IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MAINE COMMUNITY HEALTH OPTIONS, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 16-967C Judge Eric G. Bruggink

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

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Federal Register

Regulatory Guidance

Rules

Other Authorities

INTRODUCTION

For the reasons set forth in Plaintiff's Complaint and its Motion for Summary Judgment (Pl. Br.), Plaintiff Health Options is seeking relief in this Court because of the Government's refusal to honor the statutory payment requirements contained in the Risk Corridors Program (RCP) of the Affordable Care Act (ACA). The RCP is straightforward: in exchange for Qualified Health Plan (QHP) issuers agreeing to participate in entirely new health insurance marketplaces, which Congress specifically contemplated would provide affordable health insurance to tens of millions of previously uninsured or under-insured Americans, Congress guaranteed that for *each* of the first three years of those marketplaces (also known as health care exchanges), any QHP issuer that experienced higher-than-budgeted costs above a certain level would receive a payment from the Government to cover (offset) a portion of its cost overruns. By the same token, the RCP obligated QHP issuers to pay *to the Government* a portion of any gains realized due to lower-than-budgeted costs below a certain threshold, ensuring that both sides were protected against outsized gains or losses.

The entire point of the program was to help stabilize rate premiums during the first three years of the new exchanges. Without the guarantee, insurers would have had to charge far higher premiums to protect themselves against the risk of *adverse selection*, *i.e.*, new enrollment by a pool of previously uninsured individuals that was disproportionately unhealthier and thus more expensive to insure than the existing pool of insureds. And because premiums are set on an annual basis, RCP payment calculations and, ultimately, both payments in (by QHP issuers) and payments out (by the Government) were to be made annually.

Everyone involved in the creation and administration of this program understood how this was supposed to work because Congress expressly "based" the RCP on the Medicare Part D

risk corridors program. In other words, the concept of risk corridors was not a new one: the health care industry and the U.S. Department of Health and Human Services (HHS) and its Centers for Medicare and Medicaid Services (CMS)—the agency charged with administering these programs under Medicare and the ACA—were familiar with how it worked. Indeed, the Government has publicly acknowledged numerous times its absolute obligation to honor its statutory obligation to make payment on an annual basis. And health insurers have been required to pay into the program in a timely way when they have lower-than-budgeted costs below a certain threshold.

The Government defends its actions both on jurisdictional grounds and on the merits by asking this Court to: (1) ignore the text of the RCP as written; (2) ignore the only logical explanation of how the RCP fits within the ACA as a whole; (3) ignore the intent of Congress in 2010 when the ACA was enacted; (4) ignore repeated statements by HHS after the enactment of the ACA acknowledging that RCP payments are required annually and are an "obligation of the federal Government"; (5) give primacy to the Government's current litigating position, and 2015 and 2016 budget measures passed by a subsequent Congress (even though those budget measures did not amend the RCP), to discern the intent of Congress in 2010; and (6) conflate the budgetary authority of HHS, as the agency charged with administering the ACA, with the obligations of a unitary United States Government to pay its debts under a money-mandating statute. None of the Government's arguments hold water.

The weakness to the Government's litigating position is demonstrated not merely by its lack of fidelity to the text and purpose of the RCP, and its plea to this Court to ignore the intent of the 2010 Congress and White House that enacted and signed the law, but also by the obvious incongruity between, on the one hand, multiple public statements made by high-ranking HHS

officials that fully support the plain meaning of the statute and Health Options' position here, and, on the other hand, the advocacy positions advanced by the Government's litigation team at the Department of Justice. The Government is wrong on the merits, and comes nowhere close to demonstrating that its position is entitled to deference.

Because the facts are not in dispute (a point which the Government concedes),[1] this case is ripe for resolution in Health Options' favor on its motion for summary judgment. Below, we first briefly address (in opposition) the Government's motion to dismiss this case for lack of subject-matter jurisdiction. On that issue, the Government misconstrues binding precedent and conflates *jurisdictional* issues with *merits* issues. For that reason, this Court should reject it, as two other judges on this Court addressing the identical argument have already as of the filing of this brief.

Second, we explain why the Government's motion to dismiss Health Options' statutory claim for failure to state a claim should be denied, and reiterate why Health Options is entitled to summary judgment. The statute can only be fairly read to require the Government to make timely and complete annual RCP payments to Health Options. The Government's argument to the contrary would eviscerate the statute, and conjure a parallel reality where the risk-mitigation purpose of the RCP is set aside as meaningless in favor of the Government's administrative convenience and political contrivance. The Court should not indulge the Government's position,

[1] While conceding that the facts are not in dispute, the Government makes the vague and unsupported claim that Health Options' statement of undisputed material facts "selectively quotes" various public statements in which the Government has conceded that risk corridors payments are an obligation of the federal Government intended to be paid annually; but the Government does not respond in substance to any of the factual points made by Health Options. Def.'s Opp. to Pl.'s Mot. Summ. J. (Govt. Br.) at 1 n.1. Accordingly, the Court may and should treat those facts as established. *See* RCFC 56(e) ("If a party fails to properly support an assertion of fact or fails to properly address another party's assertion of fact as required by RCFC 56(c), the court may[, *inter alia*,] . . . consider the fact undisputed for purposes of the motion.").

either as a means of statutory interpretation or out of misplaced notions of deference.

ARGUMENT

Health Options is entitled to summary judgment because there is no genuine dispute as to any material fact and, for the reasons stated in its motion for summary judgment and this reply, it is entitled to judgment as a matter of law. *See* RCFC 56(a). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Santa Fe Pac. R.R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002). It follows, then, that the Government's motion to dismiss must also be denied because, on the uncontroverted facts asserted, Health Options has stated a colorable claim for relief that can be redressed by a favorable decision from this Court. *See Prairie Cty., Mont. v. United States*, 113 Fed. Cl. 194, 198 (2013) (quoting *Indian Harbor Ins. Co. v. United States*, 704 F.3d 949, 954 (Fed. Cir. 2013)). "'The court assumes all well-pled factual allegations are true and indulges in all reasonable inferences in favor of the nonmovant.'" *Id.* at 198-99 (quoting *Terry v. United States*, 103 Fed. Cl. 645, 652 (2012)).

I. THIS COURT HAS JURISDICTION OVER HEALTH OPTIONS' CLAIM.

A. Jurisdiction Arises Under the Tucker Act.

This Court has subject-matter jurisdiction over Health Options' claim under the Tucker Act. This Court can and should take note that two other judges of this Court hearing similar disputes under the RCP have concluded jurisdiction exists. *See Health Republic Ins. Co. v. United States*, No. 16-259C-MMS, 2017 WL 83818, at **10-12 (Fed. Cl. Jan. 10, 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).

The jurisdictional inquiry for Health Options' claim is simple. The statute and regulations:

(1) must "be such that they can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained[,]" and

(2) must "be money-mandating as to the class of which plaintiff claims to be a member." *Roberts v. United States*, 745 F.3d 1158, 1162 (Fed. Cir. 2014) (citations and quotations omitted). Plaintiff need only make a "nonfrivolous assertion that it is within the class of plaintiffs entitled to recover under the money-mandating source . . . ." *Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008).

As alleged in its opening brief, Health Options easily meets this threshold standard. And "whether [Health Options] can recover under the particular facts of the case is a merits question and not a jurisdictional issue." *Roberts*, 745 F.3d at 1167; *Jan's Helicopter*, 525 F.3d at 1307 ("The [Supreme] Court [has] made clear that the merits of the claim [are] not pertinent to the jurisdictional inquiry.").

