2017-1224

In The

United States Court of Appeals

For The Federal Circuit

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, an Illinois Non-Profit Mutual Insurance Corporation,

Plaintiff – Appellant,

v.

UNITED STATES,

Defendant – Appellee.

APPEAL FROM THE UNITED STATES COURT OF FEDERAL CLAIMS IN CASE NO. 1:16-CV-00744-CFL, JUDGE CHARLES F. LETTOW.

BRIEF OF APPELLANT

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CERTIFICATE OF INTEREST

1. The full name of every party represented by me is:

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY

2. The name of the real party in interest (if the party named in the caption is not the real party in interest) represented by me is:

JENNIFER HAMMER, ACTING DIRECTOR
OF THE ILLINOIS DEPARTMENT OF INSURANCE,
AS STATUTORY LIQUIDATOR OF LAND OF LINCOLN

3. All parent corporations and any publicly held companies that own 10 percent or more of the stock of the party represented by me are:

None

4. The names of all law firms and the principals or associates that appeared for the party now represented by me in the trial court or are expected to appear in this Court are:

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

CONSTITUTIONAL PROVISION

STATUTES

RULES

REGULATIONS

OTHER AUTHORITIES

STATEMENT OF RELATED CASES

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

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

Name of the Case	Docket No.	Judge
Health Republic Insurance Company v. U.S. (Filed Feb. 2016)	16 CV 00259	Judge Sweeney
Highmark Health Insurance v. U.S. (Filed May 2016)	16 CV 00587	Judge Wolski
Moda Health Plan, Inc. v. U.S. (Filed June 2016)	16 CV 00649	Judge Wheeler
BCBS of NC v. U.S. (Filed June 2016)	16 CV 00651	Judge Griggsby
Maine Community Health Options v. U.S. (Filed August 2016)	16 CV 00967	Judge Merow
New Mexico Health Connections v. U.S. (Filed September 2016)	16 CV 01199	Judge Bruggink
BCBS of Idaho v. U.S. (Filed October 2016)	16 CV 01384	Judge Lettow
Minuteman Health v. U.S. (Filed October 2016)	16 CV 01418	Judge Griggsby
BCBSM v. U.S. (Filed October 2016)	16 CV 01253	Judge Williams
Montana Health Coop. v. U.S. (Filed October 2016)	16 CV 01427	Judge Wolski
Alliant Health Plans, Inc. v. U.S. (Filed November 2016)	16 CV 01491	Judge Braden
Blue Cross and Blue Shield of South Carolina and Blue Choice Health Plan of South Carolina, Inc. v. U.S. (Filed November 2016)	16 CV 01501	Judge Griggsby
Evergreen Health Cooperative v. U.S. (Filed June 2016)	16 CV 2039 (D. Md)	Judge Russell
Health Net, Inc. v. U.S. (Filed Dec. 2016)	16 CV 01722	Judge Wolski
Gerhart v. United States v. U.S. (Filed May 2016)	16 CV 151 (S.D. Iowa)	Judge Ebinger

INTRODUCTION

Lincoln is an Illinois non-profit mutual insurance company that was specifically created to provide coverage on the Illinois exchange under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010). Appx58, Appx62.[1] Lincoln was a qualified health plan issuer ("QHP") in the Department of Health and Human Services ("HHS") Federal Exchange Program in Illinois for calendar years 2014, 2015 and 2016, and provided low-cost ACA health insurance coverage to over 50,000 Illinois insureds. *Id.* It incurred significant expenses and hundreds of millions of dollars of claims under the ACA programs. Appx81-83, Appx470, Appx665, Appx669.

Lincoln was placed into liquidation by the Illinois Department of Insurance after the Government refused to timely make over $75 million in risk-corridors payments admittedly owed to Lincoln under the ACA. Appx19, Appx531.

Lincoln seeks damages owed by the Government for failing to timely pay mandatory risk-corridors payments specified in Section 1342 of the ACA and in its implementing regulations that HHS "shall pay". Appx55. The Government has specifically admitted, in writing, its statutory and regulatory obligations to pay the full amount of risk-corridors payments owed to Lincoln for Calendar Years 2014 and 2015, but the Government has failed to pay the full amounts due. Appx289,

[1] "Appx" refers to Joint Appendix.

Appx291, Appx302, Appx310, Appx523, Appx685. Instead, the Government has paid Lincoln only a pro-rata share of the total amount due for 2014, and nothing for 2015, asserting that full payment to Lincoln is limited by available appropriations, even though no such limits appear anywhere in the ACA or its implementing regulations or in Lincoln's contracts with the Government. Appx291. Lincoln challenges the Government's failure to pay the owed amounts until some indeterminate time in the future.

Lincoln also seeks damages for the Government's breaches of its risk-corridors payment obligations under express or implied-in-fact contracts, defendant's breach of a covenant of good faith and fair dealing implied in the Government's contracts with Lincoln, and the Government's taking of Lincoln's property without just compensation in violation of the Fifth Amendment of the United States Constitution. Appx88-98.

This action seeks damages from the Government for the remaining risk-corridors payments admittedly due for 2014 of $3,925,418.50, but unpaid, and for the amounts also now admitted as due for calendar year 2015 of $71,833,251.00, but again unpaid.

