2017-2395

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff – Appellant,

v.

UNITED STATES,
Defendant – Appellee.

APPEAL FROM THE UNITED STATES COURT OF FEDERAL CLAIMS IN CASE NO. 16-967C, JUDGE ERIC G. BRUGGINK

BRIEF OF APPELLANT

October 6, 2017

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CERTIFICATE OF INTEREST

Counsel for Appellant Maine Community Health Options certifies the following:

1. Full name of every party represented by me:

   Maine Community Health Options

2. Name of Real Party in interest (Please only include any real party in interest NOT identified in Question 3) represented by me is:

   Maine Community Health Options

3. Parent corporations and publicly held companies that own 10% or more of stock in the party:

   Maine Community Health Options does not have any parent corporation, nor do any publicly held companies own 10 percent or more of Maine Community Health Options' stock.

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court (and who have not or will not enter an appearance in this case) are:

   Daniel W. Wolff, Xavier Baker, and Skye Mathieson (Crowell & Moring LLP).

5. The title and number of any case known to counsel to be pending in this or any other court or agency that will directly affect or be directly affected by this court's decision in the pending appeal:

The following cases pending before the Court of Federal Claims are related cases within the meaning of Federal Circuit Rule 47.5:

Case	Docket Number	Judge
Alliant Health Plans, Inc. v. United States	No. 16-1491C	Judge Braden
Atkins v. United States	No. 17-906C	Judge Kaplan
BCBSM, Inc. v. United States	No. 16-1253C	Judge Coster Williams
Blue Cross and Blue Shield of Alabama v. United States	No. 17-95C	Judge Campbell-Smith
Blue Cross and Blue Shield of Kansas City v. United States	No. 17-95C	Judge Braden
Blue Cross and Blue Shield of Tennessee v. United States	No. 16-651C	Judge Horn
Blue Cross of Idaho Health Service, Inc. v. United States	No. 16-1384C	Judge Lettow
Common Ground Healthcare Cooperative v. United States	No. 17-877C	Judge Sweeney
EmblemHealth, Inc. v. United States	No. 17-703C	Judge Wheeler
Farmer v. United States	No. 17-363C	Judge Campbell-Smith
First Priority Life Ins. Co. v. United States	No. 16-587C	Judge Wolski
HealthNow New York Inc. v. United States	No. 17-1090C	Judge Hodges
Health Alliance Medical Plans, Inc. v. United States	No. 17-653C	Judge Campbell-Smith
Health Net, Inc. v. United States	No. 16-1722C	Judge Wolski

Health Republic Ins. Co. v. United States	No. 16-259C	Judge Sweeney
HPHC Insurance Co., Inc. v. United States	No. 17-87C	Judge Griggsby
Harvard Pilgrim Health Care, Inc. et al. v. United States	No. 17-1350C	Judge Griggsby
HealthyCT, Inc. v. United States	No. 17-1233	Judge Firestone
Maine Community Health Options v. United States	No. 17-1387C	Judge Bruggink
Medica Health Plans v. United States	No. 17-94C	Judge Horn
Minuteman Health Inc. v. United States	No. 16-1418C	Judge Griggsby
Molina Healthcare v. United States	No. 17-97C	Judge Wheeler
Montana Health CO-OP v. United States	No. 16-1427C	Judge Wolski
Montana Health CO-OP v. United States	No. 17-1298	Judge Wolski
Neighborhood Health Plan, Inc. v. United States	No. 16-1659C	Judge Smith
New Mexico Health Connections v. United States	No. 16-1199C	Judge Bruggink
Ommen v. United States	No. 17-712C	Judge Lettow
Sanford Health Plan v. United States	No. 17-357C	Judge Bruggink
QCC Ins. Co., et al. v. United States	No. 17-1312	Judge Coster Williams
Wisconsin Physicians Service Ins. Corp. v. United States	No. 17-1070C	Judge Braden
Vullo v. United States	No. 17-1185	Judge Wolski

6. The following cases pending before this Court are related cases within the meaning of Federal Circuit Rule 47.5:

Case	Docket Number	Circuit
Blue Cross and Blue Shield of North	No. 17-2154	Federal Circuit

Carolina v. United States		
Land of Lincoln Mutual Health Ins. Co. v. United States	No. 16-1224	Federal Circuit
Moda Health Plan, Inc. v. United States	No. 17-1994	Federal Circuit

Oct. 6, 2017

/s/ Stephen J. McBrady
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STATEMENT OF RELATED CASES

No prior appeal related to the same civil proceeding has been filed.

A series of actions related to the risk-corridors payments under the Affordable Care Act are pending in the Court of Federal Claims, certain district courts, and this Court that may affect or be affected by the Court's decision in this appeal.

The following cases pending before the Court of Federal Claims are related cases within the meaning of Federal Circuit Rule 47.5:

Case	Docket Number	Judge
Alliant Health Plans, Inc. v. United States	No. 16-1491C	Judge Braden
Atkins v. United States	No. 17-906C	Judge Kaplan
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New Mexico Health Connections v. United States	No. 16-1199C	Judge Bruggink
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QCC Ins. Co., et al. v. United States	No. 17-1312	Judge Coster Williams
Wisconsin Physicians Service Ins. Corp. v. United States	No. 17-1070C	Judge Braden
Vullo v. United States	No. 17-1185	Judge Wolski

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Land of Lincoln Mutual Health Ins. Co. v. United States	No. 16-1224	Federal Circuit
Moda Health Plan, Inc. v. United States	No. 17-1994	Federal Circuit

INTRODUCTION

Prior to the passage of the Affordable Care Act ("ACA") in 2010,[1] approximately 47 million Americans did not have health insurance. Through the ACA, Congress sought to make health insurance available and affordable for all Americans. In order to do that, Congress created a new health insurance marketplace—so-called health insurance "exchanges"—through which individuals could purchase insurance from health insurance companies, including non-profit Consumer Operated and Oriented Plan ("CO-OP") insurers like the Appellant in this case. *See generally King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).

Congress needed partners—namely health insurers—to accomplish the objective of affordable health insurance for all Americans. So it made certain statutory commitments to insurers to entice them to enter the exchanges. After all, nobody (including the Government) knew how much it would cost to insure millions of

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

previously uninsured Americans—insurers lacked underwriting data and, under the ACA, nobody could be turned away.

One of the Government's statutory commitments is at the heart of this litigation: the "risk corridors program" ("RCP"). Codified in Section 1342, the RCP was designed as a temporary (three-year) program through which health insurers and the Government were to share in the risk of pricing premiums for the influx of new insureds. The RCP worked by requiring health plans that realized lower-than-expected allowable costs in a benefit (calendar) year to pay a percentage of their realized savings to the Government ("payments in") and, conversely, by requiring the Government to pay a percentage of realized excess costs to plans that realized higher-than-expected allowable costs in a benefit year ("payments out"). In this way, the RCP was designed to help stabilize the market by smoothing out gains and losses in the critical first years of the exchanges and to give insurers time to obtain sufficient experience and data to appropriately price coverage for the 2017 benefit year and beyond.

Maine Community Health Options ("Health Options") is a non-profit health insurer created, under the ACA's CO-OP program,

specifically to operate on the ACA exchanges. Unlike traditional insurers, Health Options had no other lines of business, such as large group insurance sold to employers, on which it could rely to offset the costs of operating in the untested waters of the exchanges.

At issue in this case is the Government's liability to Health Options for failing to pay what it owes Health Options under the RCP for benefit years 2014 and 2015. In both years, Health Options fully performed in accordance with its obligations under the RCP. In fact, as a result of *lower*-than-expected allowable costs in 2014, Health Options actually owed (and timely paid) the Government over $2 million under the RCP. But, despite full performance by Health Options, and despite the Government's concession that the $23 million owed to Health Options under the RCP is an "obligation of the United States Government for which full payment is required," the Government has made only partial payment to Health Options, totaling $38,363.44.[2]

[2] For benefit year 2014, Health Options owed (and paid) the Government $2,045,819.48 based on its participation in the individual market. The Government owed $241,717.00 for Health Options' participation in the small group market, but paid only $38,363.44 (*i.e.*, 15.9%) of the 2014 total. *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015). For benefit year 2015, the Government owes $22,739,206 million to Health Options for its

The Court of Federal Claims ("CFC") let the Government off the hook. It granted the Government's motion to dismiss and denied Health Options' motion for summary judgment on liability. In its decision, the CFC inexplicably declined to rule on the nature of the Government's obligation to Health Options under the RCP, but determined instead that whatever statutory obligation did exist was amended by subsequent appropriation riders, which were put into place several years *after* the enactment of the ACA (and after Health Options had performed in the relevant benefit years). As set forth below, the CFC's decision contains numerous errors of law and should be reversed and remanded with direction to grant judgment in favor of Health Options.

JURISDICTION

This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1295. On July 31, 2017, the CFC entered an Opinion and Order in *Maine Community Health Options v. United States*, 133 Fed. Cl. 1 (2017), disposing of all claims, and entered judgment. Appx1-24. The

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participation in the individual and small group markets, but has made no payment toward that amount. *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016).

lower court exercised jurisdiction over Health Options' claim of money damages pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1), and the Affordable Care Act, 42 U.S.C. § 18062. Health Options filed a timely notice of appeal to this Court on August 2, 2017. Appx791-792.

STATEMENT OF THE ISSUE

Whether the CFC erred in holding that an obligation of the U.S. Government to pay Health Options in accordance with the money-mandating statutory formula set out in Section 1342 of the ACA was subsequently amended by Congress by way of appropriations riders for the 2015 and 2016 fiscal years, respectively, despite the fact that those appropriations riders: (i) did not amend or express an intent to amend ACA Section 1342; (ii) were enacted only after the Government's obligation arose under Section 1342 for each of the affected benefit years; and (iii) did not abridge the availability of the Judgment Fund to pay judgments entered by the CFC.

STATEMENT OF THE CASE

I. THE ACA CREATED NEW MARKETPLACES TO PROVIDE AFFORDABLE HEALTHCARE TO PREVIOUSLY UNDER- AND UNINSURED POPULATIONS.

The ACA changed the healthcare industry landscape in an effort to bring affordable healthcare to scores of otherwise uninsured

individuals. Its provisions require, among other things: individuals to carry health insurance; states to facilitate online exchanges for buying and selling insurance; and private health insurance companies to guarantee coverage and provide preventative health benefits to insured individuals at no cost.

Expanding healthcare coverage comes at a cost; indeed, healthcare is complicated. The new mandates by themselves, when coupled with the uncertainty of a new and untested pool of health insurance enrollees, would have led insurers under normal market conditions to set high premiums to compensate for that uncertainty (assuming they would have decided to enter the market in the first place). Thus, in order to mitigate that risk and prevent unaffordable premiums for the millions of Americans for whom the ACA was designed to help obtain health insurance, Congress included in the ACA three marketplace premium stabilization programs, commonly referred to as the "Three Rs": (1) the RCP; (2) a transitional reinsurance program (which, like the RCP, is a temporary program for the first three benefits years under the exchanges (2014-2016)); and (3) a permanent risk adjustment program. As the Department of Health and Human Services ("HHS")—

the department responsible for implementing the ACA—stated, the RCP was intended to "protect [insurers] . . . against inaccurate rate setting" and permit insurers "to lower rates by not adding a risk premium to account for perceived uncertainties." 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013).

II. THE RCP WAS CREATED AS A RISK-SHARING PROGRAM.

Section 1342 of the ACA (42 U.S.C. § 18062) states in relevant part (emphases added):

> (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall*** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.
>
> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 of the target amount, the Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount;

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

As the statute shows, Congress was not working from scratch in creating the RCP. To the contrary, it modeled Section 1342 on the analogous risk corridors program in Medicare Part D. *See* § 1342(a). Of particular relevance to this case is the fact that payments under Medicare Part D's risk corridors program (both in and out) are made annually, and the program is not administered in a budget-neutral manner (*i.e.*, some years the Government pays out more than it takes in, and some years the opposite is true). *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year . . ."); 42 C.F.R. § 423.336 (same); U.S. Gov't Accountability Off., GAO-15-447, Patient Protection and Affordable Care Act (2015) ("GAO Part D Rep.") at 14, *available at* http://www.gao.gov/assets/670/669942.pdf ("the payments that CMS

makes to issuers [under the Medicare Part D program] is not limited to issuer contributions.").

As it was directed to do by ACA Section 1342, HHS implemented the RCP in the Code of Federal Regulations through notice-and-comment rulemaking. The resulting regulations largely parroted the statute itself as it related to the payment provisions and formulas. *See* 45 C.F.R. § 153.510. HHS also required insurers to submit data regarding their revenue and cost on an annual basis, at which point insurers were entitled to receive payment under the RCP's payment methodology. 45 C.F.R. §§ 153.510, 153.530.