The Government attempts to re-cast merits-related arguments as jurisdictional ones.[2] The Federal Circuit has rejected these very arguments, stating that "[t]here is no requirement in the Tucker Act that there must be a finding that money is due before the Court of Federal Claims can exercise its jurisdiction" including, among other claims, allegations "that an agency has misinterpreted its statutory mandate to pay out monies." *Kanemoto v. Reno*, 41 F.3d 641, 647 (Fed. Cir. 1994) (citations and quotations omitted). *See, e.g.*, *Lummi Tribe of the Lummi Reservation v. United State*s, 99 Fed. Cl. 584, 594 (2011) (where statute at issue mandated that the Government "shall . . . make grants" and "shall allocate any amounts" pursuant to a particular formula, jurisdiction existed because "[s]uch mandatory language is sufficient to confer jurisdiction on this court") (citing *Eastport S.S. Corp. v. United States*, 372 F.2d 1002,

[2] Because the Government's contention that this Court lacks jurisdiction is so closely tied to the merits of Health Options' statutory claim, we rely on the arguments laid out in our opening brief (Pl. Br. at 18-20, 23-40) and below as further demonstration that it is both cognizable and ripe.

1009 (Ct. Cl. 1967), *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877, and *Wolfchild v. United States*, 96 Fed. Cl. 302, 339 (2010)). Similarly, the RCP mandates that the Government "shall pay" certain amounts pursuant to a statutorily prescribed formula. The Government's failure to do so is therefore properly challenged in this Court. *Accord Health Republic*, 2017 WL 83818 at **10-12; *Land of Lincoln*, 129 Fed. Cl. at 95-98.

B. Health Options' Claim Is Ripe.

The Government's contention that Health Options' claim is not ripe is similarly misplaced because Health Options has met the Federal Circuit's two-prong ripeness test commonly referred to as "fitness" and "hardship." *See CBY Design Builders v. United States*, 105 Fed. Cl. 303, 331 (2012).

Health Options meets the "fitness" prong because "further factual development would not significantly advance [this Court's] ability to deal with the legal issues presented." *Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc.*, 527 F.3d 1278, 1295 (Fed. Cir. 2008) (citing *Nat'l Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 812 (2003). As HHS has conceded, the Government owes Health Options RCP payments for the 2014 and 2015 plan years and Health Options has not received those payments, and will not do so in light of the 2015 and 2016 Spending Bills.[3] Indeed, the Government itself has confirmed the precise amounts due to Health Options.[4] In light of the parties' agreement on this issue, there is no "further fact development"

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

[4] CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf (CMS 2014 Payment Letter); CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf (CMS 2015 Payment Letter) ("Today we are confirming that all 2015 benefit year risk corridors collections will be used to pay a portion of

that will eliminate Health Options' current claim or affect the Court's ability to deal with the issues presented. On this issue, everyone agrees: Health Options is owed funds that the Government has not, and will not, pay. Its claim is thus fit for adjudication. *See Health Republic*, 2017 WL 83818 at **12-18; *Land of Lincoln*, 129 Fed. Cl. at 95-98.

Health Options meets the "hardship" prong because the complained-of conduct has an "immediate and substantial impact" on its operations. *Id.* The Government's unpaid balance of $22,950,776.02 alone establishes hardship. *See Coal. for Common Sense in Gov't Procurement v. Sec'y of Veteran Affairs*, 464 F.3d 1306, 1316 (Fed. Cir. 2006); *Inter-Tribal Council of Ariz., Inc. v. United States*, 125 Fed. Cl. 493, 504 (2016) (finding that plaintiff's breach of trust claim established hardship because government's "years of missed payments and lack of security" was threatening the sustainability of the trust at issue).

II. HEALTH OPTIONS IS ENTITLED TO SUMMARY JUDGMENT.

The RCP was intended to serve a specific objective within the framework of the ACA: to mitigate the risk that health insurers—QHP issuers operating on the new exchanges—were assuming in light of the ACA's expansion of myriad coverage requirements and their attendant costs. *See, e.g.*, 42 U.S.C. § 18021(a)(1)(B) (among other requirements, requiring QHPs offered on the exchanges to cover a package of "essential health benefits."). The RCP was one of the enticements that drew insurers such as Health Options into the marketplaces in the first place. Furthermore, by design, the program is annual in nature: annual premium setting, annual enrollment, annual cost calculation, and annual payment—either in or out, depending on how an insurer's final costs compared to its anticipated budget. Nothing in the RCP conditions payments out on payments in, and to read the statute that way makes no sense: that would have undermined the Government's effort to draw insurers into the market on the front end and negated the risk-

---

balances on 2014 benefit year risk corridors payments.").

mitigation for those insurers on the back end. Moreover, (1) the RCP was expressly based on the risk corridor program established under Medicare Part D—an annual, non-budget neutral program. It also cannot be ignored that when and if insurers in the new marketplaces realized gains *over* the statutory threshold, payment to the Government was *required*. It is inconceivable that if payments owed to the Government exceeded payments to insurers under the RCP, the Government would now be taking the same position that it asks the Court to endorse. Indeed, the Government's actions speak for themselves: QHP issuers that have owed money to the Government under the RCP (for lower than projected allowable costs in 2014 and 2015) have been required to submit their RCP payments to the Government in a timely, *annual* manner. Health Options timely paid to the Government $2,045,819.48 due to it realizing lower-than-expected costs on the individual exchange for the 2014 plan year.

Unsurprisingly, HHS acknowledged in contemporaneous statements issued soon after the ACA became law that it also shared this straightforward understanding of the law. For example, HHS acknowledged that the RCP "is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." HHS Notice of Benefit and Payment Parameters for 2014 (2014 Payment Rule), 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013). And even in more recent statements, high-ranking HHS officials have acknowledged that the RCP was intended to make complete, annual payments. Pl. Br. at 15-17 (¶¶ 7-12, 20).

On its merits, the Government's position is flatly inconsistent with the text and purpose of the RCP, and for that reason alone should be rejected. The weakness of its arguments becomes all the more apparent when one takes into account—as this Court should—the ACA politics that have animated the Government's subsequent positions and current litigating

position. After the fact—*i.e.*, after Congress passed the ACA, and after HHS promulgated implementing regulations reiterating the RCP statutory text, and after insurers such as Health Options had already entered the exchanges and enrolled millions of new customers—the Government modified its position. But the Government's new position ignores the fact that Congress has never amended the ACA's mandatory "shall pay" requirement, and makes a charade of statutory interpretation. For these reasons, the Government's argument should be rejected.

A. Congress Intended QHP Issuers Owed Money Under the RCP to Receive Full, Annual Payments.

1. The Court Must Give Effect to the Intent of the Enacting Congress.

Because the Court's objective is to discern and give effect to Congress's intent, its analysis must begin with the statute. *See Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011); *Lamie v. United States Tr.*, 540 U.S. 526, 534 (2004). The Government would have this Court ignore the plain text of the statute and the intent of Congress in 2010 (when the ACA was enacted) and instead infer Congress's intent from *subsequent* actions of a different Congress in 2014 and 2015 (affecting the appropriations available to HHS to fulfill RCP obligations, *inter alia*). Below, we address the absurdity of trying to discern the intent of Congress in 2010 from the actions of Congress several years later. The *intent* that is paramount to deciding this case is the 2010 enacting Congress's intent in designing the RCP.