JURISDICTIONAL STATEMENT

On November 10, 2016, the Court of Federal Claims entered an Opinion and Order and Final Judgment for Defendant-Appellee the United States of America (the "Government") against Plaintiff-Appellant Land of Lincoln Mutual Health Insurance Company ("Lincoln"), that disposed of all parties' claims.

The Court exercised jurisdiction under the Tucker Act, 28 U.S.C. § 1491(a)(1) and the Affordable Care Act, 42 U.S.C. § 18062.

Lincoln filed a timely notice of appeal on November 15, 2016. The Court has jurisdiction under 28 U.S.C. § 1295.

STATEMENT OF ISSUES PRESENTED

1. Did the court below err in granting the Government's motion for judgment on the Administrative Record and in denying Lincoln's motion for judgment on Lincoln's statutory claim (Count I) seeking full, timely risk-corridors payments that the Government concedes it owes but has not paid, in violation of the clear dictates and intent of the statute and its implementing regulations?

2. Did the court below err in granting the Government's Rule 12(b)(6) motion to dismiss Lincoln's contract and Takings claims in Counts II-V?

3. Did the court below err in failing to exercise jurisdiction over Lincoln's claim for collateral declaratory relief as to risk-corridors payments for calendar year 2016?

STATEMENT OF THE CASE

I. Congress Enacts The Risk-Corridors Program To Stabilize The New Health Insurance Marketplaces Created By The Affordable Care Act.

Congress enacted the ACA on March 23, 2010, instituting a series of landmark reforms in the health care industry with the goal of increasing competition in the health insurance marketplace and broadening health insurance access to millions of uninsured Americans. Pub. L. 111-148, 124 Stat. 119. To effectuate that goal, Congress created "Health Benefit Exchanges," which enable insurers to sell individual and small group insurance plans across state-wide marketplaces. 42 U.S.C. § 18031. Health plans issued through these Exchanges—referred to as QHPs—are subject to a number of regulatory requirements. *See* 42 U.S.C. § 18021. Among them, QHPs must execute agreements with the Centers for Medicare & Medicaid Services ("CMS"), a federal agency within HHS. Appx105, Appx116, Appx128. These agreements set forth the various responsibilities of QHPs, in exchange for which CMS promises to "undertake all reasonable efforts to implement systems and processes that will support QHP functions." Appx109.

The promise of insuring millions of previously uninsured Americans, however, came with unique challenges. Most significantly, insurers who were considering participating in the Exchanges faced significant difficulties in calculating the risks of insuring this until-now uninsured population. This

uncertainty, combined with the ACA's requirement that QHPs guarantee issuance to prospective beneficiaries, meant that insurers were unable to prospectively price premiums for new enrollees with significant reliability. Appx391-392. This uncertainty and the corresponding risk of losses to insurers from insuring this new population meant that there was a very real possibility that insurers would either set premiums at high levels in the early years of the Exchanges, or that they would not participate in the Exchanges, absent a program to address the impact of this uncertainty.

Recognizing this problem, Congress included in the ACA three "premium stabilization programs" designed to mitigate insurers' risks in the early years of the Exchanges—reinsurance, risk corridors, and risk adjustment—with the twin aims of incentivizing insurers to participate in the Exchanges, while stabilizing the new marketplaces once insurers did so. 42 U.S.C. §§ 18061-18063. As CMS has explained, these "premium stabilization programs" were created to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance during the ACA's initial years. Appx391-392. The financial protections that Congress included in the premium stabilization programs thus provided QHPs with the security to become participating insurers in their respective states' Exchanges, despite the significant financial risks imposed by the uncertainty of the new healthcare markets. *Id.*

Of these three premium stabilization programs, the risk-corridors program in particular was "intended to protect QHP issuers in the individual and small group market against inaccurate rate setting." Appx397. As a result of "uncertainty about the population during the first years of Exchange operation, issuers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted." *Id.* The risk-corridors program accordingly "protect[ed] against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains." Appx396.

Section 1342 of the ACA establishes the terms of the risk-corridors program, requiring the Secretary of HHS to establish a program providing for the sharing in gains or losses between the Government and QHPs participating in the individual and small group markets "for any plan year" during the first three years of ACA Exchanges—*i.e.*, calendar years 2014, 2015, and 2016. 42 U.S.C. § 18062. Congress expressly modeled this program after a similar program implemented as part of the Medicare Part D prescription drug benefit program, *id.*, which also requires full and annual payments pursuant to a similar statutory formula. 42 U.S.C. § 1395w-115(e)(3)(A).

Under the ACA's risk-corridors program, the Government shares risk with QHPs by collecting charges ("payments in") from a health insurer if the insurer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and by

making payments to the QHP ("payments out") if the QHP's premiums fall short by a certain amount, subject to adjustments for taxes, administrative expenses and other costs and payments. 42 U.S.C. § 18062. To determine whether a QHP pays into or receives payment from the risk-corridors program, HHS compares "allowable costs" (*e.g.*, claims costs subject to adjustments for health care quality, health IT, risk adjustment payments and charges and reinsurance payments) and the "target amounts"—the difference between a QHP's earned premiums and allowable administrative costs. *Id.* Both "allowable costs" and "target amounts" are statutorily defined on a "plan year basis." *See* 42 U.S.C. § 18062(c).