At no point in the rulemaking process did HHS so much as suggest that the RCP would be administered in a budget-neutral manner. That would, of course, contradict the clear, unqualified "shall pay" directives in the statute. By contrast, HHS *did* indicate that one of the RCP's companion programs, the risk adjustment program, was budget neutral. *See* 76 Fed. Reg. 41,930, 41,938 (July 15, 2011). Furthermore, the final regulations as codified do not reflect a budget-neutral RCP. On the contrary, in the preamble to the final regulations, HHS said just the opposite—that HHS anticipated making ***prompt***

payment to insurers after making the annual determination of the amount due (or owed by the QHP issuer). *See* 77 Fed. Reg. 17,220, 17,238-39 (Mar. 23, 2012), Appx119. HHS then elaborated upon this principle a year later, in its first Notice of Benefit and Payment Parameters ("Payment Rule"), an annual rulemaking articulating the payment policies and requirements for participation in the ACA marketplaces. In that publication, HHS observed that:

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

78 Fed. Reg. at 15,473 (emphasis added), Appx123.

As HHS elsewhere observed, the point of the RCP was that insurers *and the Government* would share in the risk of setting premiums in the early years of the exchanges. *See* 77 Fed. Reg. at 17,220.

III. HEALTH OPTIONS PARTICIPATED IN THE MAINE AND NEW HAMPSHIRE EXCHANGES, RELYING ON THE RCP TO MITIGATE AGAINST MARKET INSTABILITY.

Section 1322 of the ACA established the CO-OP model to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans . . ." and promote the entry of competing entities

into the markets, with the goal of giving individuals more choice and controlling the cost of premiums. ACA § 1322. CO-OPs are required to derive substantially all of their business from the individual and small group markets served by the exchanges, where individuals can purchase health plans that meet certain standards established by CMS and the exchanges ("qualified health plans" or "QHPs").

A "QHP issuer" is any health insurer selling a QHP on the exchanges. Health Options is a QHP issuer organized under the CO-OP model. It was created specifically in response to the ACA's call for expanded and affordable health insurance and is required to participate on the exchanges. Health Options is Maine's only CO-OP insurer and attracted over 80% of enrollment through the Maine individual and small group market exchanges in its first year of operations. Its enrollment grew to over 75,000 members and it remains the largest insurer on the individual market in Maine, insuring two-thirds of the individuals in the individual market in 2016 and 45% today. But for its existence, there would have been only one carrier on Maine's individual marketplace in 2014. As a CO-OP, Health Options insures many individuals that have typically lacked insurance coverage or have been

underinsured. For example, Health Options has consistently insured 80% of the Ryan White (HIV/AIDS Program) patient population in Maine. Health Options also operated as a CO-OP insurer in New Hampshire, but withdrew from that market beginning in benefit year 2017 due in large part to financial difficulties resulting from the Government's decision to withhold $23 million in RCP payments owed to Health Options. As a result, the 89% of the New Hampshire Ryan White population that Health Options insured was forced to find new coverage or forego coverage altogether.

Health Options, like many of its peers in the industry, faced a new and untested health insurance market created by the ACA. The ACA's success depended on insurers participating in the market at a reasonable price point for the millions of uninsured Americans Congress intended to obtain insurance. Congress knew that without provisions to mitigate the risk posed, insurers like Health Options would have had to set premiums at dramatically higher rates to account for market uncertainty (if not decline to enter the market altogether, which would have reduced competition and driven up premiums in its own right). That of course would have undermined the ACA's very purpose.

Even with the RCP, the exchanges experienced substantial instability caused in part by the Government's "transitional policy"—*i.e.*, the temporary waiver of the ACA's requirements on incumbent health insurers. This transitional policy, announced *after* plans like Health Options had committed to provide insurance on the exchanges *and* priced their products, allowed healthier individuals to retain their non-ACA compliant—and therefore, cheaper—health insurance, rather than enrolling in coverage in an exchange. *See* CMS "Letter to State Insurance Commissioners" (Nov. 14, 2013), *available at* https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf. As a result, a disproportionate share of the early enrollees to the new exchange plans (QHPs) came from the ranks of the uninsured, who are statistically more costly to insure.[3]

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

Section 1342 of the ACA plainly and unambiguously mandates full payments to QHP issuers. The text mandates that the Government

[3] *See* Milliman, A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 Individual Market, at 4 (fig. 7) (July 2016), *available at* http://www.milliman.com/insight/2016/A-financial-post-mortem-Transitional-policies-and-the-financial-implications-for-the-2014-ACA-individual-market/.

"***shall pay to the plan***" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). The implementing regulations at 45 C.F.R § 153.510 reiterate that when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the amounts set forth in the ACA. (emphases added). In March 2013, HHS issued its first Payment Rule to set the payment parameters for the Three Rs (*i.e.*, the ACA's three risk mitigation programs) for the forthcoming year.[4] Consistent with the text of ACA Section 1342, its implementing regulations, and the risk corridors program administered under Medicare Part D, HHS stated that: "The risk corridors program is *not statutorily required to be budget neutral. Regardless of the balance of payments and receipts*, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473 (emphasis added), Appx123.

Subsequently, in November 2013, legislation was introduced to strike the RCP from the ACA. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013). It did not pass.

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

(Legislation was later introduced to *amend* the RCP to "ensur[e] budget neutrality." Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014). This legislation also did not pass.) Citing HHS's commitment to meeting its statutory obligations, the bill's sponsor pledged to withhold support for any forthcoming annual appropriation unless it defunded the ACA.[5]

An historic budget impasse ensued that shut down the Government for over two weeks.[6] Months later, in March 2014, HHS reversed course and indicated *for the first time* in the preamble to its 2015 Payment Rule that it intended to administer the RCP in a budget-neutral manner, and would offset current-year liabilities with future collections—directly contradicting its statement in the preamble to the 2014 Payment Rule. 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014).

HHS's reversal occurred after Health Options had already set premiums and enrolled members for the 2014 benefit year. In a follow-

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[5] Marco Rubio, The Wall Street Journal, "Marco Rubio: No Bailouts for ObamaCare" (Nov. 18, 2013), *available at* http://www.wsj.com/articles/SB10001424052702303985504579205743008770 21.

[6] *See, e.g.*, Jonathan Weisman & Jeremy W. Peters, The New York Times, "Government Shuts Down in Budget Impasse" (Sept. 30, 2013), *available at* http://www.nytimes.com/2013/10/01/us/politics/congress-shutdown-debate.html.

up Q&A guidance letter, HHS stated that it anticipated RCP "payments in" would be sufficient to cover "payments out," but that it would "establish in future guidance or rulemaking" what it would do if that assumption proved wrong. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (describing how payments would be calculated), Appx129.

Even then, however, CMS acknowledged that, notwithstanding its newly announced decision to administer the RCP in a budget-neutral manner, *full payment* remains due to insurers. *See, e.g.*, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added), Appx132.[7] In the ensuing years, HHS repeatedly

[7] *See* 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added), Appx135; CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) ("HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as [a] fiscal year 2015 obligation of the United States Government for which ***full payment is required***.") (emphasis added), Appx142; CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("[T]he Affordable Care Act requires the Secretary to make ***full payments*** to issuers" and HHS will "record payments due as an obligation of the United States Government for which ***full payment*** is required") (emphases added), Appx144; Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20,

acknowledged that the ACA requires full payment of amounts due under the RCP. Exactly *when* full payment would be remitted has never been clarified. Indeed, despite stating in its April 11, 2014 letter that it would announce through future rulemaking or guidance how the Government would cover RCP obligations in the event amounts collected were less than amounts owed, HHS has never done so.

Although Congress has never substantively amended the RCP, the appropriations riders for the 2015 and 2016 fiscal years included language (the 2015 and 2016 Spending Riders, respectively) prohibiting HHS from using certain sources of appropriated funds to pay the obligated risk corridors payments.[8] As discussed in more detail below, the Spending Riders did not amend the ACA, or nullify or even modify the Government's statutory payment obligations under the RCP.

2016), *available at* https://energy commerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (quoting Acting Administrator of CMS's testimony as part of hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight"), Appx147.

[8] Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2491 (2014) ("2015 Spending Rider"), Appx684; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2624 (2015) ("2016 Spending Rider"), Appx697 (collectively, the "Spending Riders").

V. HEALTH OPTIONS (AND MANY OTHERS) FILE SUIT TO COLLECT UNPAID RCP PAYMENTS.

Health Options filed its complaint for damages in the CFC for RCP payments owed by the Government for benefit years 2014 and 2015. Numerous other insurers have filed suit in the CFC for unpaid RCP payments. Three of those cases are currently pending before this Court. *See Land of Lincoln Mut. Health Ins. Co. v. United States*, No. 17-1224; *Moda Health Plan, Inc. v. United States*, No. 17-1994; *Blue Cross and Blue Shield of N.C. v. United States*, No. 17-2154.

At the CFC, the Government defended principally on three grounds: (1) the CFC lacked jurisdiction, either because the RCP payments Health Options seeks are not presently due or because the case is not ripe; (2) Health Options failed to state a claim because Section 1342 did not create an obligation for which the United States is liable, evidenced primarily by the fact that Congress did not appropriate funds to make RCP payments; and (3) Health Options failed to state a claim because even if Section 1342 created an obligation of the United States, that obligation was abrogated by subsequent appropriations acts.

Health Options moved for summary judgment on liability; the Government moved to dismiss for the reasons stated in the preceding paragraph. On the Government's jurisdictional defenses, the CFC ruled that it had jurisdiction because Health Options' claim was for presently due money and was ripe. *See* Appx3, Appx12. The CFC's decision on that point was consistent with every other CFC opinion that has addressed jurisdiction.[9] On the merits, the CFC expressly avoided answering the question of whether Section 1342 created an obligation of the United States in the first instance. *See* Appx12. Instead, the CFC determined that whatever obligation Section 1342 created was irrelevant because, through the Spending Riders, Congress negated whatever obligation might have otherwise existed. *See* Appx12. Health Options timely appealed. Appx791-792.

[9] *See Molina Healthcare of Calif., Inc. v. United States*, 133 Fed. Cl. 14, 28-30 (2017), *Blue Cross & Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457, 472-75 (2017), *appeal docketed*, No. 17-2154 (Fed. Cir. June 14, 2017); *Moda Health Plan, Inc., v. United States*, 130 Fed. Cl. 436, 449-51 (2017), *appeal docketed*, No. 17-1994 (Fed. Cir. May 9, 2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 776 (2017); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 95-98 (2016), *appeal docketed*, No. 17-1224 (Fed. Cir. Nov. 16, 2016).

SUMMARY OF THE ARGUMENT

Section 1342 unambiguously states that the Government "shall pay" insurers like Health Options when they have satisfied all of the statutory preconditions entitling them to payment for a benefit year. The Government's payment obligation is expressly capped at a percentage of the insurer's losses. An RCP payment, therefore, does not make the insurer whole—by receiving an RCP payment, the insurer has, by definition, lost money (in realizing excess costs). The RCP payment is intended to mitigate some of the insurer's loss. That was the point of the RCP, in which, by design, the Government shared in the risk with the insurer.

The Government's payment obligation under Section 1342 arose without regard to the availability of an appropriation to pay it. *Molina*, 133 Fed. Cl. at 30-31. That is the nature of the money-mandating "shall pay" directive. The statute itself created the obligation (when insurers performed as required). How the Government chooses to pay its obligation has no bearing on the question of its liability in the first instance.

The Spending Riders, by their text, merely placed a temporary limitation on CMS's authority to use certain appropriated funds to pay its RCP obligation—they did nothing to nullify the underlying payment obligation. The United States' statutory payment obligation had already accrued by the time the Spending Riders were enacted. *Id.* at 18, 33-36. For this reason, the presumption against retroactivity also counsels against the notion that the Spending Riders abridged the obligation created by Section 1342.

The CFC understood that the Government could only avoid liability if either of the following questions could be answered in the affirmative:

1. Is the Government's money-mandating obligation to pay—which is already limited by the express terms of the statutory formula to a certain percentage of insurers' excess costs—also *implicitly* capped to the extent of "payments-in" (*i.e.*, "budget neutral")?

   Or

2. Did the 2015 and 2016 Spending Riders fully repeal the Government's obligation?

Appx12. The court avoided the first question, and said the answer to the second question was "yes."

The court's decision cannot be squared with applicable legal principles. The court's first error was to take an analytical shortcut, by which it asserted that it need "not reach the first issue because the answer to the second question is clear." Appx12. In approaching the analysis in that manner, the CFC put the cart before the horse, analyzing Congress's attempt to annul an obligation before first analyzing what the obligation entailed. A proper analysis of the "obligation" question unequivocally establishes that Section 1342 required full and annual RCP payments.