Further, the Court's review of the ACA includes not only the specific text of the RCP, but also the purpose of the RCP and how it fits within the design of the ACA statutory scheme as a whole. *See King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) ("[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme." (quoting *Utility Air Regulatory Group v. EPA*, 134 S. Ct. 2427, 2441 (2014) (internal quotations

omitted))); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."); *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984) ("If a court, employing the traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."); *Kilpatrick v. Principi,* 327 F.3d 1375, 1384 (Fed. Cir. 2003) ("[I]n determining whether Congress has directly spoken to the point at issue, a court should attempt to discern congressional intent either from the plain language of the statute or, if necessary, by resort to the traditional tools of statutory construction[.]"). Here, Health Options is correct not only because of the plain meaning of the statute, but also because its interpretation is the only one that makes sense in the broader context of the ACA and the RCP.

2. Congress Intended the Government to Make Complete RCP Payments on an Annual Basis.

Section 1342 directs HHS to establish risk *corridors* (plural) for each "plan year" 2014, 2015, and 2016. The term "plan year" means 12 consecutive months under the ACA, 45 C.F.R. § 155.20, and Congress's use of the plural "corridors" was intentional. *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 thing" (quotation and citations omitted)). The RCP's "Payment Methodology" also demonstrates the intent of the program to be administered on an annual basis by predicating the determination of appropriate payment amounts on figures that are calculated annually. The RCP mandates payments to any QHP issuer that, for the applicable year, had "allowable [health care] costs" that were more than three percent greater than a "target amount." *See* ACA § 1342(b). The RCP defines "allowable costs" and the "target amount" in section (c) with reference to "a plan for any year" and the "amount of a plan for any year." *See* ACA §§

1342(c)(1)(A), 1342(c)(2), 1342(b). "Target amounts" necessary to calculating RCP payments are based on payments and receipts under the related risk adjustment and reinsurance provisions, which are annual. 45 C.F.R. § 153.510(a)-(d), (g).

The clarity of Congress's intent is amplified by the fact that it stated expressly that the RCP "shall be based" on the Medicare Part D program, under which CMS makes full, annual payment. Pl. Br. at 7, 22, 24, 30, 39. The Government objects to this proposition on two grounds. First, it states Medicare Part D is administered on an annual basis because of agency discretion, not statutory obligation. Govt. Br. at 22. Second, it contends that the omission from the ACA of language permitting HHS to make RCP payments "in advance of appropriations Acts," as exists in Medicare Part D, signals that Congress did not intend RCP payments under the ACA similarly to be made independent of amounts collected from the QHP issuers who owed money. *Id.* Both contentions are wildly mistaken.

The Government's argument leaves unaddressed the elephant in the room: if Congress did not intend RCP payments (in or out) to be made annually, there would have been no point to the program. The Government ignores this most obvious fact. By making the RCP in the ACA "based on" the equivalent program in Medicare Part D, Congress is presumed to be aware not only of what the statute says, but of how it is administered by HHS. *See Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85 (1988) ("We generally presume that Congress is knowledgeable about existing law pertinent to the legislation it enacts"). If Congress intended a different outcome—in other words, a risk corridors program that did not actually look anything like the Medicare Part D program and omits the key element of the program that goes to the very heart of its efficacy—surely it would not have made the RCP "based on" Medicare Part D.

As for the absence in the ACA of the precise budgetary authority found in Medicare Part

D, that is a red herring, and ignores the words Congress *did* use: "shall be based on." To require Congress to repeat the exact same statutory language would relegate its mandate that RCP "shall be based on" Medicare Part D surplusage. Congress frequently adopts concepts from existing programs into new legislation—it need not reinvent the wheel every time it legislates, especially as it relates to programs already familiar to the affected community. Indeed, the mandate in Section 1342 to make payment annually is even more clear than in Medicare Part D, which provides that HHS "shall establish a risk corridor," 42 U.S.C. § 1395w-115(e)(3); the mandate found in Section 1342 states that the Government "***shall pay.***"[5] The Government's position that the Court should interpret the statute to allow it to *withhold* payment (if paying at all) until long after the year for which Congress intended the payment to be made is nonsensical, and serves to exacerbate premium rate inflation for later years, vitiating the objective of *stabilizing* premiums.

B. The Government Has Acknowledged Congress Intended Full Payment to be Made on an Annual Basis.

Before it adopted the position that the RCP would be administered in a budget-neutral fashion, the Government acknowledged that the RCP was not actually structured to be budget neutral and that full payment should be made annually. In the preamble to its proposed rules to implement the RCP, HHS recognized that the RCP "serves to protect against uncertainty in the Exchange" and will do so by "limiting the extent of issuer losses (and gains)." Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Proposed RCP Rule), 76 Fed. Reg. 41,930 (July 15, 2011). It stressed the timely and annual nature of payments to be made in the preamble to the final rule, stating that:

[5] Indeed, even absent the "based on" language in the ACA, the Government's argument would be overstated. *See, e.g., N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 745-48 (Ct. Cl. 1966) (finding Government obligated to make payment even where statute did not state the payment was an "obligation"); *District of Columbia v. United States*, 67 Fed. Cl. 292, 333-34 (2005) (same).

> 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.*

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Final RCP Rule), 77 Fed. Reg. 17,220, 17,238 (Mar. 23, 2012) (emphasis added).

Thus, HHS: (1) acknowledged the risk-mitigation purpose of the RCP; (2) acknowledged that payment should be made annually; and (3) acknowledged that payments out, from the Government to QHP issuers owed a payment, were not conditional on payments in (*i.e.*, that the RCP was not intended to be budget neutral)—otherwise, it could not have advanced the view that QHP issuers deserved payment within the same 30-day period in which it was requiring QHP issuers that owed money to the Government to make those payments.

As finally promulgated, HHS's regulations implementing the RCP only strengthen the guarantee of § 1342, stating that "issuer[s] *will receive* payment from HHS . . . *under the following circumstances* . . . ." 45 C.F.R. § 153.510(b) (emphasis added). In other words, if "the . . . circumstances" justify an RCP payment for a given year, HHS guaranteed that the QHP issuer "will receive" payment. There is no ambiguity.

Following that, in the preamble to HHS's first "Payment Rule" rulemaking—the 2014 Payment Rule, promulgated on March 11, 2013—HHS yet again reiterated 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." 2014 Payment Rule, 78 Fed. Reg. at 15,473 (emphasis added). It has, of course, long been true that courts give greater weight to agency intent expressed contemporaneously with the promulgation of regulations or the enactment of a new statute than

to later, inconsistent interpretations—especially where the inconsistency is neither acknowledged nor explained, as is the case here. *See, e.g.*, *Comcast Cable Commc'ns, LLC v. FCC*, 717 F.3d 982, 1003 (D.C. Cir. 2013); *Wyo. Outdoor Council v. U.S. Forest Servs.*, 165 F.3d 43, 53 (D.C. Cir. 1999); *Cmty. for Creative Non-Violence v. Watt*, 670 F.2d 1213, 1216 (D.C. Cir. 1982) ("[I]n interpreting an agency's regulations, a court may rely upon the agency's contemporaneously issued Policy Statement as an accurate representation of the agency's intent.").

What is more, where Congress intended a program in the ACA to be budget neutral, it clearly said so, and HHS implemented those programs explicitly as budget neutral, as it did with the Reinsurance and Risk Adjustment programs, the other two premium stabilization programs. With respect to the Reinsurance program, HHS pronounced:

> If HHS determines that all reinsurance payments requested under the national payment parameters from all reinsurance-eligible plans in all States for a benefit year will not be equal to the amount of all reinsurance contributions collected for reinsurance payments under the national contribution rate in all States for an applicable benefit year, HHS will determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments for all States.