Pursuant to the statutory formula, QHPs with "allowable costs" that are less than 97% of the QHP's "target amounts" are required to remit charges for a percentage of those costs savings to HHS. On the other hand, QHPs with "allowable costs" greater than 103% of the QHP's "target amounts" will receive payments from HHS to offset a percentage of those losses. In that case, Section 1342(b) provides that "the Secretary [of HHS] *shall pay*" to the QHP the determined amount. 42 U.S.C. § 18062(c) (emphasis added). Congress did not impose any financial limits or restraints on the Government's mandatory risk-corridors obligations and payments to QHPs in either Section 1342 or any other section of the ACA. Congress also did not limit HHS's obligation to make full risk-corridors payments owed to QHPs due to appropriations, restriction on the use

of funds, or otherwise in Section 1342 or elsewhere in the ACA. And this makes sense given the purpose of the program: If Congress had made the obligation to make "payments out" to QHPs contingent on "payments in" from QHPs during this same three-year period, then this limitation would have simply replaced one type of uncertainty with another.

As to the source of funding for the risk-corridors program, HHS had no financial obligation under the program until after it became effective in 2014; accordingly, Congress did not include a specific appropriation for risk-corridors payments during the passage of the ACA in 2010 for that future expense. Nonetheless, as the Government Accountability Office ("GAO") later recognized in a September 2014 report, Congress had long granted HHS a substantial annual lump-sum program management budget to cover expenses under the programs it managed, and that budget could have been used to make any risk-corridors payments in excess of payments in, assuming it was renewed by Congress after 2014. Appx401-408.

II. Lincoln Participates In The Health Care Marketplace In Reliance On HHS's Assurances Of Full, Timely Risk-Corridors Payments.

After the ACA was enacted, HHS repeatedly assured insurers that they would receive full and timely risk-corridors payments if they participated in the ACA exchanges. In March 2012, HHS issued regulations codifying the amount eligible insurers "will receive" using a formula identical to the statutory formula

under Section 1342. 45 C.F.R. § 153.510(b). The regulation nowhere stated—or even suggested—that payments to insurers would be limited based on the amount of payments in received by HHS from other insurers under the program. The preamble to the final rule adopting these regulations stated that "HHS would make [any risk-corridor] payments [owed] to QHP issuers … within a 30-day period after HHS determines that a payment should be made" (Appx269)—the same period in which QHPs who owed money under the program were required to remit payment, 45 C.F.R. § 153.510(d). HHS reasoned that QHPs would "want prompt payment," and that "the payment deadline should be the same for HHS and QHP issuers." Appx269.

In March 2013, HHS reaffirmed its payment obligations in another final rule, which left in place the regulatory formula for determining how much insurers "will receive." Appx260. The preamble to the rule expressly stated that "the risk corridors program is not statutorily required to be budget neutral," meaning that HHS "*will remit* payments as required under Section 1342" "[*r*]*egardless of the balance of payment receipts*." *Id.* (emphasis added). Relying on these assurances, Lincoln—and dozens of other insurers, including many health cooperatives like Lincoln fostered by the ACA to lower insurance costs—agreed to participate in the ACA exchanges, signed QHP contracts, priced their plans based on the expected risk of participating in the new insurance exchanges, and sold health insurance

plans for the 2014 calendar year covering millions of Americans, including millions who were previously uninsured. Appx105, Appx116, Appx128.

III. HHS Defaults On Its Obligation To Make Full, Timely Payments While Continuing To Recognize That Full Payments Are Due.

Beginning in 2014, after Lincoln had already agreed to participate in the calendar year 2014 Illinois ACA exchanges, HHS announced for the first time that it would not honor its commitment to make the statutorily-required risk-corridors payments on a timely basis. In April 2014, CMS issued an informal bulletin stating that "if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year w[ould] be reduced pro rata to the extent of any shortfall" (Appx297)—*i.e.*, QHPs would not be paid at that time the amounts owed by HHS for that year. In May 2014, CMS codified this policy in a final rule.

Neither the bulletin nor the 2014 regulation purported to interpret Section 1342 or HHS's 2012 implementing regulations, alter those regulations in any material way, or offer *any* justification for the change in approach. HHS's 2014 regulation made clear, moreover, that although HHS was changing its approach to implementing the risk-corridors program, it had not changed the underlying obligation—reflected in the statute itself, as well as the 2012 implementing regulation—that "the [ACA] *requires* the Secretary to make *full payments* to

issuers," including through "other sources of funding," if necessary. Appx291 (emphasis added).

On December 16, 2014, Congress enacted the annual omnibus appropriations bill for fiscal year 2015, which for the first time prohibited HHS from using any of its lump-sum program-management budget for payments under the risk-corridors program in the 2015 fiscal year. Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014). Congress enacted an identical provision the following year for fiscal 2016. Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015). Both bills were limited on their face to appropriations made under those Acts and did not purport to amend Section 1342 or alter the formula for determining the total amount owed to any insurer under the risk-corridors program.