Second, the court improperly elevated *perceived* congressional intent over actual statutory text in analyzing the Spending Riders. Under the CFC's reasoning, because the Spending Riders blocked the use of funds transferred from certain accounts, they "implicitly limited HHS to user fees funds to satisfy RCP payments." Appx10. The court then expanded its premise of "implicit" intent, stating as part of its central holding that "Congress made clear its *intention* that *no public funds* be spent to reimburse risk corridor participants *beyond their user fee contributions*." Appx21 (emphases added). The problem is that Congress never said that. Conspicuously absent from the Spending

Riders is any mention that "*no public* funds" may be spent on RCP reimbursements. Congress also *could* have barred RCP payments from "this Act or any other Act." In fact, Congress used that precise language in other provisions of the *same* Spending Riders, but did not do so with respect to payments owed under Section 1342. Because Congress only blocked *HHS's* ability to make RCP payments from certain funds, but did not bar any or all funds to pay the RCP debts *of the United States*, the Government's RCP obligations were not abrogated. Section 1342 created an obligation of the United States. The claim here is thus against the United States, not HHS (and any judgments on liability can be exercised against the Judgment Fund, as necessary).

Third, the CFC failed to apply the presumption against retroactivity based on its misunderstanding of when the Government's obligation to pay insurers arose. Specifically, the CFC failed to recognize that the Government's legal obligation under Section 1342 albeit undefinitized, attached *before* the passage of the Spending Riders in December of 2014 and 2015, respectively. The court improperly determined that the Government was not actually liable for its

"unmatured" obligation "until the end of the plan year after all of the expenses for that year are accounted for." Appx15. As such, the CFC held that "Congress timely intercepted its RCP obligations . . . by passing the appropriations provisions in December of each year." Appx15. By that logic, Health Options set 2014 rates in accordance with the statute; committed to enter the exchanges; signed up members; provided insurance for nearly the entire 2014 benefit year; and committed to provide healthcare on the exchanges for 2015; *before* any obligation to *ever* make payment arose on the part of the United States. According to the CFC, no payment obligation could arise until the accountants tallied the numbers. But in addition to the fundamental unfairness of such a framework, black letter fiscal law makes clear that obligations can arise before the Government's debt is actually due. *See* II GAO, *Principles of Fed. Appropriations Law* ("GAO Redbook"), at 7-4 - 7-5 (3d ed. 2004), *available at* http://www.gao.gov/legal/redbook/overview. For obvious reasons, a money-mandating statute can create an *obligation* before that obligation is *definitized*.

STANDARD OF REVIEW

This Court reviews dismissal of an action under Fed. R. Civ. Proc. 12(b)(6) *de novo*. *Boyle v. United States*, 200 F.3d 1369, 1372 (Fed. Cir. 2000).

ARGUMENT

The decision of the CFC should be reversed and remanded with instructions to enter judgment for Health Options.

I. SECTION 1342 REQUIRES RCP PAYMENTS TO BE MADE ANNUALLY AND IN FULL, WITHOUT REGARD TO BUDGET NEUTRALITY.

The CFC erred in concluding that it need not determine the extent and nature of the obligation defined in Section 1342. Under controlling precedent, Health Options is entitled to 2014 and 2015 RCP payments as a matter of law, and this Court should reverse the CFC's opinion and order holding otherwise.

This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and quotations omitted)). As set forth below, the RCP's text and the ACA's structure require full, annual payment.

A. Section 1342 Mandates That Insurers Receive Full Payment.

Congress effectuated the RCP's risk mitigating purpose by mandating in plain terms full payment to insurers as defined in its "Payment Methodology" without regard to budget neutrality (no differently than it mandated full payment to the Government where applicable). A risk-sharing program of this sort only works if full payment is made—risk would not be mitigated if the mitigation payments are not actually made. *See N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973) ("We cannot interpret federal statutes to negate their own stated purposes."). Not surprisingly, the text of Section 1342 and the ACA statutory scheme as a whole require full payment.

First, the text mandates that the Government "*shall pay to the plan*" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). "[T]he mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion." *Lexecon v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Congress used "shall" and "may" throughout the ACA, often within the same section of the law, underscoring Congress's deliberate intent to invoke their distinct

meanings. *See, e.g.*, ACA §§ 2713, 2717(a)(2), 1104(h); *see also Lopez v. Davis*, 531 U.S. 230, 241 (2001) ("Congress' use of the permissive 'may' . . . contrasts with the legislators' use of a mandatory 'shall' in the very same section."). The enacting Congress used "shall" to signify mandatory obligations and "may" to impose discretionary ones. The use of "shall" in Section 1342 dictated a mandatory RCP payment structure based on a formula that "explicitly capped the Government's liability at a certain percentage of a lossmaking insurer's allowable costs . . . [a]ccordingly, the Government must make full payments to insurers up to the amount specified in Section 1342." *Molina*, 133 Fed. Cl at 37, 37 n.16 (rejecting the argument that this construction exposed the Government to "uncapped liability"). The "shall pay" directive—juxtaposed with a detailed statutory formula—"unambiguously" indicates that "full" "payments out" were to be paid pursuant to that formula. *Id.* at 32-33.

In public statements (made prior to Health Options and other insurers finally and irrevocably committing to provide insurance on the exchanges), HHS acknowledged that the RCP "is not statutorily required to be budget neutral" and, in recognition of the statutory

mandate to make payment, promised payment "[r]egardless of the balance of payments and receipts." 78 Fed. Reg. at 15,473, Appx123; *see also Moda*, 130 Fed. Cl. at 456 (finding "the unambiguous language of Section 1342 dispositive" of the fact that Congress did not intend the RCP to be budget neutral).[10]

Second, Section 1342 explicitly instructed that the ACA's RCP "shall be based on" the Medicare Part D RCP, which is not budget neutral. *See* ACA § 1342(a); GAO Part D Rep. at 14 ("for the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers is not limited to issuer contributions."). This too compels rejection of a second, "implicit" cap (*i.e.*, limited to "payments in"), beyond the statute's delineated payment methodology. In modeling the RCP on the equivalent program in Medicare Part D, it is presumed that Congress legislated with awareness of how the Part D RCP is administered. *See Lorillard v.*

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

Pons, 434 U.S. 575, 580-81 (1978); *cf. Engel v. Davenport*, 271 U.S. 33, 38-39 (1926) ("The adoption of an earlier statute by reference makes it as much a part of the later act as though it had been incorporated at full length." (citations omitted)). If Congress had intended the ACA *not* to track this defining characteristic of Part D, surely Congress would have said so explicitly (or, perhaps more likely, would not have expressly stated that Section 1342 was to be "based on" Part D).

Government sharing in the risk is a critical design feature of the ACA's RCP no less than it is of the Medicare Part D RCP[11]: it was inherent to the incentive offered to insurers in exchange for their participating in the exchanges and offering affordable premiums; it is also what differentiates the RCP from the ACA's risk adjustment program (which by design redistributes payments from plans serving healthier populations to plans serving less healthy populations). *See* 77 Fed. Reg. at 17,220; 76 Fed. Reg. at 41,930, Appx114. A budget-neutral

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

program would eliminate the Government's risk and thus negate the central tenet of the RCP. Indeed, if "payments out" were subject to "payments in" and issuers experienced losses across the board, no issuer would receive anything. That is precisely the opposite of how the RCP was designed to operate.

In short, the text of Section 1342 dictates that the ACA RCP is *not* budget neutral because Congress mandated that Section 1342 "shall be based on" Medicare Part D—which is not budget neutral—a point that Congress is presumed to know.

Third—and critically—Congress's repeated and specific statements over a dozen times applying or exempting various ACA provisions from budget neutrality illustrate that Congress was aware of the implications of modeling the RCP on Medicare Part D. *See, e.g.*, ACA § 3007(p)(4)(C) ("The payment modifier established under this subsection shall be implemented in a budget neutral manner."). Yet Congress expressly *omitted* from Section 1342 any reference to budget neutrality. To find that Section 1342 is budget neutral would require the court to *insert* into Section 1342 a budget-neutrality requirement that Congress chose not to include when it passed the law. Courts "may

not add terms or provisions where Congress has omitted them . . . ." *Sale v. Haitian Ctrs. Council, Inc.*, 509 U.S. 155, 168 n.16 (1993); *Molina*, 133 Fed. Cl. at 19 ("[t]he words 'budget neutral' do not appear anywhere in the ACA's Section 1342 . . . [t]he Court should not add words if they are not there.").

Congress also omitted any words limiting RCP payments to appropriations. Congress frequently uses language, such as "subject to the availability of appropriations," to limit a statute's budget impact. *See, e.g.*, *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 188-89 (2012) (noting that certain payments were "subject to the availability of appropriations" under the statute at issue); *see also Prairie Cty., Mont. v. United States*, 113 Fed. Cl. 194, 199 (2013), *aff'd*, 782 F.3d 685 (Fed. Cir. 2015) ("the language 'subject to the availability of appropriations' is commonly used to restrict the government's liability to the amounts appropriated by Congress for the purpose." (citing *Greenlee Cty.*, 487 F.3d at 878-79)). In the RCP, however, Congress did not include such limiting language in any form, despite having specifically included such language elsewhere within the ACA. *See, e.g.*, 42 U.S.C. § 280k(a) ("The Secretary . . . shall, *subject to the availability of appropriations*,

establish a 5-year national, public education campaign . . . ." (emphasis added)).

The Government argued below that because the Congressional Budget Office (CBO) did not score Section 1342, and scored the ACA *in toto* as budget neutral, Congress must have intended for Section 1342 to be budget neutral.[12] The Government's syllogism is faulty for multiple reasons. First, whether Congress "expected" the Government to make money, lose money, or break even on the RCP does not matter. What matters is what Congress wrote in the statute it enacted. Second, whatever the CBO had to say (or not say) is irrelevant to the Court's interpretation of what Congress actually said in the statutory text. *See Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009) (stating "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent").

Third, as Judge Wheeler pointed out in granting judgment for the insurers in *Moda* and *Molina*, the CBO's "failure to speak on Section 1342's budgetary impact" says nothing about the CBO's viewpoint on

[12] In the risk corridors litigation, the Government has created a strawman in the form of supposedly "uncapped" RCP obligations. But the liability is not "uncapped"—as noted, it is statutorily fixed as a percentage of insurers' losses. *See* Argument, Section I.A.

the subject (let alone that of Congress)—if anything, the opposite inference should be drawn from the CBO's failure to address the budgetary impact of the RCP specifically given that it expressly scored the reinsurance and risk-adjustment programs as budget neutral, and presumably would have done the same for the RCP had it thought the RCP would be budget neutral. *Moda*, 130 Fed. Cl. at 455; *Molina*, 133 Fed. Cl. at 32.

Finally, in the only report in which the CBO actually addressed the budgetary impact of the RCP, it concluded the RCP was *not* budget neutral. *See* CBO, "The Budget and Economic Outlook: 2014 to 2024" (Budget Outlook) at 9 (Feb. 2014), *available at* https://www.cbo.gov/publication/45010.

Congress has repeatedly considered—but declined to pass—legislation intended to make the RCP budget neutral. *See infra* Argument, Section II.A. If the RCP were *already* budget neutral, those legislative efforts would have been unnecessary and absurd. *See, e.g.*, *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 22 n.6 (2011) (noting that congressional attempts to amend a law provide support for

the proposition that the law in its current form does not already do what the amendment proponents are seeking).

For the reasons above, the plain terms of Section 1342 mandated full payment to insurers without regard to budget neutrality.

B. Section 1342 Mandates That Insurers Receive or Remit Timely Annual Payments.

The text and structure of Section 1342 and the ACA as a whole also dictate that RCP payments—both "in" and "out"—be made on an annual basis. This is exactly how HHS understood the law, and stated that it would apply its congressional mandate. *See* 77 Fed. Reg. at 17,238-39 (stating that the same deadlines should apply to both "payments in" and "payments out"), Appx119-120; 78 Fed. Reg. at 15,473 (setting a 30-day deadline from determination of charges for insurers to make "payments in"), Appx123.

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

The RCP's text requires HHS to pay insurers the amount owed annually. First, the RCP explicitly states that "for any plan year . . . [HHS] shall pay to the plan" the delineated amounts. "Plan year" means 12 consecutive months under the ACA. 45 C.F.R. § 155.20

(in related Exchange Establishment Rule, defining "*Plan year*" as a "consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise."); *see Moda*, 130 Fed. Cl. at 451-53 (the calculation of payment amounts in and out of the program on a "plan year" basis reflects an annual program).

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

Third, Congress, by referencing the plural "corridors" when it directed that HHS "shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," did so intentionally to create risk corridors for each of the calendar years referenced. ACA § 1342(a); *see Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) ("Ordinarily the legislature by use of a plural term intends a reference to more than one matter or thing") (quotation and citations omitted); *Dakota, Minn. & E.R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) (finding that Congress's use of the plural was evidence of its intent); *Moda*, 130 Fed. Cl. at 451-52 (holding that Section 1342 requires *annual* payments and finding that Section 1342 "offer[s] clues as to Congress's intent" by requiring an RCP for "calendar years 2014, 2015, and 2016" rather than "calendar years 2014 through 2016"). Congress is presumed to draft statutes purposefully. *See Arcadia v. Ohio Power Co.*, 498 U.S. 73, 79 (1990) ("In casual conversation, perhaps, such absentminded duplication and omission are possible, but Congress is not presumed to draft its laws that way."). Congress intended to create three risk corridors, one for each year the RCP was in effect.