45 C.F.R. § 153.230(d). Regarding the Risk Adjustment program, HHS stated unambiguously that "Risk adjustment payments . . . would be fully funded by the charges that are collected from plans with lower risk enrollees (that is, transfers . . . would net to zero)." HHS Notice of Benefit and Payment Parameters for 2014 (Proposed 2014 Payment Rule), 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012); *see also, e.g.*, 2014 Payment Rule, 78 Fed. Reg. at 15,441 (Risk Adjustment methodology provides for a "budget-neutral revenue redistribution among issuers"). Clarity about such a significant aspect of a premium stabilization program makes sense, as clarity best serves the QHP issuers' ability to properly plan financially and fulfill the purposes of the RCP.

As for the Government now questioning whether "full payment" may or need ever be

paid, and its startling assertion that "Congress planned the program to be self-funding," Govt. Br. at 30, that, too, must be rejected as revisionist history put forth for the convenience of litigation.

As detailed in Health Options' Statement of Undisputed Material Facts, HHS acknowledged even after the commencement of the risk corridors litigation in this Court that "full payment" by the Government is an obligation of the United States. *See* Pl. Br. at 15-17 (¶¶ 7-13, 20). To be clear, Health Options is not suggesting that agency pronouncements that "full payment" is due to QHP issuers, in and of themselves, give rise to the right to full payment. That right, along with the Government's obligation to make payment, is cemented by the statute itself, for the reasons discussed herein and in the motion for summary judgment. The relevant point to be made here is that, HHS having repeatedly *acknowledged* the obligation to make full payment, the Government may not now, through litigation counsel, expect to be taken seriously that, all along, it believed "Congress planned the program to be self-funding." Indeed, if HHS interpreted it that way, it would not have reiterated that, in the event of a shortfall at the end of the three-year program, it would make up the difference through other sources of funding.[6] Such a "true-up" would have been unnecessary if the program were self-funding. How could there be a "shortfall" if payments out only ever had to equal payments in? Clearly, HHS never believed that the program was self-funding. In any event, it is not supported by the text and purpose of the statute.

[6] CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf (November 19 Guidance) ("In the event of a shortfall for the 2016 program year, [HHS] will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments."); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF (same).

The Government's litigating position is all the more startling in light of the fact that no mention was made at any time during the HHS rulemaking process of either: (1) the policy position HHS adopted post hoc, *i.e.*, that the RCP was to be administered in a budget neutral manner, or (2) the litigating position advanced in this case, *i.e.*, that Congress intended the RCP to be self-funded. It is hornbook administrative law that an agency cannot say one thing during rulemaking and then take a different position altogether after the rulemaking docket has closed. If HHS were genuinely of the view at the time it promulgated its implementing regulation that § 1342 allowed it, and that HHS intended, to implement the RCP in a budget-neutral manner, then it was obligated as a matter of administrative law, the ACA, and the Administrative Procedure Act to make that clear in its rule proposal and allow the public to comment on that proposal. *See* 5 U.S.C. § 553 (rulemaking). As the D.C. Circuit has emphasized:

> Notice requirements are designed (1) to ensure that agency regulations are tested via exposure to diverse public comment, (2) to ensure fairness to affected parties, and (3) to give affected parties an opportunity to develop evidence in the record to support their objections to the rule and thereby enhance the quality of judicial review.

Int'l Union, United Mine Workers of Am. v. MSHA, 407 F.3d 1250, 1259 (D.C. Cir. 2005); *see also Sprint Corp.*, 315 F.3d at 373 (pointing out that notice and public comment also improves the quality of agency rulemaking). It is unthinkable under federal APA jurisprudence that an agency could accomplish what the Government is asking this Court to endorse. *See, e.g.*, *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-09 (D.C. Cir. 2014) (vacating part of an HHS rule setting hospital reimbursement rates where it was diametrically opposed to the proposed rule for lack of adequate notice). Although this case does not arise under the APA, the governing principles of statutory interpretation and administrative law are no less applicable to the question of what § 1342 means, and those governing principles should cause this Court to reject the

Government's position as inconsistent with § 1342 and HHS's implementing regulation. *See also infra* Part II.C.5 (explaining why the Government is not entitled to deference).

C. The Government's Current Position Is Inconsistent with Section 1342 and the Intent of Congress.

The Government urges this Court to adopt a view of the RCP that defies logic. According to the Government, the RCP's lack of independent budgetary authorization and the actions of later Congresses to curtail HHS's authority to make RCP payments demonstrate that the 2010 Congress intended the RCP to be self-funding, and thus administered in a budget neutral manner. In so arguing, the Government ignores the text and purpose of the RCP (and would have this Court do the same), distorts case authorities, and misconstrues basic tenets of statutory interpretation.

Outside of litigation, the Government *has never* taken the position that the RCP was intended to be self-funding. We can only presume that officials at HHS recognize the implausibility of that position, as reflected in the many statements of high-ranking HHS officials, summarized above and in our motion for summary judgment, repeatedly acknowledging the Government's obligation to make full payment. *See* Pl. Br. at 15-17 (¶¶ 7-12, 20). It is true that, on its own, HHS adopted the position that the RCP should be administered across its three-year span in a budget-neutral manner. That position—which is inconsistent with its initial interpretation of the RCP, was never discussed in the notice-and-comment rulemaking process, and was adopted only after its earlier interpretation and pronouncements rankled ACA opponents in Congress—is legally untenable in its own right. But, HHS has nevertheless conceded (at least outside of litigation) that, sooner or later, the United States would have to make full payment to QHP issuers. In essence, it was a policy of kicking the can down the road, with the recognition that the Government has an obligation to make full payment. That is a matter of public record.

It has only been within the context of this litigation (and the other RCP cases pending before the Court) that the Government (speaking through the Department of Justice) has taken the *contrary* position that the RCP was intended to be self-funded and, as a result, full payment may never be made. That is a litigating position and not supported by the law or HHS's actions.

1. The Government's Obligation to Pay Under the RCP Does Not Depend on Congress Also Creating an Independent Appropriation.

In contending that the RCP was intended to be administered in a budget neutral manner, the Government conflates budget authority (the ability to pay) with liability (the obligation to pay). For the reasons stated in Health Options' motion for summary judgment and above, the ACA makes plain that Congress obligated the United States to make complete RCP payments where the statutory triggers are met no differently than it obligated QHP issuers to make payments in where the reciprocal triggers are met. The availability of an appropriation is of course important to the functioning of any money-mandating program, but it has nothing to do with liability. When and if this Court renders a judgment, that judgment is payable from the Judgment Fund. *See* Pl. Br. at 40.

2. CBO's Failure to Score the RCP Is Irrelevant and, in Any Case, Supports Health Options.

The Government also relies on the Congressional Budget Office's (CBO's) omission of the RCP from its scoring, and Congress's purported reliance on that omission in voting on the law. But neither the cherry-picked comments of certain Members of Congress nor the actions (or inaction) of the CBO itself adds weight to the Government's position. The Government's effort to manufacture congressional intent from non-congressional pronouncements not contained in the laws themselves are precisely why legislative history frequently "has no bearing; what matters is the law the Legislature *did* enact." *Shady Grove Orthopedic Assocs., P.A. v. Allstate Ins. Co.*, 559 U.S. 393, 403 (2010). As the Supreme Court has observed:

> [L]egislative history is itself often murky, ambiguous, and contradictory. Judicial investigation of legislative history has a tendency to become . . . an exercise in 'looking over a crowd and picking out your friends' . . . judicial reliance on legislative materials like committee reports, which are not themselves subject to the requirements of Article I, may give unrepresentative committee members—or, worse yet, unelected staffers and lobbyists—both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text.

Exxon Mobil Corp. v. Allapattah Servs., Inc., 545 U.S. 546, 568 (2005) (quoting Patricia M. Wald, "Some Observations on the Use of Legislative History in the 1981 Supreme Court Term," 68 Iowa L. Rev. 195, 214 (1983)).