Even after these appropriations bills, HHS continued to reassure QHPs, including in a February 27, 2015 final rule and a November 19, 2015 public announcement, that "the Affordable Care Act *requires* the Secretary to make *full payments* to issuers." Appx286, Appx291 (emphasis added). Similarly, on November 2, 2015, HHS and CMS expressly "reiterat[ed] that risk corridor payments are an obligation of the U.S. Government." Appx306. Consistent with that statement, and with the annual nature of the risk-corridors program, CMS has booked its full, unpaid obligations from the 2014 and 2015 risk-corridors programs

as liabilities on its balance sheets for fiscal years 2015 and 2016, respectively. Appx291, Appx308, Appx411, Appx472.

On October 1, 2015, after collecting risk-corridors data from QHPs for calendar year 2014, HHS and CMS announced that they had collected $362 million in fees under the risk-corridors program, and that HHS owed $2.87 billion in payments for the 2014 program year. Appx302. Due to the massive shortfall and restriction on the use of its lump-sum program-management budget for payments under the risk-corridors program, HHS and CMS prorated the risk-corridors payments owed to QHPs to the amount collected from risk-corridors payments in, resulting in a prorated payment rate of 12.6%. *Id.* As a result, Lincoln, which was owed $4,492,243.70, was paid just $566,825.22 in risk-corridors payments for the 2014 year program, leaving $3,925,418.48 still owed to it. Appx318.

HHS announced the same day that it would collect full corridors charges from QHPs in November 2015 and would begin making the prorated risk-corridors payments in December 2015, showing that it believed the risk-corridors program required full, annual payments from QHPs, that are subject to substantively identical "shall pay" language as HHS. Appx302. On April 1, 2016, CMS reaffirmed that "remaining risk corridor claims *will be paid*"—but the amounts owed would be delayed and contingent upon the Government's receipt of sufficient risk-corridors charges/collections for calendar years 2015 and 2016. Appx304

(emphasis added). The Government's conduct left Lincoln and other QHPs owed large, past due risk-corridors payments to guess when—if ever—the Government will make those risk-corridors payments.

On November 18, 2016, after collecting risk-corridors data from QHPs for calendar year 2015, CMS confirmed that all 2015 benefit year risk-corridors collections would be used to pay a portion of balances on 2014 benefit year risk-corridors payments. Appx665-666. CMS explained that the payments received for 2015 would cover just 1.6% of the $5.9 billion still owed for 2014 and 2015. *Id.* According to the release, Lincoln's reimbursable losses in the ACA individual and small group markets totaled $71,833,251 for the 2015 program year. Appx669. Lincoln's prorated payment from the 2015 collections, however, would be just $149,224.78, which would be paid toward HHS's 2014 obligation to Lincoln. *Id.* HHS thus continues to owe Land of Lincoln $75,758,669.50 total under the 2014 and 2015 risk-corridors programs.

IV. Lincoln Files This Action Under The Tucker Act, And The Trial Court Grants Judgment To The United States.

In June 2016, Lincoln brought this action against the Government in the Court of Federal Claims under the Tucker Act, seeking to recover money due under the risk-corridors program. Appx55. Lincoln alleged that the Government's failure to pay the full amount owed to Lincoln for 2014 and 2015 violated the risk-corridors statute, Section 1342 (Count I); breached CMS's QHP agreement, or

alternatively its implied-in-fact contract with Lincoln (Counts II and III); breached the implied covenant of good faith and fair dealing in those contracts (Count IV); and unlawfully took Lincoln's property without just compensation in violations of the Fifth Amendment's Takings Clause (Count V).

As there were no disputed questions of fact as to what transpired before HHS, the trial court resolved Lincoln's statutory claim under Section 1342 (Count I) on cross-motions for judgment on the administrative record. *Land of Lincoln Mutual Health Ins. Co. v. United States*, 129 Fed. Cl. 81 (2016). In November 2016, it granted judgment to the Government, concluding that the Government was not liable to Lincoln under Section 1342 because the statute does not "express[ly] authoriz[e]" HHS to "make up any shortfall in the 'payments in' to cover all of the 'payments out' that may be due," and "does not explicitly require 'payments out' to be made on an annual basis." Appx25.

The trial court's decision began by recognizing that it had jurisdiction over Lincoln's statutory claims under the Tucker Act because Section 1342 is "money-mandating"—i.e., it creates a legally enforceable "'right of recovery in damages,'" (Appx13)—and Lincoln's claim for relief under the statute is non-frivolous. Appx12. The trial court also found Lincoln's claims "ripe," despite the possibility that HHS could make additional payments in the future, because those payments would not "affect Lincoln's underlying claim" seeking payment now. Appx19.

On the merits, the court stated that it was deferring, under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), to HHS's "three-year, budget-neutral interpretation" of Section 1342 in its May 2014 final rule. Appx26. According to the trial court, HHS's statement that it would "administer risk corridors in a budget neutral way over the three-year life of the program," 79 Fed. Reg. at 30,260, was an "interpretation," of Section 1342 (Appx26) —one contrary to Lincoln's position that the statute "establishes an entitlement to 'payments out' on an annual basis and in full" (*id.* at 24)—even though HHS reaffirmed in the same rule that "the [ACA] requires the Secretary to make full payments to issuers," 79 Fed. Reg. at 30,260.