Fourth, Congress further underscored the annual payment structure dictated by the RCP's plain text by mandating that the RCP "shall be based on the program for regional participating provider organizations under [the Medicare Part D risk mitigation program]." ACA § 1342(a). Medicare Part D explicitly provides for a "risk corridor" specific to each year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year . . ."); *see also* 42 C.F.R. § 423.336(a)(2)(i) (same). Part D also requires payment for each risk corridor in the year following the corridor. *See* 42 C.F.R. § 423.336(c)(2) (CMS makes payments "in the following payment year . . . ."); *see also Moda*, 130 Fed. Cl. at 452 (noting Congress's explicit directive that the RCP be "based on" the Medicare Part D's annual RCP). Congress reinforced its explicit provision for annual "payments out" in the text of the RCP by reference to the only other comparable risk mitigation program—a program premised on annual payments.[13]

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

2. HHS Interpreted the RCP to Require Timely Annual Payments.

HHS's contemporaneous interpretation of Section 1342 was consistent with the statutory text and Health Options' expectation of annual payment, and it is the only interpretation that is consistent with the RCP's purpose. First, HHS immediately recognized that the RCP "serves to protect against uncertainty in rate setting by qualified health plans *sharing risk* in losses and gains *with the Federal government*," 77 Fed. Reg. at 17,220 (emphases added), and will do so by "limiting the extent of issuer losses (and gains)." 76 Fed. Reg. at 41,930, Appx114. It reiterated that principle in its final rule, and accordingly indicated that it would "address the risk corridors payment deadline in the HHS notice of benefit and payment parameters," noting that:

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

77 Fed. Reg. at 17,238 (emphasis added), Appx119.

In its first Payment Rule, HHS set a 30-day deadline for issuers to remit payment upon notification of charges. *See* 78 Fed. Reg. at 15,473, Appx123. And, as HHS stated in the preamble to its implementing

regulations, it believed the same deadline should apply to both "payments in" and "payments out" of the program. Significantly, HHS requires insurers to submit their data to HHS ***annually*** to facilitate calculation of RCP payments. 45 C.F.R. § 153.530(d).

Thus, before the dispute arose, the Government agreed that Congress intended both RCP payments to the Government and from the Government to be made annually. And for good reason: that is the only reading that is consistent with the text and the overall purpose and structure of the ACA. A premium rate stabilization program would not do much good if insurers could not rely on complete and timely payment. As the Supreme Court pointed out, Congress designed the ACA to prevent an economic "death spiral," in which "premiums rose higher and higher, and the number of people buying insurance sank lower and lower, [and] insurers began to leave the market entirely." *King*, 135 S. Ct. at 2486. A program by which the Government mitigated insurers' risk by sharing in that risk was necessary to incentivize health insurance companies to enter and remain on the exchanges. *See, e.g.*, *Health Republic*, 129 Fed. Cl. at 776 ("If these programs did not provide for prompt compensation to insurers upon the

calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges. Further, if enough insurers left the exchanges, one of the goals of the Affordable Care Act—the creation of 'effective health insurance markets,'—would be unattainable." (internal citations omitted)).[14]

HHS's original interpretation is fully supported by the fact that the very "death spiral" the Supreme Court recognized, and that the RCP was intended to avoid, has resulted, at least in part, from Congress's failure to appropriate sufficient funds to satisfy the Government's RCP obligations.[15] To suggest, as the Government does

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[14] It is worth noting that CMS *actually made* an annual RCP payment for the 2014 benefit year (albeit an incomplete one), a fact which makes no sense if the Government's payment obligation was not annual. *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (conceding that the remaining amounts owed to Health Options are an "obligation of the United States Government for which full payment is required."), Appx142.

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

in this litigation, that insurers of all sizes that sustain significant short-term losses, and report on their costs and receipts on an annual basis as the ACA requires them to do, can readily bear those losses over multiple years, all while keeping premiums affordable for enrollees in each successive year, is anathema to the structure and purpose of the ACA. "It is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494 (citations omitted); *accord Bob Jones Univ. v. United States*, 461 U.S. 574, 586 (1983) (statutory interpretations that frustrate the object and purpose of the statute are disfavored).

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

The Government argued below that Congress never specified an appropriation to fund the RCP and that, therefore, no obligation ever arose. That is error, conflating Congress's sovereign authority to obligate the United States in the first instance (*i.e.*, create a liability) with Congress's authority to appropriate funds to pay its obligations. As discussed *supra* at Argument, Section I.A., Congress did not limit

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have announced their withdrawal from the ACA marketplaces or the individual market . . . .").

the Government's RCP liability with its typical words of limitation (*e.g.*, "subject to appropriations"). Nor, as a matter of fiscal law, does the Government's liability for full and annual RCP payments turn on whether Congress specifically appropriated funds.

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

Collins v. United States, 15 Ct. Cl. 22, 35 (1879) (emphases added).[16]

Under the Tucker Act, Health Options may recover unpaid funds when

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[16] *See also United States v. Langston*, 118 U.S. 389, 391-94 (1886) (finding the Government liable for statutory promise of payment in absence of a specific appropriation); *Strong v. United States*, 60 Ct. Cl. 627, 630 (1925) (awarding statutorily mandated military pay despite lack of an appropriation); *Parsons v. United States*, 15 Ct. Cl. 246, 246-47 (1879) (awarding statutorily mandated payment despite lack of an appropriation, noting that "*[t]he absence of an appropriation constitutes no bar to the recovery of a judgment in cases where the liability of the government has been established.*") (emphasis added); *see also Graham v. United States*, 1 Ct. Cl. 380, 382 (1865) (entering judgment for difference where congressional appropriation fell short of statutorily obligated amount); *Miller v. United States*, 86 Ct. Cl. 609, 610 (1938) (same); *Danford v. United States*, 62 Ct. Cl. 285, 287-88 (1926) (entering judgment for statutorily promised payment amount where no

the Government fails to meet its obligation under a money-mandating statute. *See, e.g.*, *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012); *District of Columbia v. United States*, 67 Fed. Cl. 292, 302-05 (2005). The RCP is unequivocally money-mandating because, *inter alia*, it dictates that the Government "shall pay" RCP payments. Whether, when, and how Congress appropriates the required funds are irrelevant to this Court's decision regarding the Government's legal *obligation* to make the full "payments out" in the first instance. There is no requirement for Congress to create a specific appropriation. *See, e.g.*, *Langston*, 118 U.S. at 391-94 (Government liable for statutory promise to pay despite absence of a specific appropriation); *Collins*, 15 Ct. Cl. at 35; *supra* note 16.

This Court's decision in *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011) (*en banc*), drives home the point. *Slattery* addressed whether the Government could be sued under the Tucker Act for breaches committed by a Government entity that was not funded by appropriations ("NAFI"). The Government argued that because a NAFI

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congressional appropriation was made, noting that "[t]he fact that Congress made no appropriation for the two years for which [Plaintiff] was not paid does not preclude the plaintiff from obtaining relief in this court.").

is not funded by appropriations, there was no Tucker Act jurisdiction to adjudicate claims for a NAFI breach. After canvassing the long line of cases from the Court of Claims, Federal Circuit, and Supreme Court, this Court abrogated its own contrary precedent[17] and held that the Tucker Act's broad grant of jurisdiction for any claim "founded either upon . . . any Act of Congress or . . . upon any express or implied contract with the United States . . .," 28 U.S.C. § 1491(a)(1), was *not* limited to the subset of instances where a specific appropriation could be identified. It held, "the jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid." *Slattery*, 635 F.3d at 1321. The Court ruled that any resulting judgment—despite the lack of appropriations involved in creating the original obligation—could be satisfied by the Judgment Fund. *See id.* at 1317 (Judgment Fund's purpose "was to avoid the need for specific appropriations to pay [Court of Claims] judgments").

Although *Slattery* specifically addressed jurisdiction over a contract claim, the holding applies with equal force here because the

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

Tucker Act draws no distinction between constitutional, statutory, or contract claims against the Government. The Government's argument that RCP plaintiffs must identify a specific appropriation as a predicate condition to state a claim under Section 1342 amounts to a ***second*** "jurisdictional" test of the very sort rejected in *Slattery*. *Id.* at 1316 (reasoning that Tucker Act jurisdiction is determined by identification of a money-mandating statute; hence, there is no need to identify a specific appropriation which would amount to a "second waiver" of sovereign immunity (citing *Mitchell v. United States*, 463 U.S. 206, 218 (1983))).

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

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

As Judge Wheeler pointed out in *Molina*, the Government's argument that Section 1342 could not have created an obligation on the part of the United States absent Congress *also* creating a dedicated appropriation "is completely contrary to a mountain of controlling case law holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation." 133 Fed. Cl. at 36. Similarly, addressing Section 1342 specifically and a GAO report about how the RCP was to be funded, the federal district court for the District of Columbia observed that "not only is it possible for a statute to authorize and mandate payments without making an appropriation, but GAO has found a prime example in the ACA." *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d

165, 185 (D.D.C. 2016). The Government itself acknowledged this principle, arguing (in total agreement with Health Options here) that:

> ***a plaintiff may establish liability irrespective of an appropriation***, and then if successful –
>
> ***it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund***, 31 U.S.C. § 1304(a). The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund.

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

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

II. LATER APPROPRIATIONS ACTS DID NOT ABOLISH THE GOVERNMENT'S RCP OBLIGATIONS.

The CFC made two critical errors in determining that the Spending Riders repealed the Government's payment obligations under Section 1342. First, the CFC erred by failing to analyze the nature of the Government's obligation under Section 1342, as addressed in the

preceding section of this brief. The problem, as Judge Wheeler pointed out in *Molina*, is that if a court does not first consider and fully appreciate the obligation created in the first instance, it cannot apply the proper legal norms for analyzing what effect, if any, subsequent actions of Congress had on that obligation.

Second, due in large part to its failure to consider the obligation created by Section 1342 in the first instance, the CFC erred in finding that a subsequent Congress, through the Spending Riders, somehow abolished any obligation the Government otherwise had to make the RCP payments claimed by Health Options.

The fact that Congress curtailed *HHS's* ability to make RCP payments through appropriations riders, well after the exchanges were under way, and after the Government's obligations to Health Options (and other issuers) had already accrued, cannot alter the *Government's liability* for its extant RCP obligations. The debt claimed is that of the United States, in light of Health Options performing on the exchanges in accordance with the statutory requirements of Section 1342. The fact that the Spending Riders limited the administering agency's ability to make payment did not abolish the Government's obligation. *See Moda*,

130 Fed. Cl. at 455-62 (finding that neither the 2015 nor 2016 Spending Riders repealed or amended the RCP).

As discussed above, the existence of a legal obligation is distinct from the means by which the Government fulfills the Government's obligation. The fact that the appropriations riders imposed temporary restrictions on specific funding sources for HHS to fulfill those obligations did not modify the underlying obligations. There is a clear distinction between appropriations legislation (for annual funding of discretionary government operations) and substantive legislation (which fixes rights and obligations, including of the United States itself). Indeed, Congress considered substantive legislation to modify or repeal the ACA as a whole, and the RCP specifically, and declined to do so on multiple occasions.

A. Congress Declined to Amend the RCP.

Congress frequently amends or repeals laws through substantive legislation. The 113th Congress, which passed the 2015 Spending Rider, directly considered two pieces of proposed legislation to amend

the ACA to limit or eliminate RCP payments.[18] Neither bill passed. During the 2016 budget process, Congress considered an amendment expressly indicating that "Effective January 1, 2016, the Secretary shall not collect fees and shall not make payments under [the RCP]." 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015) (statement of Sen. McConnell). Senator Patty Murray spoke against the amendment, raising a point of order to strike the proposed amendment, because RCP "is a vital program to make sure premiums are affordable and stable for our working families. Repealing it would result in increased premiums, more uninsured, and less competition in the market." *Id.* at S8354. The Senate voted against the amendment. Congress also considered more narrow legislation that would have required the RCP to be administered on a budget-neutral basis. *See, e.g.*, S. Rep. No. 114-74, 12 (June 25, 2015); *see also id.* at 121, 126. Congress voted against that legislation, too.[19]

In other words, Congress considered modifying or repealing the

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[18] *See* Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014) (seeking to amend the RCP to "ensur[e] budget neutrality."); Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) (seeking to eliminate the RCP).

[19] To date, Congress has considered dozens of amendments to the ACA generally and the RCP specifically. *See* Appx151.