Further, as explained in our motion for summary judgment, "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent." *Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009); *see also Ameritech Corp. v. McCann*, 403 F.3d 908, 913 (7th Cir. 2005) (Easterbrook, J.) ("Congress did not vote [on], and the President did not sign" the CBO opinion, and thus it "cannot alter the meaning of enacted statutes"). Thus, the Government's position illustrates precisely the dangers the Supreme Court feared by elevating various disparate sources to subvert the statutory text.

In any event, and for what it is worth, the CBO's statements actually support Health Options' position that the RCP was not intended to be budget neutral. In a 2014 report, it stated:

> By law, risk adjustment payments and reinsurance payments will be offset by collections from health insurance plans of equal magnitudes; those collections will be recorded as revenues. As a result, those payments and collections can have no net effect on the budget deficit. ***In contrast, risk corridor collections (which will be recorded as revenues) will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit***.

CBO, "The Budget and Economic Outlook: 2014 to 2024" at 59 (Feb. 4, 2014) (emphasis

added), *available at* https://www.cbo.gov/publication/45010 (CBO Budget Outlook).[7] And while this report came after the RCP had launched, it demonstrates that any decision of the CBO not to score the RCP should not be confused with an opinion that the RCP was intended to be budget neutral.[8] CBO's view of the RCP, though irrelevant to congressional intent, clearly supports Health Options' position.

3. The 2015 and 2016 Spending Laws Did Not Alter the Government's RCP Liability.

The Government takes the position that the appropriations actions of Congress in the 2015 and 2016 Spending Laws—cabining HHS's appropriations for RCP payment obligations to QHP issuers—"confirm what is implicit in the structure of the Act itself—that Congress intends HHS to administer the risk corridors program as a self-funding program of redistribution among insurers." Govt. Br. at 35. This claim should be rejected for multiple reasons. First, as a legal matter, what Congress intended in 2014 or 2015 cannot, by definition, bear on the intent of Congress in 2010 when it enacted the ACA. *See Massachusetts v. EPA*, 549 U.S. 497, 530 n.27 (2007) ("[P]ost-enactment legislative history is not only oxymoronic but inherently entitled to little weight" (quoting *Cobell v. Norton*, 428 F.3d 1070, 1075 (D.C. Cir. 2005))).

Second, the assertion is incongruous with what the Government argues elsewhere. The idea that the Government believes that Congress intended in 2010 for HHS to administer the RCP in a budget-neutral manner is belied not only by the statements made by HHS in 2011

[7] Similarly, the Government Accountability Office concluded that RCP payments out were not conditioned on payments in, and could be made from HHS's general appropriation. *See* GAO, B-325630, HHS—Risk Corridors Program (Sept. 30, 2014) (GAO RCP Op.), *available at* http://gao.gov/assets/670/666299.pdf.

[8] Indeed, because the RCP is not budget neutral, just like Medicare Part D, the CBO may have declined to score it because it could not predict the net cost of the program, as had been the case with the Medicare Part D risk corridor program, which fluctuated between net revenue and net cost for several years. CBO Budget Outlook at Table 2-1. Ultimately, the answer to the question does not matter because the CBO's views are not relevant to the question of what Congress intended.

through 2013, discussed above, but also by the fact that the Government is asking the Court for deference to its position. We address the issue of deference below, but as an initial matter we note that the two arguments are incompatible: the only reason an agency would ever ask for (let alone be granted) deference would be because the governing statute is ambiguous. For the reasons stated above and in the motion for summary judgment, the statute is clear and unambiguous, and requires payment. But as a matter of addressing the Government's own arguments, the Court must at least find that the Government cannot have it both ways: the statute cannot be at once both "implicit[ly]" clear *and* ambiguous.

Moreover, the Government's suggestion that, even if the *2010 Congress* did not enact a budget-neutral RCP, Congress *later* amended it, is without merit. The 2015 and 2016 Spending Laws 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—that law remains unchanged. *See* Pl. Br. at 40.

Congress can *only* amend a law by: (1) changing the words of the statute it wishes to amend, or (2) "clearly manifesting" an intent in a different statute to change the earlier law. Regarding the RCP, it has done neither. The Government argues that, even though Congress *declined* to pass multiple contemporaneous bills that would have substantively amended the ACA and the risk corridors program, Congress somehow achieved a substantive amendment of the RCP through the 2015 and 2016 Spending Laws. That makes no sense. Congress could have amended the RCP by standalone legislation, but it did not. The Spending Laws restricted RCP payments from particular funding sources, but they did not also substantively amend the law. It defies logic that Congress "clearly manifested" intent to amend the RCP by declining to amend the RCP in standalone legislation, and then passing the Spending Laws which restricted certain

funding sources—but *did not* amend the substantive law. The Government's attempt to brush off this fact in a footnote (Govt. Br. at 35 n.20) only serves to punctuate the weakness of its position. Its focus on trying to explain Congress's intent in passing the 2015 and 2016 Spending Laws is a red herring.

There are two points to make about this: First, the 2015 and 2016 Spending Laws would have been completely unnecessary had Congress thought (and more importantly, had Congress thought that HHS thought) that the RCP as enacted was budget neutral. Second, the 2015 and 2016 Spending Laws could not have substantively amended the ACA to make it budget neutral because, had that been what the Spending Laws did, they would have failed in Congress or by veto—as other efforts to amend the ACA failed. The Government never confronts these points.

The cases cited by the Government do not help its cause. To begin, the general rule is that Congress is presumed not to amend substantive law unless its intent to do so is "clearly manifest." *N.Y. Airways*, 369 F.2d at 749 ("[t]he intent of Congress to effect a change in the substantive law via provision in an appropriation act must be clearly manifest."). *Gibney v. United States* is squarely on point. There, the Court of Claims held that language nearly identical to the language at issue in the present case[9] was "a pure limitation on an appropriation bill [that] does not have the effect of either repealing or even suspending an existing statutory obligation." 114 Ct. Cl. 38, 50-51 (1949). This Court should similarly find that mere appropriations language has not amended a preexisting statutory obligation of the Government.

[9] *Compare* 114 Ct. Cl. 38, 44 ("none of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided") *with* 2015 Appropriation Bill, Pub. L. No. 113-235, § 227 ("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" RCP payments.).

The Government's principal case law is distinguishable because it involves appropriations language that "clearly manifested" an intent to amend the underlying law. *See United States v. Will*, 449 U.S. 200, 205-08 (1980); *United States v. Dickerson*, 310 U.S. 554, 556-57 (1940); *Republic Airlines, Inc. v. U.S. Dep't of Transp.*, 849 F.2d 1315, 1317 (10th Cir. 1988). *See* Pl. Mot. at 33-36. As it regards the RCP, all Congress did was limit the use of particular funding sources. For its part, Section 1342 of the ACA remains unchanged, and nothing in the 2015 and 2016 Spending Laws vitiates the payment obligations of the United States that accrue under the RCP.

4. The ACA Does Not Support the Government's "Three-Year" Program Argument and, in Any Event, That Argument Distracts From the Central Issue Before the Court.

Because the Government places so much reliance on it, Health Options will address HHS's purported policy of administering the RCP across the "three-year" horizon of the temporary RCP. To be clear, however, the Government's portrayal in litigation of HHS's purported "three-year" policy is a sleight of hand belied by HHS's actions.