The trial court thought the "interpretation" it attributed to HHS warranted *Chevron* deference because it found Section 1342 ambiguous and found HHS's purported interpretation reasonable. The court found Section 1342 ambiguous with respect to the *amount* of payments based on its belief that Congress "'did not enact an appropriation'" funding the risk-corridors program, so "the only statutory source of funding" for the program is the payments received by HHS from other insurers under the risk-corridors program. Appx23. The court also found the statute ambiguous with regard to timing because the statute "does not explicitly require 'payments out' to be made on an annual basis, whether in full or not." Appx25. The court concluded that the interpretation it attributed to HHS was

reasonable notwithstanding the devastating consequences of non-payment for insurers—especially small co-ops like Lincoln—because even under this approach the program would "serve the program['s goal]" of "protect[ing] … qualified health insurance plans" albeit to a lesser "extent." Appx26-27 (emphasis added).

The court also dismissed Lincoln's remaining claims under Rules of the Court of Federal Claims ("RCFC") 12(b)(6). While the court found that Lincoln had stated non-frivolous claims under Counts II-V for jurisdiction and ripeness purposes (Appx15-20), it later in the same opinion ruled that Lincoln had not alleged a valid express contract under Count II for any commitment pertaining to the risk-corridors program (Appx28-31) or valid and implied contract or takings claims in Counts III-V. Appx34-36. It also concluded Counts III-V could not stand because of its ruling on Count I that HHS has no statutory or regulatory obligation to fully pay risk-corridors annually. *Id.*

V. The Trial Court In *Health Republic* Rules, Contrary To *Lincoln*, That Congress Required Annual Risk-Corridors Payments.

On January 10, 2017, Judge Sweeney, issued an Opinion and Order in *Health Republic Insurance Co. v. United States*, 2017 U.S. LEXIS 8 (Fed. Cl. Jan. 10, 2017), and reached a contrary decision to *Lincoln*, concluding that Congress required annual risk-corridors payments to QHPs irrespective of appropriations. That contrary decision is attached as part of the Rule 30(a)(1) appendix.

The *Health Republic* case is the earliest filed risk-corridors action and has been certified as a class action. It is based on nearly identical facts as this matter. In her order, Judge Sweeney denied the Government's Rule 12(b)(1) motion to dismiss for lack of jurisdiction and ripeness. In the Government's jurisdiction and ripeness arguments there it asserted (as here in its motion for judgment on the Administrative Record) that "in the absence of any explicit deadline … HHS may defer payment to insurers until the conclusion of the 3-year risk corridors program, or to whenever it has the funds available to make full payment." *Health Republic* at 18. The court noted the underlying premise of the argument was that insurers are not entitled to receive risk corridors payments on an annual basis. *Id.* at 19. Judge Sweeney rejected that argument as a matter of law, concluding, in direct contrast to the Lincoln decision, that "Congress intended HHS make annual risk corridors payments to eligible qualified health plans." *Id.* at 19. She noted that "HHS must calculate separate risk corridors payments for each of the three years of the program (*Id.)*; that "HHS is required to base the risk corridors program on a pre-existing program which makes annual payments to eligible insurers" (*Id.)*, and that "the purpose of, and interplay among, the three premium stabilization programs suggest that risk corridors payments should be made annually." *Id.* at 21. She concluded that failing to require annual payments would defeat the statute's purpose and was "non-sensical". *Id.* at 22-23. She ruled that "HHS is

required to make annual risk corridors payments to eligible qualified health plans." *Id.*

Judge Sweeney also ruled, in the alternative, that even if the ACA was ambiguous as to whether HHS was required to make annual risk corridors payments, her ruling would be the same because HHS itself interprets the ACA as requiring annual payment. *Id.* at 23. She gave deference to HHS's July 2011 proposed rule that QHPs owed money should be paid promptly for risk corridors, at the same time as QHPs must pay in risk-corridors charges. *Id.* at 24. She also relied upon HHS's own conduct in making annual risk-corridors payments with available funds and concluded that "there can be no dispute that HHS construes its regulations to require annual risk corridors payments." *Id.* at 25 (emphasis added).

SUMMARY OF ARGUMENT

As shown herein, Lincoln is indisputably owed risk-corridors payments from the Government. The amounts owed to Lincoln are expressly mandated by statute, regulation, and contract and are specifically determinable as an accounting matter. The facts show that the Government has acknowledged that (a) QHPs such as Lincoln are owed these payments, (b) those payments are obligations of the United States and (c) the Government has recorded or will record those amounts as payment obligations of the Government for 2014 and 2015. The Government has to date simply failed to pay the acknowledged amounts in full purportedly because

of funding shortfalls. It has only paid QHPs pro rata based on the funds it had available. The issue in this appeal is whether the Government is required to pay the owed risk-corridors payments now, where the obligation to make them is conceded and the amounts are not disputed, or at some indefinite point in the future after 2016, as the trial court found. Because it found that payment could be delayed, the trial court erred in granting the Government's motion for judgment on the Administrative Record as to Count I and in denying Lincoln's motion for judgment on the Administrative Record on Count I.