RCP—but *did not do so*. The legislation seeking to make the RCP budget neutral also highlights what is patently clear about the RCP from the text of the ACA, *i.e.*, *the Government's obligation to make "payments out" was not capped by budget neutrality*.

B. Eliminating One Funding Source Does Not Negate the Obligation.

Beginning with the 2015 Spending Rider, passed on December 16, 2014, Congress curtailed certain funding sources available to HHS to make RCP payments. The Government argued, and the court below agreed, that the Spending Riders eradicated whatever obligation to pay otherwise existed. That was error.

As an initial matter, to interpret appropriations riders to have accomplished what Congress declined to do through substantive legislation would render our constitutional system of checks and balances a nullity. Congress considered repealing the ACA, and did not do so. Congress considered amending the RCP, and did not do so. What Congress *actually did* was limit CMS's ability to make RCP payments from certain accounts. That is a mere administrative point; it did not modify the Government's legal obligation. Restricting appropriations alone, without more, does not amend the underlying legislation. *See*

Greenlee Cty., Ariz. v. United States, 487 F.3d 871, 877 (Fed. Cir. 2007); *Gibney*, 114 Ct. Cl. at 53 (noting that the court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation"); *see also*, *Blanchette v. Conn. Gen. Ins. Corps.*, 419 U.S. 102, 134 (1974) ("Before holding that the result of the earlier consideration has been repealed or qualified, it is reasonable for a court to insist on the legislature's using language showing that it has made a considered determination to that end . . . ." (citations and quotations omitted)).

Nor does a restriction like that contained in the Spending Riders absolve the Government of its obligation to make payments mandated by law. *See Molina*, 133 Fed. Cl. at 41. Even where an agency is unable or unwilling to honor an obligation, the Judgment Fund exists for the very purpose of discharging the Government's obligation. *See id.* at 28-29.

The legal standard for finding that an appropriation act negated an existing statutory right is stringent—it is presumed not to happen. In this case, two related, bedrock principles undermine the CFC's

holding. *First*, even where the change would have only prospective effect, Congress is presumed not to amend preexisting substantive statutory obligations except where it signals otherwise "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted); *accord United States v. Welden*, 377 U.S. 95, 102 n.12 (1964) ("Amendments by implication, like repeals by implication, are not favored."). Nothing in the Spending Riders expresses or clearly implies an intent to abolish the obligation created by Section 1342.

Second, this general rule of statutory interpretation "applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980). Because appropriations laws "have the limited and specific purpose of providing funds for authorized programs," the statutory instructions included in them are presumed not to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). "[I]t can be strongly presumed that Congress will specifically address language on the statute books that it wishes to change." *United States v. Fausto*, 484 U.S. 439, 453 (1988); *Greenlee Cty.*, 487 F.3d at 877 ("It has long been established that the mere failure of Congress to appropriate funds,

without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." (citing *N.Y. Airways v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966)).

By their terms, the Spending Riders merely restricted HHS's ability to use certain sources of money to make payments under the RCP; they did not change the law or the Government's legal obligation under Section 1342, or signal an "intent" to modify what Congress had previously legislated in Section 1342.[20] Restricting appropriations alone, without more, does not amend the underlying legislation. *See Greenlee Cty.*, 487 F.3d at 877; *Gibney*, 114 Ct. Cl. at 53 (noting that the court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation"). Nor does it absolve the Government of its obligation to make payments mandated by law. *See id.*

Applicable case law amplifies these principles and illustrates the CFC's flawed reasoning. In *Langston*, for example, the diplomatic

[20] *See* 2015 Spending Rider, Appx684; 2016 Spending Rider, Appx697.

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

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

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

Judge Wheeler analyzed the relevant cases in his decisions in *Moda* and *Molina* and observed two types of cases where courts have found a congressional intent to abridge, by way of appropriations, a substantive legal obligation. The first type involves appropriations that bar the use of *any* appropriation to pay for something, signaling an intent to choke off *all* funding, and thus to negate the obligation. *See Moda*, 130 Fed. Cl. at 459-62 (citing *United States v. Dickerson*, 310 U.S. 554, 554-55, 60-62 (1940); *Will*, 449 U.S. at 205-08, 222-24)). Congress accomplishes this when the spending bill restricts funding from "this Act or any other Act." *Id.* A second type involves Congress affirmatively dedicating a specific appropriation to the obligation at

issue, signaling exclusivity, and thus a newly imposed limitation on the obligation. *See Molina*, 133 Fed. Cl. at 38-40 (citing *Highland Falls–Fort Montgomery Cent. School Dist. v. United States*, 48 F.3d 1166, 1168-72 (Fed. Cir. 1995)).

Here, as Judge Wheeler pointed out, the two Spending Riders do not match either type. All Congress did in the Spending Riders was cut off a specific funding source, not "all" funding sources under "this Act or any other Act," and Congress was silent as to the RCP obligation itself. Indeed, as Judge Wheeler pointed out, Congress used the "any appropriation" limitation in *other* provisions of the Spending Riders, unrelated to the RCP, making its absence from the provision regarding the RCP all the more probative of the limited reach of the RCP funding restrictions. *See Moda*, 130 Fed. Cl. at 462.

The CFC in the decision below conducted an analysis of substantially the same controlling precedent. But the court mishandled the "touchstone of statutory analysis" by giving the *actual text* of the Spending Riders short shrift. In attempting to distinguish the instant action from Plaintiff's cited cases, the CFC improperly elevated perceived congressional intent, as drawn from snippets of legislative

history, over the plain text of what Congress *actually* legislated (and failed to legislate) in the two Spending Riders. This was error and merits reversal. The test is what Congress says in the statute, not what individual members or even committees say *about* the statute. *See United States v. Mitchell*, 109 U.S. 146, 150 (1883) ("The whole question depends on the intention of Congress *as expressed in the statutes*."). *See also* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 369-90 (2012) (pointing out that "legislative history" is written tendentiously with the aim of influencing judges).

The CFC's decision is replete with illustrations of its misplaced reliance on selective legislative history, leading to its erroneous conclusion that "it is precisely the demonstrated clear Congressional intent that prevents the payment *of federal funds* to make RCP payments." Appx17 (emphasis added). The CFC improperly held that because the Spending Riders blocked a single CMS account, they "*implicitly* limited HHS to *user fees funds* to satisfy RCP payments." Appx10 (emphases added). The CFC also enlarged this "implicit" conclusion by stating that "Congress made clear its *intention* that *no*

public funds be spent to reimburse risk corridor participants *beyond their user fee contributions*." Appx21 (emphases added).

These holdings are untenable. While Congress succeeded in limiting one HHS funding source, the text of the Spending Riders makes crystal clear that Congress did not prohibit *all* "federal funds" or "public funds" from being used to make RCP payments. 2015 Spending Rider, Appx684; 2016 Spending Rider, Appx697. To accomplish that, Congress *could* have mandated that no funds "in this Act or any other Act" be used to make RCP payments, which would have blocked *all* public funds. *Molina*, 133 Fed. Cl. at 34. But Congress did not.

In fact, Congress used this precise language in other provisions of the *same* Spending Riders and could have done the same with respect to Section 1342.[21] The Government has offered no coherent explanation

[21] *See, e.g.*, Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. No. 113-235), § 716 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 717 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 718 ("None of the funds appropriated by this or any other Act shall be used to pay . . . ."); § 731 ("None of the funds made available by this or any other Act may be used to write, prepare, or publish . . . ."), § 735 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 736 ("None of the funds made available by this Act may be used to procure . . . ."); Consolidated

for why Congress expressly blocked access to *one* CMS account, if it supposedly "intended" that "no public funds" may be spent on RCP reimbursements, or if it sought to bar payment from "this Act or any other Act." The Spending Riders passed by Congress do not amend Section 1342; they do not state that "no public funds" may be spent on RCP reimbursements; they do not bar payment from "this Act or any other Act"; by their express terms, the Spending Riders block one CMS account as a source of funding. Seeking to divine Congress's "intent," beyond what it actually wrote, is rank speculation.

Also conspicuously absent from the statutory text is the CFC's speculation that Congress's "implicit[]" "intention" was to *cap* "RCP payments" at "user fee contributions." Appx10, Appx21. To accomplish that, the Spending Riders *could* have expressly stated Congress's intent that Section 1342 must be budget neutral and capped at "payments in." But the Spending Riders did not. *Molina*, 133 Fed. Cl. at 31-32, 37-38.

Appropriations Act, 2016 (Pub. L. No. 114-113), § 714 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 715 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay . . . ."), § 716 ("None of the funds appropriated by this or any other Act shall be used to pay . . . ."), § 733 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used . . . .").

Even if, *arguendo*, the CFC "believed" that "Congress believed" that blocking one specific account would functionally nullify the obligation by blocking all potential federal funds, *Molina*, 133 Fed. Cl. at 40-41, none of those speculative "belie[fs]" are memorialized in the text of the Spending Riders. For this Court, what matters is the language that garnered sufficient votes in Congress to actually become law—*not* the perceived intent or desires of individual representatives. The Spending Riders *did not by their express terms amend Section 1342 to eliminate its mandate to make annual and complete RCP payments*. *See id.*

When the Spending Riders are analyzed under these presumptions, their text cannot be interpreted as having accomplished what the CFC held. All Congress accomplished through the Spending Riders was to temporarily limit one funding source from which funds could be paid. That did not modify the Government's legal obligation. Under controlling presumptions, this Court cannot read Congress's hyper-specific mere appropriations rider to have sufficiently overcome the battery of stringent presumptions disfavoring repeal by appropriation or by implication.

C. Even if the Obligation Had Been Amended, It Could Not Be Applied to the RCP Payments in Question.

Even if the Government could overcome the presumptions against implied repeal or amendment via appropriations rider generally (which it cannot), the Government's argument would run headlong into a wall in this case, given that its position would result in the *retroactive* negation of the Government's obligation. After all, by the time Congress enacted the Spending Riders for the respective benefit years, Health Options had already performed. For benefit years 2014 and 2015, the Government's obligation (albeit undefinitized) accrued no later than fall 2013 and 2014 respectively, when Health Options and the Government fully executed QHP Agreements for benefit year 2014 and benefit year 2015. Those contracts required Health Options to undertake myriad obligations in connection with offering QHPs on the exchanges. By contrast, the Spending Riders restricting appropriations were enacted *11.9 months* into the benefit year.

Judge Wheeler recognized this in *Molina*, where he flatly rejected—as "wholly without merit"—the Government's misplaced argument that any obligation existing under Section 1342 did not accrue until all costs were tabulated following the applicable benefit

year. 133 Fed. Cl. at 38. The Molina court admonished the Government that:

> Not only is there no authority to support this statutory interpretation, it is contrary to the function of the [RCP]. Section 1342 was created to provide insurers with some protection against substantial losses while developing their QHPs *well before any payment under the risk corridor program would have been expected* . . . . Under the Government's interpretation, Section 1342 would not have served that function because insurers could only rely on Section 1342 after they had entered the Exchanges.

Id. (emphasis added). Judge Wheeler made clear that the "binding" obligation of Section 1342 attached when participating insurers committed to performance and "entered the Exchanges." *Id.* It is bedrock fiscal law that the Government became liable for its obligation long before—and independent of—when the accountants and actuaries finally tabulated and definitized the gains/losses in July of the following year. *Id.*; *see* II GAO Redbook at 7-4 - 7-5 (An "obligation arises when the definite commitment is made, *even though the actual payment may not take place until a future fiscal year*. . . . [T]he term 'obligation' includes both matured and unmatured commitments . . . An unmatured commitment is a liability which is *not yet payable* but for which a definite commitment nevertheless exists.") (emphases added). Precise definitization may affect when insurers could perfect their legal claims

for entitlement in filing before the CFC, but the underlying obligation arose under Section 1342 and attached when the insurers committed to performance.

The CFC ducked the presumption against retroactivity by moving the goal posts. *See* Appx13 n.4. Specifically, the court stated that "plaintiff's concerns regarding retroactivity are not implicated" because Congress's Spending Riders came *before* "the entitlement [wa]s fixed." Appx13. The premise is invalid. The Government's obligation arose before it came due, and therein lies the court's mistake—its erroneous conclusion that the Government was not *liable* for any "unmatured" obligations "until the end of the plan year after all of the expenses for that year are accounted for." Appx15. Because of its mistaken sequencing, the court found that Congress had "timely" enacted the Spending Riders *before* the Government incurred any obligation under Section 1342. Appx12-13.

The court's analysis was wrong at each step. As Judge Wheeler pointed out in *Molina*, it is absurd to suggest that insurers could not count on the United States to honor its statutory commitments *after* they performed their end of the statutory program. 133 Fed. Cl. at 38.