Withholding payment until the end of the three-year RCP program is at odds with the risk corridors program. Taken at face value, it defeats the very point of the RCP that HHS recognized early on. *See, e.g.*, 2014 Payment Rule, 78 Fed. Reg. at 15,473. Incredibly, the Government states that "CHO offers no reason why the protection provided by the statute must be in the form of full annual payments, rather than payments spread out over the three years of the program." Govt. Br. at 23. For obvious reasons, the non-payment of millions of dollars owed to a nonprofit like Health Options—for years—directly and negatively affects its operations and the functioning of the marketplace. Testifying under oath in federal court in mid-December 2016, Kevin Counihan—HHS's Director and Marketplace Chief Executive Officer at CMS—acknowledged that the Government's "non-payment of the risk corridor payments" in

2014 (beyond the partial 12.6% payment) "*had a deleterious effect on the solvency of some insurance companies.*" Transcript of Bench Trial 2612:9-10, *United States v. Aetna, Inc., et al.*, CA No. 16-1494 (Bates, J.) (D.D.C. Dec. 16, 2016) (emphasis added).[10]

This should come as no surprise. After all, HHS recognized the need for prompt payment years ago. Final RCP Rule, 77 Fed. Reg. at 17,238-17,239. Ruling against the Government on this argument in another case pending before this Court, Judge Sweeney recently stated about the RCP: "If these programs did not provide for prompt compensation to insurers upon the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges," and "one of the goals of the Affordable Care Act – the creation of 'effective health insurance markets,' [§ 18091(2)(I)–(J)] – would be unattainable." *Health Republic*, 2017 WL 83818 at *15. In fact, the plaintiff in the *Health Republic* case itself went into receivership and left its exchange following the Government's refusal to make full RCP payments. *See* Compl. ¶ 19, *Health Republic Ins. Co. v. United States*, No. 16-259C (Sweeney, J.) (Feb. 24, 2016), ECF No. 1. Health Options has fought to continue operations despite substantial losses attributable to the Government's failure to make payment. This year, however, Health Options has had to withdraw from the New Hampshire exchange because of financial constraints caused at least in part by the Government's refusal to pay its RCP debt. The Government's refusal to acknowledge the obvious effects of its actions is startling. Regardless, "[i]t is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494.

Substantively, there is no merit to the Government's so-called "three-year payment framework." It is belied by the fact that, in practice, HHS has tried to make annual payments—

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

there would have been no reason for this had it actually believed no annual payment was necessary. Oddly, appearing in this Court in another risk corridors case (*Moda Health Plan, Inc. v. United States*, No. 16-649C), Government counsel—attempting to explain the limited effect the Court should give to Judge Sweeney's conclusion (in *Health Republic*) that payments under the RCP were intended by Congress to be made annually—stated:

> [Judge Sweeney] only decided a point that isn't really in dispute and that's that HHS is required to at least make some payments annually, as HHS has done for each of the two years in which it's made payments.

Transcript of Oral Argument at 6:21-24, *Moda Health Plan, Inc. v. United States*, No. 16-649C (Wheeler, J.) (Fed. Cl. Jan. 13, 2017). But nowhere, in this case or any other, has the Government advanced or explained that baffling new position.

In reality, HHS's stated objective back in spring 2014 was only to kick the "full-payment" can down the road and hope that either enough payments came in to fund the payment obligations to QHP issuers, or that Congress would eventually provide an appropriation to do so. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (April 11 Guidance) (confirming partial payment on an annual basis and stating that HHS would announce through future rulemaking or guidance how the Government would cover RCP obligations in the event amounts collected were less than amounts owed); November 19 Guidance (confirming annual partial payment). In litigation, the Government now says that full payment may never be made. Whatever the case, either analyzing the "three-year" plan as of its announcement by HHS in the spring of 2014 or now in the context of this litigation, it is little more than a gambit to justify not making the RCP payments in the timely manner intended by Congress in 2010 and *required* under the statute. As Health Options has shown elsewhere, the failure to make full, annual payments is unlawful.

5. This Court Should Not Defer to HHS's Regulation or Informal Statements Cited by the Government.

a. Congress never delegated the authority to make budgeting-related decisions to HHS.

The Government cites no support for the proposition that Congress, the traditional budgeting body, intended to delegate interpretative authority over the money-mandating portions of the RCP to HHS, an agency with no claim to any such expertise. *See King*, 135 S. Ct. at 2489. Because the Government seeks to exceed the ACA's scope of delegated authority on this "major question," *id.*, this Court should not defer to the Government's request for *Chevron* deference.

Deference to agency determinations centers on agencies' "body of experience and informed judgment . . . ." *United States v. Mead Corp.*, 533 U.S. 218, 227-28 (2001) (quotation marks omitted). Courts "must be guided to a degree by common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 121 (2000).

Although the Government argues that the issues of whether and when QHP issuers can expect payment is not a decision of immense "economic and political significance," Govt. Br. at 23, it has previously acknowledged that these very issues "implicate a total of $2.5 billion in federal funding for the 2014 benefit year and potentially comparable amounts for the 2015 and 2016 benefit years." Def. Mot. Stay at 2, ECF No. 8. As in *King*, common sense dictates that Congress did not delegate a critical budgeting decision of such significance to HHS, an agency with healthcare policy expertise but lacking in tax and budgeting expertise. *See King*, 135 S. Ct. at 2489. The Government has provided no support for the proposition that Congress entrusted HHS with multi-billion dollar decisions affecting the public treasury.[11] *See Cathedral Candle Co.*

[11] Congress assesses "Budget Justifications" submitted by the agency in making its federal budgeting determinations. HHS, Budget & Performance, *available at*

v. U.S. Int'l Trade Comm'n, 400 F.3d 1352, 1365 (Fed. Cir. 2005) (no *Chevron* deference where "Congress did not authorize the [agency] to construe the [statutory provision] either through regulation or adjudication . . .").[12]

b. In any event, this Court need not look to HHS's interpretations at all because the statute clearly establishes full, annual payments.

Under any theory of deference, where the statute is unambiguous, the Court does not defer to an agency's interpretation; the statute itself controls. *See Chevron*, 467 U.S. at 842. As detailed *supra* Part II.A.2, Congress statutorily mandated that the Government "*shall pay*" a certain amount of cost overruns back to QHP issuers, regardless of receipts under the RCP. The inquiry ends there.

c. Even if the RCP were ambiguous, the Government's informal statements do not merit Chevron deference.

Striking about the Government's plea for deference is that it totally ignores the only regulation it promulgated by way of notice-and-comment rulemaking addressing the RCP payment scheme. *See* 45 C.F.R. § 153.510. We assume it ignores that regulation because, as noted above, that regulation only *strengthens* what is obvious about Section 1342 itself: payments out under the RCP are obligated without regard to payments in (and vice versa).

The Government's plea for deference instead focuses on its subsequent, informal pronouncements. That is odd, since, *even if* Section 1342 were ambiguous (which it is not), such statements would at best be entitled to "respect" under the *Skidmore/Mead* standard of deference. Pl. Br. at 38-39; Govt. Br. at 19. The Government provides absolutely no response to Health Options' argument on this point even though the principal precedent cited by the Government,

---

https://www.hhs.gov/about/budget/index.html?language=es#.

[12] *See also Gonzales v. Oregon*, 546 U.S. 243, 258-59 (2006). The Government urges that *Gonzales* does not support this point. Govt. Br. at 22 n.10 (citing 546 U.S. at 257). But the Court explained this exact proposition in the two pages following the Government's citation.

Cathedral Candle[13] (Govt. Br. at 19), drew precisely this distinction between regulations promulgated following notice-and-comment rulemaking and informal agency pronouncements—and the deference each type of pronouncement merits.[14]

d. HHS's informal interpretations are neither persuasive nor entitled to deference under the Skidmore/Mead framework.