HHS's failure to make full risk-corridors payments on a calendar year basis, but instead to operate the program as budget neutral and only pay each year on the basis of "payments in" collections, and after all three years of the program, with any additional appropriations (a) directly contradicts the plain language of the ACA—that HHS "shall pay" risk corridors on a "calendar year" basis, (b) contradicts its requirement that the risk-corridors program be based on Medicare Part D's risk-corridors program (which is not budget neutral and is paid annually) and (c) contradicts the fundamental purpose of the risk-corridors program to reduce QHPs losses and risk in each year of the first three ACA benefit years, 2014, 2015, and 2016, thereby contravening and undermining the entire purpose of the risk-corridors program to share risk between the Government and the health insurer.

HHS did not make any informed, reasoned decision about how to meet its statutory obligation to operate the risk-corridors program. Instead, it reneged, without justification, on its prior assurances that the risk-corridors program would not be budget neutral and that full risk-corridors payments would be due annually. The only apparent basis for what HHS did (and failed to do) is that Congress, years after creating the risk-corridors payment obligation in 2010, failed to appropriate sufficient funds to HHS for it to make such payments in 2015 (for the 2014 benefit year) and later years. That is not a legal basis that changed HHS's statutory obligation that it "shall pay" nor does it provide any reasoned regulatory basis to interpret a plain statutory direction of "shall pay" to mean "shall pay at some indefinite point in the future if there is enough money to pay." No deference is due HHS's refusal to fully pay risk-corridors payments on an annual basis. Lincoln is entitled to judgment on the Administrative Record on Count I for breach of a clear statutory and regulatory obligation.

It was also error for the trial court to dismiss Lincoln's well-pled Counts II, III, IV and V *on a 12(b)(6) motion*. The trial court itself found Lincoln stated plausible claims in Counts II through V for jurisdiction and ripeness purposes. The trial court also erred by using its unsupported judgment on Count I for the Government in assessing the legal validity *on the merits* of independent claims II through V. The trial court erred because it did not make all reasonable inferences

for Lincoln on the facts as pled in Courts II-V, as the law requires. The Court should vacate dismissal of Counts II through V and remand to the trial court for reconsideration.

Finally, the Court does have jurisdiction over Lincoln's claim for collateral declaratory judgment as to risk-corridors payments for calendar year 2016. As Lincoln is entitled to judgment for risk-corridors payments for fiscal years 2014 and 2015, its legal basis for such payments for 2016 is exactly the same, and a declaration of a right to judgment for that amount when it is determined in 2017 is appropriate.

STANDARDS OF REVIEW

The review of each issue raised here is *de novo*.

The Court reviews legal determinations of the Court of Federal Claims, such as judgment on the Administrative Record, *de novo. E.g., Roth v. United States*, 378 F.3d 1371, 1381 (Fed. Cir. 2004). The Court reviews dismissal of an action under Fed. R. Civ. Proc. 12(b)(6) *de novo*. *E.g., Boyle v. United States*, 200 F.3d 1369, 1372 (Fed. Cir. 2000). The Court also reviews jurisdiction *de novo. Waltner v. United States,* 679 F.3d 1329, 1332 (Fed. Cir. 2012).

ARGUMENT

I. The Court Erred In Granting The Government—And Denying Lincoln—Judgment On The Administrative Record As To Lincoln's Statutory Claim (Count I).

A. The Tucker Act Permits Suits To Collect Unpaid Amounts Under The Money-Mandating Risk-Corridors Statute Regardless Of Whether HHS Is Able To Pay From Any Congressional Appropriation.

Under the Tucker Act, the Court of Federal Claims has jurisdiction to review "any claim against the United States founded either upon the Constitution, any act of Congress, any regulation of an executive department, or any express or implied contract with the United States." 28 U.S.C. § 1491(a)(1). That grant of jurisdiction waives the United States' sovereign immunity with respect to monetary claims against the Government. *United States v. Mitchell*, 463 U.S. 206, 212 (1983). To sustain a Tucker Act claim, a plaintiff must first "identify a separate [money-mandating] source of substantive law that creates the right to money damages." *Fisher v. United States*, 402 F.3d 1167, 1172 (Fed. Cir. 2005). A statute is money-mandating when "it can fairly be interpreted as mandating compensation." *Mitchell*, 463 U.S. at 217. A cause of action under the Tucker Act "accrues … when 'all events have occurred to fix the Government's alleged liability'"—*i.e.*, when the statutory preconditions have been met. *Martinez v. United States*, 333 F.3d 1295, 1303 (Fed. Cir. 2003).

Monetary relief is available under the Tucker Act even when the obligation cannot be paid from existing agency appropriations because Congress has made a separate fund—known as the Judgment Fund—available for payment of Tucker Act judgments. 31 U.S.C. § 1304. The purpose of that fund is "to facilitate the payment by the United States of its obligations" without "the need for specific appropriations." *Slattery v. United States*, 635 F.3d 1298, 1303, 1317 (Fed. Cir. 2011). The Tucker Act thus does not "limi[t] jurisdiction over [claims] by the source of funds to pay any judgment on the claim." *Id.* at 1316; *see also N.Y. Airways, Inc. v. United States*, 369 F.2d 743 (Ct. Cl. 1966); *Gibney v. United States*, 114 Ct. Cl. 38 (1949). Nor does Congress's failure to appropriate funds for an agency to meet a statutory obligation "defeat a Government obligation created by statute." *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (quoting *N.Y. Airways*, 369 F.2d 748); *see also, e.g., United States v. Langston*, 118 U.S. 389 (1886); *Prairie Cty., Mont. v. United States*, 782 F.3d 685, 689-90 (Fed. Cir. 2015); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949).