These QHP commitments—by which the insurers committed to perform, fixed their rates, and entered the Exchanges, and provided coverage—were executed long before the Spending Riders (restricting RCP payments for the specific fiscal year) were passed. *See id.* Hence, the Government's undefinitized obligation to honor RCP payment pre-dated the passage of the Spending Riders. *See id.*

As noted *ante*, the text of the Spending Riders makes clear that they did not repeal or amend the Government's payment obligation. Even if the obligation had been amended, however, the impacted payment obligation had already attached, and the CFC should have analyzed the text of the Spending Riders under the more stringent presumption against *retroactive repeals* of obligations. The CFC committed reversible error because it misunderstood when the Government's obligation arose and applied the wrong legal presumption to analyze the Spending Riders.

CONCLUSION

Section 1342 created a mandatory obligation to make full and annual RCP payments and nothing in the Spending Riders changed the obligation of the Government under Section 1342. The Government

remains liable in full for its RCP obligations. The CFC erred in holding otherwise. For these reasons, Health Options respectfully requests that the Court reverse the CFC's judgment and remand with instructions to enter judgment for Health Options.

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In the United States Court of Federal Claims

No. 16-967C
(Filed: July 31, 2017)

* *

MAINE COMMUNITY HEALTH OPTIONS,

Plaintiff,

v.

THE UNITED STATES,

Defendant.

Money mandating statute; Affordable Care Act; Risk Corridors Program; 42 U.S.C. § 18062; Appropriations riders; Limitation on use of funds.

* *

Stephen McBrady, Washington, DC, for plaintiff. *Daniel Wolff* and *Xavier Baker*, of counsel.

Marc S. Sacks, United States Department of Justice, Commercial Litigation Branch, Civil Division, Washington, DC, for defendant. *Charles E. Canter*, *Terrance A. Mebane*, *Frances M. McLaughlin*, *L. Misha Preheim*, and *Phillip M. Seligman*, of counsel. Also on the briefs were *Chad A. Readler*, Acting Assistant Attorney General, *Ruth A. Harvey*, Director, *Kirk T. Manhardt*, Deputy Director.

OPINION

BRUGGINK, *Judge.*

This is a claim for statutory entitlement to payment under the "Risk Corridors Program" ("RCP") created by section 1342 of the Affordable Care Act ("ACA"), codified at 42 U.S.C. § 18062 (2012) ("section 1342"). The RCP is in essence a program in which insurers, and potentially the government, share both the risk and reward inherent in setting plan premiums. Plaintiff, Maine Community Health Options ("CHO") is a non-profit corporation with its principal place of business in Lewiston, Maine.

It provides health insurance to its members under the federally-facilitated market place in Maine and New Hampshire. CHO is approved by the Centers for Medicare and Medicaid Services ("CMS") to offer qualified health care plans ("QHPs"). Plaintiff alleges that it is owed but has not been paid approximately $23 million under the RCP program for program years 2014 and 2015. CHO filed a motion for summary judgment on November 3, 2016. Defendant filed its opposition and moved for dismissal under Rules 12(b)(1) and 12(b)(6) on January 13, 2017. In an order dated March 9, 2017, we denied defendant's motion to dismiss for lack of jurisdiction and ripeness and preserved the remaining issues raised in plaintiff's motion for summary judgment and defendant's motion to dismiss for failure to state a claim. We also asked for additional targeted briefing. That briefing is complete. Supplemental oral argument was heard on July 24, 2017.

We conclude that Congress timely barred the use of appropriated funds to pay any amounts due under the RCP program beyond those collected from participating health care insurers. That conclusion makes it unnecessary to pursue defendant's alternative argument that the statute cannot be construed to make the government a guarantor of deficiencies in collections under the risk corridors program.

BACKGROUND

The general way in which the program operates is that insurers whose costs for a calendar year exceed a target amount are entitled to a payment to partially recoup those expenses. Insurers whose costs are below the target amount pay a percentage of that delta into the program. The target amount is set with regard to the premiums established for each year. In this way, all participating insurers share in the risk and reward of setting premiums too high or too low. This lawsuit poses the question of whether the government has obligated itself to share in the risk by making up the difference when payments into the program fail to satisfy the amounts owed to insurers whose costs exceed the target.

There is only one count in the complaint: "Violation of Statutory and Regulatory Mandate to Make Payments." Plaintiff moved for summary judgment on that count, arguing that section 1342 mandates payment by the Department of Health and Human Services ("HHS") on a yearly basis if qualifying costs exceed a certain amount, and it is undisputed that plaintiff's costs did exceed that amount in the years 2014 and 2015.[1]

[1] Although the RCP applies to calendar years 2014, 2015, and 2016, any

Defendant does not dispute that the amounts plaintiff calculated on a yearly basis are correct. Instead it moves for dismissal for failure to state a claim for two legal reasons. First, defendant argues that Congress intended the RCP to be "budget neutral," meaning that section 1342 limits the government's payment obligations to the amounts collected from insurers whose costs are below the target amount and who therefore have paid into the RCP. If HHS collects less from insurers who must pay into the program than it owes to insurers who are due payment, then, according to defendant, the government is under no obligation to make up the difference with other funding sources. In sum, while section 1342 mandates the payment of money by HHS, that obligation is limited to the fees collected by the program. There is no underwriting by the government of deficits generated by the program.

Defendant's second and independent argument is that, even if the statutory language of the RCP provisions is construed to create an open-ended obligation on the part of the federal government to make up the deficits in the operation of the risk corridors, Congress timely barred the use of any appropriated funds other than fees collected in appropriations riders in 2014 and 2015 and that expression of congressional intent trumps any different obligation arguably created by section 1342.

In response, plaintiff asserts that Congress' failure to amend or repeal the RCP reflects that it was not intended to be budget neutral when it was originally passed and remains so today. Plaintiff also argues that the appropriations riders were not effective to limit the government's liability under the statute because section 1342 had already created an obligation before the riders were passed. Plaintiff urges that the riders should not be read to have retrospective effect.

Four other judges of this court have considered these and similar arguments. All found jurisdiction and that the claims were not premature. *Blue Cross & Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457 (2017); *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757 (2016); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81 (2016).

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payment due for 2016 would not be calculated until July 2017, thus it could not have been included in the complaint.

Three of the judges went on to address the merits of insurers' claims and the government's defense of failure to state a claim. Two judges arrived at a different conclusion than the third. *Compare Land of Lincoln*, 129 Fed. Cl. at 108 (holding that the statute was ambiguous and deferring to the agency's interpretation that payments need neither be made yearly nor in any amount over what HHS collects under the program), *and Blue Cross*, 131 Fed. Cl. at 475 (holding that the plain language of the statute and regulation do not create an annual deadline to make RCP payments), *with Moda*, 130 Fed. Cl. at 455, 460-65 (holding, *inter alia*, that the statute is not budget-neutral and that the appropriations riders did not vitiate HHS' yearly payment obligation). Here, we have already held that section 1342 is money mandating, although we preserved defendant's contention that the mandate is capped by fees received. *See Maine Cmty. Health Options v. United States*, No. 16-967C (Fed. Cl. Mar. 9, 2017) (order denying Def.'s Mot. to Dismiss for lack of jurisdiction).

I. LEGISLATIVE HISTORY

We begin with some of the legislative history of the act, which is illustrative of the history of the particular provisions at issue. On September 17, 2009, the Senate Committee on Health, Education, Labor, and Pensions reported its version of the ACA to the floor. S. 1679, 111th Cong. § 142. This version included an express provision that authorized HHS to use money in the Treasury for RCP payments to QHP issuers.[2] Over a month later, the Senate Committee on Finance subsequently reported its own version of the legislation. S. 1796, 111th Cong. § 1001 (2009). This version contained no reference to funding the RCP and modeled more closely the language eventually adopted in section 1342 of the ACA. *Id.*

Once the final draft of the ACA was prepared, the Congressional Budget Office ("CBO") released its budget scoring on March 20, 2010, notably omitting the RCP from the scoring and attributing no expenses to it. Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker, House of Representatives, Tbl. 2 (March 20, 2010).

[2] "(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to— . . . (iii) make payments under paragraph (3)." S.1679 § 3106(c)(1)(B). Paragraph 3 would have created a risk corridor program.

Congress relied on the CBO's report in passing the ACA, as stated in the legislation itself, "(1) [b]ased on . . . (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019. (2) CBO projects this Act will continue to reduce budget deficits after 2019." Pub. L. No. 111-148, § 1563(a), 124 Stat. 270; *see also Land of Lincoln*, 129 Fed. Cl. at 104.

On March 23, 2010, the ACA became law, including section 1342, which states:

> (a) In general.
>
> The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 USCS §§ 1395w-101 et seq.].
>
> (b) Payment methodology.
>
> (1) Payments out. The Secretary shall provide under the program established under subsection (a) that if--
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (2) Payments in. The Secretary shall provide under the program established under subsection (a) that if--

> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062. The statute is silent here and elsewhere as to funding for the payments out other than the implication that the payments in could be used in that manner.

II. REGULATORY FRAMEWORK

The details of how the RCP would be administered and when payments were due or would be made were largely left to HHS. It published a final payment rule on March 23, 2012, stating in relevant part:

> (a) General requirement. A QHP issuer must adhere to the requirements set by HHS in this subpart and in the annual HHS notice of benefit and payment parameters for the establishment and administration of a program of risk corridors for calendar years 2014, 2015, and 2016.
>
> (b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
> > (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
> > (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS

> will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (c) Health insurance issuers' remittance of charges. QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:
>
> (1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and
>
> (2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.
>
> (d) Charge submission deadline. A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

45 C.F.R. § 153.510 (2012); 78 Fed. Reg. 15,410, 15,531 (Mar. 11, 2013) (adding subsection (d)). At the same time, HHS also published an impact analysis of the new regulation. 77 Fed. Reg. 17,220, 17,243 (Mar. 23, 2012). It stated:

> CBO estimates that risk adjustment payments and collections are equal in the aggregate . . . . CBO did not score the impact of the risk corridors program, but assumed collections would equal payments to plans in the aggregate. The payments and receipts in risk adjustment and reinsurance are financial transfers between issuers and the entities running those programs.

Id. At 17,244.

III. AGENCY ACTION

The seemingly definitive statement notwithstanding, in the years following the adoption of its final rule, HHS took less-than-consistent positions with respect to whether the RCP would be implemented in a budget-neutral manner. During the comment and answer period for the 2013 final rule, HHS stated that "[t]he risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. Later, however, in its 2015 payment rule comment and answer, HHS stated it "intend[ed] to implement [RCP] in a budget neutral manner, and may make future adjustments, either upward or downward to this program (for example, . . . [HHS] may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal." 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014). One month later, HHS issued a bulletin outlining a pro rata approach for "payments out" if the "payments in" were not sufficient and promising that it would issue further guidance on risk corridor payments if the collections did not cover them entirely at the conclusion of the three-year program. Pl.'s Mot. Summ. J. Addendum A Doc. 5. HHS confirmed on two other separate occasions its intent for the RCP to be budget neutral over the course of the three-year program; yet it simultaneously recognized that, if there is a shortfall, "the Affordable Care Act requires the Secretary to make full payments to issuers," and "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." 79 Fed. Reg. 30,240, 30,260 (May 27, 2014); 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015).

On October 1, 2015, HHS announced that it would only be able to pay 12.6% of amounts due for 2014 due to lower payments in than requested payments out. Approximately one month later, HHS communicated that it owed $241,717 to CHO, but would only be paying the pro-rated amount of $30,499.53. On the same day, however, HHS also informed QHP issuers that all unfulfilled payments out for the RCP were required to be paid in full and would be treated as fiscal year 2015 obligations for the government. The following year, HHS notified QHP issuers that it would allocate the full amount of collections for benefit year 2015 toward benefit year 2014 payments and use benefit year 2016 collections to satisfy everything that remained, although it concluded that any outstanding payments at the end of the three-year program would be

"subject to the availability of appropriations." Pl.'s Mot. Summ. J. Addendum A Doc. 11.

In summary, HHS has attempted to maintain the general position that the RCP is not statutorily required to be budget neutral, but that HHS intended to implement it in a budget neutral manner. According to its interpretation, any additional payments owed but not covered by the RCP would be paid subject to the availability of appropriations.

IV. APPROPRIATIONS RIDERS

Both parties acknowledge that the chronology of events is especially critical, particularly pertaining to the appropriations riders. As CHO noted and the government agreed, the earliest possible HHS payments to QHP issuers could not occur before July 2015, when plaintiff submitted its cost information for benefit year 2014 to HHS. *See* Oral Arg. Tr. 54-55 (Feb. 15, 2017); Def.'s Suppl. Br. 8. HHS set a deadline of July 31, 2015 for insurers to submit premium and cost data for the preceding calendar year to HHS, and it set a deadline of August 1, 2016, for the 2015 calendar year. It began making payments for the proceeding years in December of 2015 and 2016.