Where the agency's "informal" interpretation was not subject to notice-and-comment rulemaking,[15] or exceeded Congress's delegation of authority,[16] or interpreted a parroting regulation,[17] the Court and Federal Circuit have explained that deference, to the extent that any is warranted, must be evaluated under the *Skidmore*/*Mead* framework. *See Gonzales*, 546 U.S at 256-58; *Cathedral Candle*, 400 F.3d at 1365 (informal agency interpretation of the Byrd

---

[13] 400 F.3d 1352, 1362-63 (Fed. Cir. 2005).

[14] *See Cathedral Candle*, 400 F.3d at 1365. We note that the Government would fare no better to re-cast its informal statements and litigation position as an interpretation of its own *regulation*, since 45 C.F.R. § 153.510 essentially paraphrases and "parrot[s]" Section 1342. *See Gonzales*, 546 U.S. at 257 (denying deference to informal agency interpretations of a "parroting regulation" where the agency "paraphrase[d] the statutory language" by repeating two phrases and summarizing the others); *see also Haas v. Peake*, 525 F.3d 1168, 1186 (Fed. Cir. 2008) (explaining that *Chevron* deference "does not apply if a particular regulation merely 'parrots' statutory language, because if it did, an agency could bypass meaningful rule-making procedures by simply adopting an informal 'interpretation' of regulatory language taken directly from the [ambiguous] statute in question."). *Compare* 45 C.F.R § 153.510(b) ("HHS will pay the QHP issuer…"), *with* ACA Section 1342(b) ("[T]he Secretary shall pay to the plan…").

[15] The Government asserts that the pronouncements it relies on constituted formal rulemaking. But it cites to only informal agency statements and not one piece of formal language that was actually *subject to* (not simply peripheral to) notice-and-comment rulemaking. Collectively, these cited documents comprise nothing more than two short guidance documents published on the CMS website and two examples of HHS responses to industry comments that appeared in *preambles* but were not part of rulemakings themselves. These are not regulations and, at most, are entitled to only *Skidmore* deference, as discussed in our motion and this brief. *See generally* Govt. Br. at 19-27; April 11 Guidance (agency guidance document posted on CMS website); November 19 Guidance (same); HHS Notice of Benefit and Payment Parameters for 2015 (2015 Payment Rule), 79 Fed. Reg. 13,744, 13,787 (March 11, 2014) (uncodified agency responses to industry comments); Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) (same).

[16] *See King*, 135 S. Ct. at 2489; *Cathedral Candle*, 400 F.3d at 1365.

[17] *See supra* note 14.

Amendment only merited potential *Skidmore* deference). Under the *Skidmore*/*Mead* framework, informal sub-regulatory statements are limited to "respect" to the extent that they have the "power to persuade." Govt. Br. at 20; *Skidmore v. Swift*, 323 U.S. 134, 139 (1944); *Mead*, 533 U.S. at 219. The "degree of deference depend[s] on the circumstances." *Cathedral Candle*, 400 F.3d at 1365.

Skidmore and *Mead* established eight factors by which to determine whether informal agency pronouncements have the power to persuade:

1. The thoroughness evident in the agency's interpretation;
2. the validity of the agency's reasoning;
3. the interpretation's consistency with earlier and later pronouncements; and
4. "all those factors which give it power to persuade."

Skidmore, 323 U.S. at 140.

5. The degree of the agency's care, consistency, formality, thoroughness, and logic;
6. the agency's relative "expertness" and specialized experience;
7. the highly detailed nature of the regulatory scheme and the value of uniformity in the agency's understanding of what a national law requires; and
8. any other sources of weight.

Mead, 533 U.S. at 228, 234. Each and every factor weighs against according *any* deference.[18]

As explained above, the Government cites to a handful of informal sub-regulatory statements as warranting deference: two guidance documents and two uncodified agency responses to industry comments. *See supra* note 15. Under *Skidmore/Mead*, these documents do not merit deference because they lack the power to persuade.

1. They lack validity.

The informal HHS pronouncements lack validity (Factors 2 and 5) because, even if the Government's characterization of them is accurate, such an interpretation subverts the RCP's purpose to prevent an economic "death spiral" in which "premiums r[i]se higher and higher, and

[18] As several of the factors overlap, this brief takes them in topical rather than numerical order.

the number of people buying insurance s[i]nk lower and lower, [and] insurers beg[i]n to leave the market entirely." *King*, 135 S. Ct. at 2486.[19] Per HHS, the RCP is "designed to provide issuers with greater payment stability as insurance market reforms are implemented" and would "protect against uncertainty in the Exchange by limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930-41,931.

The Government provides no sensible explanation for how a non-annual program in which issuers may not receive *any funds whatsoever* and, even if they are slated to receive funds, receives them *at the end of three years*, promotes premium stabilization. Under its current "self-funding" RCP theory, the Government seeks to expose QHP issuers to the full brunt of all risk posed by the untested marketplace by conditioning "payments out" of the program on the amount of "payments in," if any, and requires those issuers to carry potentially substantial losses on their books from year to year. Such a construction lacks persuasive power because it ushers in the very eventuality the RCP was designed to prevent.[20] *See King*, 135 S. Ct. at 2496 ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them."); *see also N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973) ("We cannot interpret federal statutes to negate their own stated purposes."); *Cathedral Candle*, 400 F.3d at 1364 (unreasonable interpretation if "at odds with the purposes served by the regulation.").

2. They lack formality.

The pronouncements' lack of formality (Factor 5) also weighs against deference because a decision of this magnitude should have undergone notice-and-comment rulemaking. Under the

[19] *See Health Republic*, 2017 WL 83818 at **22-23.

[20] The adverse effect of such a construction is already palpable. Insurance premiums are slated to rise 22% in 2017, attributable in part to "the fact that some of the programs meant to keep rates lower are ending at the end of this year" and many issuers "have either left the market or have had to raise their prices sharply to cover the cost of providing coverage." *See* discussion *supra* at pages 23-24 & n.10.

Administrative Procedure Act, "rules" are defined broadly as nearly any agency regulations that set forth what regulated entities must or should do in the future and, with very limited exceptions, they are subject to notice-and-comment rulemaking requirements. 5 U.S.C. §§ 551(4); 553. The bedrock principle underlying notice-and-comment rulemaking is that agency decisions that will significantly affect the rights and duties of regulated parties should be subject to public review and comment. *See Encino Motorcars, LLC v. Navarro*, 579 U.S. ____, slip op. at 9 (2016) ("One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions."). This is particularly important where an agency seeks to *flip-flop* on policies that may "have 'engendered serious reliance interests that must be taken into account.'" *Id*. (quoting *FCC v. Fox Tele. Stations, Inc.*, 556 U.S. 502, 515 (2009)).

It stands to reason that a decision that could mean the difference between a regulated entity receiving $0 as opposed to, in the case of QHP issuers, over $2.5 billion for 2014 alone, merits notice and comment. *See Ala. v. Ctrs. for Medicare & Medicaid Servs.*, 780 F. Supp. 2d 1219, 1231-32 (M.D. Ala. 2011), *aff'd,* 674 F.3d 1241 (11th Cir. 2012) (where CMS issued a letter setting a formula for computing how much money was owed to the Government under the Medicaid Act, it was required to undergo notice-and-comment rulemaking).