For instance, the Supreme Court held in *Salazar v. Ramah Navaho Chapter* that if a statutory beneficiary is one of several to be paid from a larger appropriation sufficient in itself to pay that beneficiary, the government is liable to that party for the full amount due, even if the agency exhausted the appropriation in service of other permissible disbursements. 132 S. Ct. 2181 (2012); *see also*

Cherokee Nation v. Leavitt, 543 U.S. 631, 637 (2005); *United States v. Langston*, 118 U.S. 389 (1886). In other words, the Government can incur a legal obligation that exceeds the money appropriated to it to meet that obligation, and that obligation can be enforced under the Tucker Act. Similarly, even when Congress later repeals an appropriations statute used to cover a government obligation, an agency's statutory obligations typically persist, since Congress is presumed not to repeal statutory obligations through appropriations bills. *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978).

This long line of authority thus recognizes a fundamental distinction between an agency's ability to incur binding legal obligations and the agency's ability to pay such obligations from an existing congressional appropriation. The absence of an appropriation "limits the authority of federal officials to enter into contracts or otherwise obligate the Government to pay funds in excess of the amounts appropriated," but it "does not … limit the Court of Federal Claims' jurisdiction or its power to enter a judgment in damages to compensate a plaintiff for an injury on a claim brought under the Tucker Act." *Samish Indian Nation v. United States*, 657 F.3d 1330, 1339 (Fed. Cir. 2011).[2] In other words, "[t]he failure to appropriate funds to meet statutory obligations prevents the accounting

[2] Although *Samish Indian Nation* was subsequently vacated in part as moot, 133 S. Ct. 423 (2012), its reasoning applies fully here.

offices of the Government from making disbursements, but such rights are enforceable in the Court of Claims." *N.Y. Airways*, 369 F.2d at 748. The key question under the Tucker Act accordingly is not whether the agency has determined that it can make payments from an existing congressional appropriation, but whether it *owes* those payments, *i.e.*, whether the statutory conditions have been met to trigger an obligation that the Government has failed to satisfy.

The ACA's risk-corridors provision is indisputably a money-mandating statute. The trial courts in Lincoln and *Health Republic* both so found. Appx13; *Health Republic* at 16. Section 1342 provides that if a QHP qualifies for risk-corridors payments, then HHS "shall pay" the amount set forth in the statute. 42 U.S.C. § 18062(b). As the court below explained, "the Federal Circuit has repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." Appx13. Accordingly, the Tucker Act creates a cause of action for monetary relief if Lincoln can show that it is owed money under the statute that the Government has not paid. Lincoln has made that showing.

B. The ACA's Plain Text Requires HHS To Make Full And Annual Risk-Corridors Payments.

Lincoln is owed additional payments under the risk-corridors program because Section 1342 of the ACA unambiguously requires the Government to make full risk-corridors payments to QHPs pursuant to the ACA's statutory

formula—regardless of the amount of "payments in" under the program—and it requires those payments to be made annually. Congress's purposes in enacting the program powerfully confirm this plain-text interpretation.

1. The Statute Requires HHS To Make Full Payments Regardless Of The Amount HHS Receives As "Payments In" Under The Program.

Statutory interpretation begins with the plain language of the text. Section 1342(b)(1) states that if a QHP qualifies for risk-corridors payments in "any plan year," then "the [HHS] Secretary *shall pay* to the plan an amount" set forth in the statute's prescribed formula. 42 U.S.C. § 18062(b)(1) (emphasis added). HHS's regulations echo this requirement, stating that "QHP issuers *will receive* payment from HHS" when they qualify for risk-corridors payments in a benefit year, and that "HHS *will pay* the QHP issuer an amount" equal to the statutory payment formula. 45 C.F.R. § 153.510(b) (emphasis added). There is nothing in the statute or regulations limiting the Government's "shall pay" obligation to make full risk-corridors payments based on the "payments in" received by HHS under the program. 42 U.S.C. § 18062(b)(1); *see Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003) ("[U]se of the word 'shall' generally makes a statute money-mandating.").

Where Congress intended a risk-mitigation provision of the ACA to be budget neutral, it knew how to include specific limiting language to that effect, as

it did under the ACA's other premium stabilization programs—the reinsurance and risk adjustment programs. *See* 42 U.S.C. § 18061(b)(1) (providing that under the reinsurance program, "the applicable reinsurance entity collects payments under subparagraph(A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph(A)"); 78 Fed. Reg. 15410, 15441 (March 11, 2013) ("The Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers."). Appx414. The risk-corridors program contains no similar limitation: Neither the term "budget neutral" nor the concept of budget neutrality appears anywhere in § 1342 or its implementing regulations. *See* 42 U.S.C. § 18062; 45 C.F.R. §§ 153.500-540. The only significant precondition for the Government payment obligation is a submission of revenue and cost data for the plan year to the Government by QHPs—and there is no dispute that Lincoln complied with that requirement.