In February 2014, prior to any plan data and payments, Congress asked the Government Accountability Office ("GAO") to determine what sources of funding would be available when RCP payments were due to QHP issuers. *U.S. Gov't Accountability Office, GAO Op. B-325630, Department of Health and Human Services--Risk Corridor Program* 1 (2014). GAO responded that the CMS Program Management ("PM") appropriation, essentially the operating budget, and "user fees" (RCP collections) could be used to make payments, but only if the appropriations from fiscal year 2014 were re-enacted.[3] *Id.* at 4-5. The GAO report did not mention any other sources of funding as available to the program.

On December 16, 2014, Congress adopted an appropriation for fiscal

[3] Re-enactment was required because "[a]n appropriation in a regular, annual appropriation law may be construed to be permanent or available continuously only if the appropriation . . . expressly provides that it is available after the fiscal year covered by the law in which it exists." 31 U.S.C. § 1301(c) (2012). This appropriation did not expressly provide such an availability.

year 2015. Beyond deciding not to adopt the same language as the previous year, Congress affirmatively prevented CMS Program Management funds from being used to satisfy an obligations under the RCP. The appropriation states:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services--Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Consolidated and Furthering Continuing Appropriations Act 2015, Pub. L. No. 113-235, div. G, title II, § 227, 128 Stat. 2130, 2491 (2014). The Chairman of the House Committee on Appropriations explained the reasoning behind this measure:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9838 (daily ed. Dec.11, 2014). Congress thus expressly barred the use of appropriated funds for RCP payments and implicitly limited HHS to user fees funds to satisfy RCP payments.

Congress adopted an identical appropriation limitation the following year, which further included the following:

> In addition to the amounts otherwise available for ''Centers for Medicare and Medicaid Services, Program Management'', the Secretary of Health and Human Services may transfer up to $305,000,000 to such account from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to support program management activity related to the Medicare Program: *Provided*, that

> except for the foregoing purpose, such funds may not be used to support any provision of Public Law 111–148 or Public Law 111–152 (or any amendment made by either such Public Law) or to supplant any other amounts within such account.

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, title II, §§ 225-226, 129 Stat. 2242, 2624-25 (2015). The import is that extra funds appropriated to Medicare's operating budget could not be used to meet other obligations created by the ACA, such as the RCP. Similar to the year before, a Senate Committee Report detailed that this appropriation rider was aimed at protecting discretionary funds (operating funds) from being used for RCP payments because that was never their intended purpose. S. Rep. No. 114-74, at 12 (2015).

DISCUSSION

Insofar as relevant here, the Tucker Act gives this court jurisdiction to hear claims for money against the United States founded upon any Act of Congress or any regulation. 28 U.S.C. §1491(a)(1) (2012). As the Supreme Court has made clear, however, the Tucker Act is merely jurisdictional; it is not a grant of substantive rights. *United States v. Testan*, 424 U.S. 392, 398 (1976). A successful plaintiff must point to a source in substantive law that creates liability. "[A] waiver of the traditional sovereign immunity 'cannot be implied but must be unequivocally expressed,'" *Id.* at 953-54 (citing *United States v. King*, 395 U.S. 1, 4 (1969)).

I. Statutory Interpretation

Plaintiff believes that this court's inquiry begins, and more importantly, ends with the text of section 1342's payment out provision, which states:

> (1) Payments out. The Secretary shall provide under the program established under subsection (a) that if–
>
> > (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, *the Secretary shall pay* to the plan an amount equal to 50 percent of the target

> amount in excess of 103 percent of the target amount; and
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, *the Secretary shall pay* to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

42 U.S.C. § 18062(b) (emphasis supplied). The use of "shall pay" creates an enforceable obligation, according to plaintiff.

As we held previously, there is no question that the statute commands payment of money by the Secretary. Thus the court has jurisdiction to decide whether plaintiff is entitled to payment, but whether the government's payment obligation is limited in some way by other provisions or by subsequent legislation remains unanswered by the language quoted above. The government urges that it is limited by both. The question generally stated then is whether the RCP contemplates merely a divvying up of fees received or if the Treasury is obligated to make up any difference. Defendant urges that Congress did not intend to obligate any payment of money beyond what is collected under the program and that, in any event, it expressly limited the funds available to make RCP payments in appropriation legislation. We do not reach the first issue because the answer to the second question is clear. Congress controls the purse. Within certain limitations, which we find not to be relevant here, it has the right to nullify what would otherwise appear to be binding commitments, and it did so here.

II. Statutory Amendment Via Appropriation

We hold that Congress clearly and timely expressed its intention that public funds not be used to pay deficiencies arising under section 1342, at least for fiscal years 2015 and 2016. While the application of this fact is complicated in part by the lack of symmetry between the program years, which operate on a calendar basis, and fiscal years, which run from October 1 to September 30, it is undisputed that the appropriations riders at issue were adopted prior to what we view as the key dates: the end of benefit year 2014 and the end of benefit year 2015. We are thus not confronted with a

situation in which the interdict comes after the entitlement is fixed.[4]

We begin with the proposition that Congress' power to spend, or not, is unimpeded by its earlier actions. This axiom of federal law has consequences as applied to the interplay between substantive legislation, such as the ACA, and the appropriations needed to fund it. The relevant principles are drawn from a few key decisions of the Supreme Court.

In *United States v. Mitchell*, 109 U.S. 146 (1883), an Indian interpreter for the Secretary of the Interior claimed he had not been paid his statutory salary. Congress had in 1834 dictated a salary of $400 per year. Yet Mr. Mitchell, who worked between 1878 and 1882, had been paid only $300 per year. Beginning in 1877, Congress had, in its annual appropriations for Indian affairs, specifically limited salaries for individuals like Mr. Mitchell to $300 per year. The Court observed the following:

> We find, therefore, this state of legislation: by the Revised Statutes, the salaries of interpreters were fixed . . . at $400 . . . . By the acts in force during the appellee's term of service, the appropriation for the annual pay of interpreters was $300 each, and a large sum was set apart for their additional compensation, to be distributed by the Secretary of the Interior at his discretion.
>
> This course of legislation . . . distinctly reveals a change in the policy of Congress on this subject–namely that instead of establishing a salary for interpreters at a fixed amount and cutting off all other emoluments and allowances, Congress intended to reduce the salaries and place a fund at the disposal of the Secretary of the Interior.

Id. at 149.

The Court noted that it did not have before it a simple case of a failure to appropriate sufficient funds to cover an obligation: "On the contrary, in this case Congress has in other ways expressed its purpose to reduce for the time being the salaries of interpreters." *Id* at 150. The court found that his salary was fixed by the subsequent appropriation acts and not

[4] Thus plaintiff's concerns regarding retroactivity are not implicated.

the earlier 1834 act.

A similar result obtained in *United States v. Dickerson*, 310 U.S. 554 (1940). Congress in 1922 had authorized the payment of an enlistment bonus to every soldier who re-enlisted within three months after the date of his discharge. The plaintiff had been honorably discharged at the termination of his enlistment in July 1938. He re-enlisted one day later. He was denied a bonus, however, because in June 1938 Congress, in a resolution appended to an appropriations bill, directed that no part of any appropriation for the fiscal year ending June 30, 1939, could be used to pay re-enlistment bonuses, "notwithstanding" the prior statute. *Id.* at 555. The Court of Claims ruled in favor of the soldier, on the grounds that the prior legislation had not been repealed. The Supreme Court reversed. It held that "[t]here can be no doubt that Congress could suspend or repeal the authorization contained in Section 9, and it could accomplish its purpose by an amendment to an appropriation bill, or otherwise." *Id.* (citing *Mitchell*, 109 U.S. at 150). Because of sloppy legislative drafting, the Court was confronted with the argument that the resolution was not phrased in a clear enough manner to warrant setting aside the bonus. A review of the legislative history of the provision persuaded the Court that Congress' intent was clear.

Although it involved application of the Compensation Clause of Article III, § 1, *United States v. Will*, 449 U.S. 200 (1980), also assists the government here. The primary question there was whether Congress had timely intercepted judicial pay raises before they took effect at the beginning of four different calendar years. While the protection afforded by the Compensation Clause is not relevant here, the Court's observations about how to implement subsequent appropriations limitations if they undercut substantive provisions offer us guidance. Although repeals by implication are disfavored, particularly if they arise in appropriations legislation, Congress can suspend or repeal a statute in force by an amendment to appropriations bill. *Id.* at 222 (citing *Mitchell*, 109 U.S. at 150). The "whole question depends on the intention of Congress as expressed in the statutes." *Id.* Because Congress' intent in *Will* was unmistakable, the only limitation on its power to reverse the pay increases was the Compensation Clause, which only applied in two of the years at issue; "[t]o say that Congress could not alter a method of calculating salaries before it was executed would mean the Judicial Branch could command Congress to carry out an announced future intent as to a decision

the Constitution vest exclusively in the Congress." *Id.* at 228.

These three cases establish that Congress can effect a change to a substantive obligation that was earlier created through language in subsequent appropriations legislation. Thus the "shall pay" language of section 1342 is not dispositive in the face of two appropriations riders that limit the sources of funding for that obligation. We must therefore parse those appropriations to answer the question.

III. The Effect Of The Appropriations Legislation

Given that section 1342's payments in and payments out are accounted for on a yearly basis, the amount owed by or owed to an insurer in the RCP cannot be known until the end of the plan year after all of the expenses for that year are accounted for. The plan years correspond to calendar years. Thus the government's liability to any particular insurer for a particular year cannot be known until the last day of that calendar year.[5]

Congress passed the two relevant appropriations provisions in December of 2014 and 2015. The 2014 bill applies by its terms to fiscal year 2015, and the 2015 bill applies to fiscal year 2016. The government's fiscal year begins in October of the preceding calendar year. Thus, for the 2014 plan year (calendar year), even assuming that payment could be made as soon as costs were completely fixed on the final day of the year, any federal funds necessary to make RCP payments would come from 2015 fiscal year funds. The same is true for the following year (2015 payments could only be made from fiscal year 2016 funds). Thus we find that Congress timely intercepted its RCP obligations in those years by passing the appropriations provisions in December of each year.

Obligation necessarily precedes payment, and the obligation here matured at the end of benefit year 2014. This is because HHS was required to collect an entire year of data before compiling the information and determining RCP payment amounts. *See* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. Once the benefit year concluded, the data was theoretically final, needing only to be reported and interpreted to ascertain what obligations

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[5] Or perhaps even beyond that date since, as defendant pointed out during oral argument, insurance claims are regularly submitted for a plan year during the first few months of a subsequent year.

existed within the RCP.

The effect of these riders was to prevent HHS from using its CMS operating fund to meet any government liability created by the RCP. This left HHS with only the user fees as available to make RCP payments. Plaintiff has not suggested an alternative source of funding for these payments, and we think for good reason. Other federal funds available to HHS are specifically set aside to pay benefits under Medicare and Medicaid. In order to touch those pools of money, Congress must expressly direct some other use for those funds. Plaintiff argues instead, citing several Court of Claims decisions, that the source of the funding is immaterial once the obligation is created. The Judgment Fund can be used to make up a shortfall, posits plaintiff. As we explained earlier, however, the law in this regard is not so simple. Congress can limit or forestall the payment of obligations it has earlier created through subsequent legislation, even by means of appropriations legislation.

The decisions of the Court of Claims and the Federal Circuit are largely consistent. Although the result in *Norcross v. United States*, 142 Ct. Cl. 763 (1958), was favorable to the complainant, the court's reasoning does not dictate the result plaintiff wishes for here. A congressman had employed a clerk in his office, unaware that she was an Austrian citizen. Congress had adopted in 1952 an appropriations rider that placed limits, during that fiscal year, on hiring foreign nationals. Plaintiff had been employed in February 1952. The case was not heard until 1958, a year in which, as Judge Jones noted, the limitations no longer had effect because, "the restriction does not apply to funds appropriated by a subsequent Congress, unless the restriction were again attached," which it was not. He then helpfully suggested to his former colleagues in Congress that there was no reason "why a subsequent Congress may not pay the reasonable value of services actually rendered even though the funds of the 1952 appropriation act could not be used."[6] *Id.* at 766. Despite the creative result, the point remains that Congress' subsequent directions, expressed even in appropriations riders, can control prior promises.

Another opinion by Judge Jones, *Gibney v. United States*, 114 Ct.

[6] Judge Jones acknowledged "some difference of opinion" as to his reasoning, but noted, citing scripture, that the court agreed she should be paid. *Id.* at 767.

Cl. 38 (1949), dealt with an attempt to limit the government's liability for overtime pay. The legislative restriction provided that "none of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided in the Federal Employees Pay Act of 1945." *Id.* at 48-49. In ruling for the employee, Judge Jones explained that

> The judgment of a court has nothing to do with the means--with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them. Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether it is to be paid out of one appropriation or out of another; whether Congress appropriate an insufficient amount, or a sufficient amount, or nothing at all, are questions which are vital for the accounting officers, but which do not enter into the consideration of a case in the courts.

