2019 Opinion and Order, plaintiff is entitled to recover damages in the amount of $19,230,875.27, which represents $846,493.02 in unpaid cost-sharing reduction reimbursements for 2017 and $18,384,382.25 in unpaid cost-sharing reduction reimbursements for 2018. No costs. The clerk shall enter judgment accordingly.

IT IS SO ORDERED.

s/ Margaret M. Sweeney
MARGARET M. SWEENEY
Chief Judge

Appendix F

RELEVANT STATUTORY PROVISIONS

26 U.S.C. § 36B. Refundable credit for coverage under a qualified health plan

(a) In general.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

(b) Premium assistance credit amount.—For purposes of this section—

> **(1) In general.**—The term "premium assistance credit amount" means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.
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> **(2) Premium assistance amount.**—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—
>
> > **(A)** the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the

State under 1311[1] of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

(3) Other terms and rules relating to premium assistance amounts.—For purposes of paragraph (2)—

(A) Applicable percentage.—

(i) In general.—Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

[1] So in original. Probably should be preceded by "section".

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

(ii) Indexing.—

(I) In general.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

(II) Additional adjustment.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be

adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) Failsafe.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

[**(iii) Repealed.** Pub.L. 111-152, Title I, § 1001(a)(1)(B), Mar. 30, 2010, 124 Stat. 1031]

(B) Applicable second lowest cost silver plan.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

(I) self-only coverage in the case of an applicable taxpayer—

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

(C) Adjusted monthly premium.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the

premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) Additional benefits.—If—

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

(E) Special rule for pediatric dental coverage.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I)[2] of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) Definition and rules relating to applicable taxpayers, coverage months, and qualified health plan.—For purposes of this section—

(1) Applicable taxpayer.—

(A) In general.—The term "applicable taxpayer" means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

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[2] Section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act, probably means section 1311(d)(2)(B)(ii) of Pub. L. 111-148, which is classified to 42 U.S.C.A. § 18031(d)(2)(B)(ii), and which does not contain subclauses.

(B) Special rule for certain individuals lawfully present in the United States.—If—

> **(i)** a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and
>
> **(ii)** the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) Married couples must file joint return.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(D) Denial of credit to dependents.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) Coverage month.—For purposes of this subsection—

(A) In general.—The term "coverage month" means, with respect to an applicable taxpayer, any month if—

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) Exception for minimum essential coverage.—

(i) In general.—The term "coverage month" shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) Minimum essential coverage.—The term "minimum essential coverage"

has the meaning given such term by section 5000A(f).

(C) Special rule for employer-sponsored minimum essential coverage.—For purposes of subparagraph (B)—

(i) Coverage must be affordable.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) Coverage must provide minimum value.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of

benefits provided under the plan is less than 60 percent of such costs.

(iii) Employee or family must not be covered under employer plan.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) Indexing.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

[**(D) Repealed.** Pub.L. 112-10, Div. B, Title VIII, § 1858(b)(1), Apr. 15, 2011, 125 Stat. 168]

(3) Definitions and other rules.—

(A) Qualified health plan.—The term "qualified health plan" has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) Grandfathered health plan.—The term "grandfathered health plan" has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(4) Special rules for qualified small employer health reimbursement arrangements.—

(A) In general.—The term "coverage month" shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.

(B) Denial of double benefit.—In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

(C) Affordable coverage.—For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—

(i) the excess of—

(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant

individual health insurance market, over

(II) 1/12 of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

(ii) 1/12 of 9.5 percent of the employee's household income.

(D) Qualified small employer health reimbursement arrangement.—For purposes of this paragraph, the term "qualified small employer health reimbursement arrangement" has the meaning given such term by section 9831(d)(2).

(E) Coverage for less than entire year.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting "the number of months during the year for which such arrangement was provided" for "12".

(F) Indexing.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(d) Terms relating to income and families.—For purposes of this section—

(1) Family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) Household income.—

(A) Household income.—The term "household income" means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) Modified adjusted gross income.—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) Poverty line.—

(A) In general.—The term "poverty line" has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) Poverty line used.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) Rules for individuals not lawfully present.—

(1) In general.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment

for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Reconciliation of credit and advance credit.—

(1) In general.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) Excess advance payments.—

(A) In general.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) Limitation on increase.—

(i) In general.—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line is:	The applicable dollar amount is:
Less than 200	$600
At least 200% but less than 300	$1,500
At least 300% but less than 400	$2,500

(ii) Indexing of amount.—In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for

"calendar year 2016" in subparagraph (A)(ii) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(3) Information requirement.—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of

circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) Regulations.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

42 U.S.C. § 18071. Reduced cost-sharing for individuals enrolling in qualified health plan

(a) In general

In the case of an eligible insured enrolled in a qualified health plan—

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) Eligible insured

In this section, the term "eligible insured" means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of Title 26, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) Determination of reduction in cost-sharing

(1) Reduction in out-of-pocket limit

(A) In general

The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket[1] limit under section 18022(c)(1) of this title in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not

[1] So in original. Probably should be "out-of-pocket"

more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) Coordination with actuarial value limits

(i) In general

The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(I) 94 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 87 percent in the case of an eligible insured described in paragraph (2)(B);

(III) 73 percent in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved; and

(IV) 70 percent in the case of an eligible insured whose household income is more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

(ii) Adjustment

The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) Additional reduction for lower income insureds

The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 94 percent of such costs;

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 87 percent of such costs; and

(C) in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of

benefits provided under the plan to 73 percent of such costs.

(3) Methods for reducing cost-sharing

(A) In general

An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) Capitated payments

The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) Additional benefits

If a qualified health plan under section 18022(b)(5) of this title offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 18031(d)(3)(B) of this title to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) Special rule for pediatric dental plans

If an individual enrolls in both a qualified health plan and a plan described in section

18031(d)(2)(B)(ii)(I)[2] of this title for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 18022(b)(1)(J) of this title.

(d) Special rules for Indians

(1) Indians under 300 percent of poverty

If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 5304(d) of Title 25) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) Items or services furnished through Indian health providers

If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services--

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[2] So in original. Probably should be "18031(d)(3)(B)(ii)(I)".

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) Payment

The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) Rules for individuals not lawfully present

(1) In general

If an individual who is an eligible insured is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present

For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority

The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to

ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Definitions and special rules

In this section:

(1) In general

Any term used in this section which is also used in section 36B of Title 26 shall have the meaning given such term by such section.

(2) Limitations on reduction

No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such title.

(3) Data used for eligibility

Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 18082 of this title and not the taxable year for which the credit under section 36B of Title 26 is allowed.