The Government's argument that such a significant change in policy was effectuated through informal procedures lacks the power to persuade and should not be accorded deference. The Government cites only (1) two guidance documents that appear on the CMS website, and (2) agency responses to industry comments that were neither codified nor *themselves* the product of notice-and-comment rulemaking. *See Principal Life Ins. Co. & Subsidiaries v. United States*, 116 Fed. Cl. 82, 104 n.47 (2014) (citing *Skidmore,* 323 U.S. at 140; *Kingdomware Techs. Inc. v.*

United States, 107 Fed. Cl. 226, 243 (2012)). The lack of formality therefore also weighs against deference.

3. They lack thoroughness of reasoning.

For the same reasons, the informal agency pronouncements lack the thoroughness of reasoning (Factors 1, 5) that is such a hallmark of agency interpretations entitled to deference. HHS's statements that it "intends to implement the [risk corridors] program in a budget neutral manner," Govt. Br. at 8, provides absolutely no reasoning to "show that there are good reasons for the new policy." Pl. Br. at 40 n.31 (citing *Fox Tele. Stations*, 556 U.S. at 515); *Christopher v. SmithKline Beecham Corp.*, 567 U. S. ___, slip op. at 10 (2012) (deference is inappropriate "when there is reason to suspect that the agency's interpretation does not reflect the agency's fair and considered judgment"). Rather, the bald statements cited by the Government reflect quite the opposite: an agency hamstrung by a frustrated Congress seeking to undermine the ACA. There is no administrative record, no questions and answers from the public, and no statements whatsoever explaining what, if any, reasoning HHS even applied. Indeed, it does not even confront these hard questions in this litigation, despite Health Options putting them front and center in its motion.

The absence of reasoned decision-making is further highlighted by the agency's original, ***directly contradictory*** pronouncement that RCP was "not statutorily required to be budget neutral." 2014 Payment Rule, 78 Fed. Reg. at 15,473. The Government's reliance on HHS's purported "three-year framework" is even more dubious because HHS has *always* attempted to administer payments annually, even if not completely—the latter point being *foisted upon HHS by Congress, not an artifact of thorough agency reasoning. See* April 11 Guidance (establishing

that partial payments will be made annually); November 19 Guidance (same). *See also* discussion *supra* at pages 24-25.

Rather than reasoned agency decision-making with the power to persuade, the record of this case reflects an agency outside of litigation trying to salvage what it well knew was Congress's intent: to make full payment annually. That is the entire reason the appropriation process has driven HHS's decision-making: it knew the RCP was not supposed to be, as the Government claims in this litigation, "self-funding." Indeed, HHS's Kevin Counihan acknowledged in his December testimony that the RCP "got changed in 2015 in a budget act in a way ***that was not intended***." *Aetna*, Transcript at 2611:20-22 (emphasis added). The Government's position has no power to persuade whatsoever.

4. They lack consistency and there is value to uniformity.

On a related point, the informal policy statements also lack consistency (Factor 3) with HHS's earlier and later pronouncements. HHS's first and final statements establish an annual, non-budget neutral RCP. HHS first pronounced that RCP payments were "not statutorily required to be budget neutral" and, in setting a 30-day deadline upon annual notification of charges for issuers to remit payments, that "payment deadlines should be the same for HHS and QHP issuers." 2014 Payment Rule, 78 Fed. Reg. at 15,473; Final RCP Rule, 77 Fed. Reg. at 17,238-17,239. Moreover, HHS's more recent pronouncements, and indeed its actions, illustrate its commitment to making payments on an annual basis and unrestricted by budget neutrality. Pl. Br. at 15-17 (¶¶ 7-12, 20) (reiterating that "full payment is required," RCP payments are an "obligation of the United States Government," and making partial payment on an annual basis). HHS's first and last word on the matter establishes full, annual RCP payments.

The Government's efforts to cherry-pick an interim, temporary change in HHS's informal position and elevate it to deference-worthy formal regulations fail because "an agency's interpretation of a . . . regulation that conflicts with a prior interpretation is entitled to considerably less deference than a consistently held agency view." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 515 (1994) (citing *INS v. Cardozo-Fonseca*, 480 U.S. 421, 446 n.30 (1987))); *cf. AT&T Corp. v. FCC*, No. 15-1059, slip op. at 14 (D.C. Cir. Nov. 18, 2016) ("An interpretation at odds with the agency's expressed intent at the time of adoption enjoys no judicial deference." (citing *Comcast Cable Commc'ns, LLC v. FCC*, 717 F.3d 982, 1003 (D.C. Cir. 2013))). The lack of consistency illustrated by HHS's singular, interim change in position lacks the power to persuade required to merit deference.

Moreover, the question of whether and when QHP issuers will be paid is an area that would greatly benefit from uniformity in order to carry out the ACA's purpose (Factor 7). HHS has explained that the RCP is "designed to provide issuers with greater payment stability as insurance market reforms are implemented" and would "protect against uncertainty in the Exchange by limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930-41,931. The gulf between annual payments unrestrained by budget neutrality, espoused by HHS (outside of litigation) and Health Options, and three-year payments subject to budget neutrality, espoused by the Government in this case, is enormous. Under the former theory, Health Options is entitled to $22,739,206 for benefit year 2015,[21] while under the latter theory, it is entitled to nothing. Even if the agency pronouncements cited by the Government had established such a shift in policy, they lack the power to persuade because HHS's earlier and later statements establish a consistent, annual, full-payment structure. Such a significant shift in

[21] Since Health Options filed its complaint, CMS has confirmed the amount owed for the 2015 benefit year. CMS 2015 Payment Letter.

agency policy, through informal statements no less, do not garner deference, especially where the effect of such a change fundamentally alters the statutory scheme.[22]

5. They reflect convenient litigating positions and politics, not reasoned agency decision-making with the power to persuade.

Skidmore/Mead deference allows for any other factors or sources of weight that might have the power to persuade (Factors 4, 8), but the Government has brought forth none. To the contrary, as Health Options has demonstrated, the cited pronouncements should be given even less weight because they are portrayed here by the Government out of context as part of a convenient litigating position. "Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate." *Parker v. OPM*, 974 F.2d 164, 166 (Fed. Cir. 1992) (quoting *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988)).

Although HHS adopted in the spring of 2014 a purported "three-year" plan to administer the RCP in a "budget neutral" manner, the record is clear that HHS always intended to make "full payment" to QHP issuers. It has only been in this litigation that the Government has spun the web of informal HHS pronouncements to advance the viewpoint that the RCP was *intended by Congress* to be "self-funding." For the reasons stated above, that position is absurd both on its face and as a matter of common sense.

III. CONCLUSION

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

[22] Moreover, for the very same reasons stated *supra* Part II.C.5.a, HHS lacks the specialized experience (Factor 6) in the area of federal budgeting, further diminishing its power to persuade with respect to informal pronouncements making fundamental changes in that area.

Dated: January 20, 2017

Respectfully submitted,

/s/ Stephen McBrady

Stephen McBrady, Esq.
CROWELL & MORING LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 624-2500
Fax: (202) 628-5116
SMcBrady@crowell.com

Attorney for Plaintiff Health Options

OF COUNSEL:
Daniel Wolff, Esq.
Xavier Baker, Esq.
Skye Mathieson, Esq.
Sharmistha Das, Esq.
CROWELL & MORING LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 624-2500

CERTIFICATE OF SERVICE

I certify that on January 20, 2017, a copy of the forgoing "Plaintiff's Reply in Support of Its Motion for Summary Judgment and Opposition to Defendant's Cross Motion to Dismiss" was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel, Serena M. Orloff, via the Court's ECF system.

/s/ Stephen McBrady
Stephen McBrady, Esq.
CROWELL & MORING LLP
1001 Pennsylvania Avenue, NW
Washington, DC 20004
Tel: (202) 624-2500
Fax: (202) 628-5116
SMcBrady@crowell.com