Id. at 52. The court explained that "a pure limitation on an appropriation bill does not have the effect of either repealing or even suspending an existing statutory obligation any more than the failure to pay a note in the year in which it was due would cancel the obligation stipulated in the note." *Id.* at 50-51. Judge Jones distinguished *Dickerson* by explaining that, unlike the legislation in *Gibney,* which it viewed as strictly a limitation on the use of particular funds for a particular year, the history of the legislation in *Dickerson* demonstrated a clear intent to suspend the legislative authorization. In the case at bar, it is precisely the demonstrated clear Congressional intent that prevents the payment of federal funds to make RCP payments.

The Federal Circuit has had occasion twice to address Congress' dealings with "payments in lieu of taxes." The first was *Highland Falls-Fort Montgomery Central School District v. United States,* 48 F.3d 1166 (Fed. Cir. 1995). There the court noted that Congress had, beginning in 1950, continually re-authorized a program of compensating local school districts for the loss of property tax revenue due to the presence of large federal military installations. The statute provided that, "the local educational agency shall be entitled to receive for such fiscal year such amount as, in the judgment of the Secretary [of Education], is equal to the

[financial burden imposed.]" 20 U.S.C. § 237(a)(2) (1988 & Supp. V 1993) (repealed 1994). There were other provisions that provided subsidies under other, related circumstances. The statute recognized, however, the possibility that appropriations might be insufficient to fully fund all the eligible recipients under any of the applicable provisions. In that case, a recipient under section 237 was not only given priority, it was assured "100 percentum of the amount to which it is entitled as computed under that section." *Id.* § 240(c) (repealed 1994). Despite that provision, from 1989 to 1993, Congress did not appropriate sufficient funds to fully fund the program, and it further capped the amount payable to section 237 recipients at $15 million. The Department of Education followed those appropriation restrictions rather than the language of section 240.

The Federal Circuit endorsed DOE's approach:

> [W]e have great difficulty imagining a more direct statement of congressional intent than the instructions in the appropriations statutes at issue here. For example, the appropriation statue for fiscal year 1989 stated: "$15,000,000 shall be for entitlements under section 2 [Sec. 237] of said Act."

Highland Falls, 48 F.3d at 1170.

Moreover, the circuit court relied on two statutory provisions which it viewed as controlling. 31 U.S.C. § 1341(a)(1)(A) (2012) provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure . . . exceeding an amount available in an appropriation . . . for the expenditure." Also, 31 U.S.C. § 1532 states that an "amount available under law may be withdrawn from one appropriation account and credited to another . . . only when authorized by law." In other words, an agency may not spend more money than Congress authorizes for it to use on a particular program, nor may it cannibalize one reticule to supplement another.

In *Prairie County v. United States,* 782 F.3d 685 (2015), the Federal Circuit had occasion to revisit the payment in lieu program. It recognized that "[i]t has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat

a Government obligation created by statute." *Id.* at 689 (quoting *N.Y. Airways v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966)).[7] Nevertheless, the court in *Prairie County* noted that Congress had spoken clearly when it wrote in 31 U.S.C. § 6906 that, "notwithstanding any other provision of this chapter no funds may be made available except to the extent provided in advance in appropriation Acts." 782 F.3d at 690.

In *Prairie County* the court distinguished several cases cited by plaintiff in this cases: *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182 (2012), and *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631 (2005). As the *Prairie County* court stated, where a government contract obligation exists, the government may be compelled to pay more than it originally appropriated. 782 F.3d at 687. This differs, however, from cases involving a benefits program because "there is greater room in benefits programs to find the government's liability limited to the amount appropriated." *Id.* at 689 (quoting *Greenlee County v. United States*, 487 F.3d 871, 879 (Fed. Cir. 2007)). Accordingly, *Ramah* and *Leavitt* are not controlling and the court's reasoning in *Prairie County* aligns with how we view similar precedent here.

Further, we agree with defendant that *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011), and *United States v. Langston*, 118 U.S. 389 (1886), do not lead to a different result. *Slattery* involved a contract claim against a non-appropriated fund instrumentality, and the court was presented with a question of jurisdiction. While it is true that the absence of general appropriations supporting the Federal Deposit Insurance Corporation did not deter the Federal Circuit from finding jurisdiction and potential liability, the court did not speak to the issue relevant here. In the present action, the remaining question is not the court's jurisdiction to hear money claims, the agency involved is not a non-appropriated fund instrumentality, and, most relevant for our purposes, the claim is not for breach of contract. As we discussed above, the Court has developed a different approach in judging Congress' ability to use appropriations limitations to bar recoveries in the case of statutory "benefits" as distinct

[7] We view it as telling, as well, that despite the statutory basis for the airlines' claims in *N.Y. Airways*, the court described Congress's own view that the obligations were more in the nature of contracts. *See* 369 F.2d at 747.

from contract claims.[8]

Langston dealt with the salary of America's ambassador to Haiti. By statute the ambassador's salary had been pegged at $7,500, and that amount had been specifically appropriated for that purpose for several years. The annual appropriations included the statement that the appropriation "shall be in full for the annual salaries thereof from and after July 1, 1878." *Langston*, 118 U.S. at 390. Beginning in 1882, however, this language was omitted and the appropriation was for only $5,000. The Court sustained the ambassador's claim for the differential in pay, despite the absence of an appropriation for the full amount because of the earlier language indicating that the $7,500 salary should continue beyond 1878, and also because the later statute did not purport to cap his pay at $5,000:

> [A] statute fixing the annual salary of a public officer at a named sum, without limitation as to time, should not be deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount for the services of that officer for particular fiscal years, and which contained no words that expressly, or by clear implication, modified or repealed the previous law.

Langston, 118 U.S. at 394. The specificity of the earlier promise, in short, was not overcome by a later appropriation short of the promised amount.

The present facts offer a reverse scenario. The language of entitlement is not specific with respect to Congress's intent to appropriate, but its subsequent language disavowing any such obligation is clear.

Finally, also relevant is the Federal Circuit's decision in *Star-Glo Assocs., LP v. United States*, 414 F.3d 1349 (Fed. Cir. 2005). There, Congress had established a program to be administered by the Department of Agriculture to compensate Florida citrus growers for the compelled

[8] The same would be true for breach of trust cases, and constitutional takings claims wherein government liability is either fixed by the constitution, and thus not subject to appropriations limitations, or by statutorily-created duties that create a fiduciary relationship between the government and some third party, such as Native American tribes.

destruction of diseased trees. The program operated for two years before Congress, in October 2000, adopted an appropriations statute with respect to the fiscal year 2000, which provided that the Secretary of Agriculture "shall use $58,000,000 of the funds of the Commodity Credit Corporation to carry out this section, to remain available until expended." *Id.* at 1352. There is no question that the plaintiff growers complied with the applicable regulations and would have been compensated but for the appropriations cap. The Court of Federal Claims held, despite the fact that plaintiffs had applied for compensation prior to the exhaustion of the appropriated funds, they could not recover because the cap barred further payments. 59 Fed. Cl. 724, 733 (2004). The Federal Circuit affirmed, although on a somewhat different basis. Initially it agreed with the applicability of the cap. Relying on legislative history as well as the language of the appropriations statute, it concluded that there was "no room to doubt that Congress intended benefits available under section 810 to be capped at $58,000,000." *Id.* at 1355.

The plaintiffs in *Star-Glo* argued, however, that the fact that their applications were submitted prior to the exhaustion of funds made the cap irrelevant, and that it made the facts distinguishable from, for example, *Highland-Falls*, where the appropriation had been exhausted prior to the plaintiff seeking additional funds. The circuit court found it unnecessary to reach the question, however, because it ruled that plaintiff did not qualify for any further payments under the terms of the statute. *Id.* at 1357-58.

Although it is difficult to harmonize the decisions in this lengthy history, we believe they lead to following controlling principles. Mere non-appropriation of sufficient funds to meet an existing obligation created by statute[9] will not thwart the courts' enforcement of the obligation. Whether Congress, in subsequent appropriations legislation, can block enforcement of a substantive obligation depends, ultimately, on how clearly it expresses its intent to do so.

These principles dictate the result here. Congress made clear its intention that no public funds be spent to reimburse risk corridor participants beyond their user fee contributions. It asked GAO what monies were available to HHS to make risk corridor payments. GAO answered that user fees and the CMS program management fund were the only sources

[9] We recognize that the case law dealing with contractual obligations, the takings clause, or those arising out of Indian trusts, is *sui generis*.

available. Congress expressly blocked the use of the latter, leaving only the former. The government's obligation was thus capped to the amount brought in from user fees. We are not presented with possible exceptions to this outcome. There were no contract commitments and Congress did not merely fail to address the source of funding. It affirmatively barred the use of public funds in a timely manner, predating the maturation of any obligation to make statutory entitlement payments.

We recognize that Judge Wheeler arrived at a different conclusion in *Moda Health* after examining the same cases. We respectfully disagree with his conclusion. He relied heavily on a distinction present in the legislation in *Dickerson* and *Will,* two cases in which appropriation bars were enforced to thwart the implementation of rights arising from substantive legislation. In both cases, Congress had used, in substance, the phrase, "the appropriation in this or any other Act." I.e., Congress was ensuring that the agencies would not subvert its intent by funding the programs at issue from other sources. Not finding that language in the appropriations riders in the present circumstances, he held that they did not limit the substantive obligation created by section 1432. *Moda*, 130 Fed. Cl. At 460-61. We disagree. These appropriations provisions were adopted after Congress inquired of GAO concerning available funding for the RCP payments. Congress was presented with two potential pools of money for RCP payments and clearly eliminated one of them, thus expressly limiting payments to the other pool—user fees. Once those funds were exhausted, the government's liability was capped.

Furthermore, we remain unconvinced by plaintiff's argument that Congress' failure to amend or repeal the RPC indicated that it did not intend the program to be budget neutral. We agree with defendant that it is imprudent to determine Congress' intent based merely upon what it was unable to do. The legislative history of the statute does not lend itself to plaintiff's interpretation. In fact, Congress opted to follow a committee design for section 1342 without an enumerated appropriation, declining to mimic a different committee's design which specifically included an appropriation. *Compare* S. 1796, 111th Cong., *with* S. 1679, 111th Cong. Congress had every opportunity to include an appropriation as it had in other sections of the ACA, *see, e.g.*, 42 U.S.C. §§ 18001(g)(1), 18031(a)(1), 18042(g), 18043(c), 18121(b), and remove any doubt of budget neutrality, but declined to do so. While the CBO's decision to omit any reference to the RCP in the ACA scoring is not dispositive, it does

suggest that plaintiff is incorrect. Plaintiff's position is further hampered in light of the subsequent appropriations riders that explicitly restrict where funding could be obtained after the GAO highlighted which sources may be available. As discussed previously, even if there were a mature obligation, Congress can amend it via appropriations legislation. *See Dickerson*, 310 U.S. at 555. Nonetheless, the actions or inactions of a previous Congress are not binding on a later Congress.

Although we raised the issue of the availability of the Judgment Fund for additional briefing, we conclude that the issue is immaterial. Retreat to the Judgment Fund assumes a liability in the first instance. *See Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990). We cannot order the payment of monies out of the Treasury beyond those arising from user fees.

CONCLUSION

Plaintiff's motion for summary judgment is denied. Defendant's motion to dismiss for failure to state a claim is granted. The Clerk is directed to dismiss the complaint and enter judgment accordingly. No costs.

s/ Eric G. Bruggink
ERIC G. BRUGGINK
Senior Judge

In the United States Court of Federal Claims

Nos. 16-967 C

MAINE COMMUNITY HEALTH OPTIONS,

Plaintiff,

JUDGMENT

v.

THE UNITED STATES,

Defendant.

Pursuant to the court's Opinion, filed July 31, 2017, denying plaintiff's motion for summary judgment and granting defendant's motion to dismiss,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that plaintiff's complaint is dismissed. No costs.

Lisa L. Reyes
Acting Clerk of Court

July 31, 2017

By: s/ Anthony Curry

Deputy Clerk

NOTE: As to appeal, 60 days from this date, see RCFC 58.1, re number of copies and listing of all plaintiffs. Filing fee is $505.00.

CERTIFICATE OF SERVICE

I hereby certify that on October 6, 2017, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Stephen J. McBrady
Stephen J. McBrady

CERTIFICATE OF COMPLIANCE

This Brief complies with the type-volume limitation of Federal Rule of Appellate Procedure ("Fed. R. App. Proc.") 32(a)(7)(B) and Federal Circuit Rule 32(a): it contains 13,336 words, excluding the portions exempted by Fed. R. App. Proc. 32(f) and Federal Circuit Rule 32(b).

This Brief complies with the typeface requirement of Fed. R. App. Proc. 32(a)(5) and the type style requirement of Fed. R. App. Proc. 32(a)(6): it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14 point size.

In preparing this certificate of compliance, I have relied upon the word count function of the word processing system that was used to prepare the motion.

Oct. 6, 2017

/s/ Stephen J. McBrady
Stephen J. McBrady