Congress also expressly modeled risk-corridors payments after the risk-corridors program under Medicare part D, stating in § 1342(a) that "[t]he [HHS] Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," and that "[s]uch program shall be based on … the program … under [Medicare] part D." 42 U.S.C. § 18062(a). There is no question that both today and when the ACA was enacted in 2010, Medicare Part D requires and required risk-corridors payments in excess of collections, which must be made

annually. *See, e.g.*, 42 U.S.C. § 1395w-115(e)(3)(A) ("For each plan year the Secretary shall establish a risk corridor for each prescription drug plan."); Appx476 (GAO confirming that Medicare Part D "payments that CMS makes to insurers are not limited to issuer contributions"). *Health Republic* thus recognized that "in the [Medicare part D] program upon which the ACA's risk-corridors program was to be based, HHS—through CMS—would make payments in the year following coverage so long as it had received the necessary cost data" and Congress would have been aware of this payment scheme when it enacted the statute. *Health Republic* at 21. There is thus no warrant to construe the ACA's risk-corridors program to function in the *opposite* manner as the program on which it is based.

Only full risk-corridors payments to QHPs advance Congress' purpose in enacting § 1342. The risk-corridors program was designed to induce QHP participation in the Health Insurance Exchanges on an annual basis by mitigating their risk of loss in each benefit year. Congress intended § 1342 to require the Government to share in those risks—or reap the rewards—of insurers' uncertainty in rate-setting in the first three years of the ACA Marketplace; HHS thus recognized that the program was intended to provide a "mechanism for sharing risks for allowable costs between the Federal government and QHP insurers," rather than simply among all participating health plans. Appx295. *See also* 78

Fed. Reg. 15,410, 15,413 (March 11, 2013) ("[T]he temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 through 2016.") The Government shares this risk only if its obligation is mandatory, and not contingent on the collections received. This is a critical point, because the Government has, with its budget neutral approach during the life of the program, instead made it into a risk-sharing program only between QHP issuers. By taking money from the "lucky" QHP issuers, the Government is simply adjusting risk across participants in the market and, more importantly, not sharing in that risk, despite its explicit understanding that it must do so.

Congress's intent can furthermore be gleaned from the overall structure and purpose of the ACA, of which § 1342 is an integral part. *See Delverde, SRL v. United States*, 202 F.3d 1360, 1363 (Fed. Cir. 2000). The Supreme Court has held that the fundamental purpose of the ACA was to stabilize the health insurance markets. *See King v. Burwell*, 135 S. Ct. 2480 at 2492-93 (2015) ("[T]he statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market … and likely create the very 'death spirals' that Congress designed the Act to avoid."). Interpreting the ACA's risk-corridors provisions to be budget neutral, however, would thwart that purpose by eliminating a key structural safeguard—risk mitigation—for QHPs who entered into the

program. A budget-neutral risk corridors program would make payments to insurers who suffer losses contingent on payments in from insurers who earned profit, which in turn would depend on *other* insurers' decisions about what rates to charge. To accurately set rates for plans sold under the ACA, therefore, QHPs would have to make difficult predictions not only about the new risk pool they would be insuring under the ACA, but also about the rate-setting decision of other insurers, creating the very uncertainty and unpredictability that Congress created the program to avoid.

Notwithstanding the ACA's clear text and Congress's purpose in enacting the risk-corridors program, the trial court concluded that the statute could be interpreted to limit payments made to insurers under the risk-corridors program to a pro rata share of the payments received by HHS from other insurers under the program. The trial court based this holding on its view that Congress "'did not enact an appropriation'" funding for risk-corridors program when it enacted the ACA in 2010, so "the only statutory source of funding" for the program is the payments received by HHS from other insurers under the risk-corridors program. Appx23.[3]

[3] Yet, the trial court itself recognized that "neither the statute nor the regulation use the word 'may' or provide any indication that HHS has discretion to refuse risk-corridors payments if funds are available. Regardless of whether the program is budget neutral or whether full payments are required annually … *it is evident that*

The trial court's conclusion defies the basic principle of appropriations law recognizing that the absence of an adequate congressional appropriation does not negate an agency's statutory obligations or defeat a claim under the Tucker Act. *See supra* at 22-25. That is particularly true in the context of the ACA, which was enacted in 2010, *five years* before any monetary obligation could possibly accrue under the risk-corridors program it established. It is hardly significant that Congress in 2010 failed to reach an agreement on how best to fund any obligations that might or might not accrue in 2015, but instead left the details of funding for future resolution. The ACA was not primarily an appropriations bill, and it left many details of funding to be determined.

The ACA did not contain any language authorizing HHS to make any payments, much less risk-corridors payments out of the funds it collected under the risk-corridors program. *See* September 2014 GAO Report (explaining that under the 2013 appropriations bill for fiscal year 2014 HHS could have made payments from "amounts collected … pursuant to Section 1342(b)(2)" under the language of the appropriations bill *for fiscal year 2014* that "'such sums as may be collected from authorized user fees … shall be credited to this account and remain available.'"). Appx404. Thus, upon the ACA's enactment, HHS *could not* have

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HHS is obliged to make payments to qualified health plans when certain criteria are satisfied and funds are available." Appx14 (emphasis added).

administered the risk-corridors program *even* in a budget-neutral manner without additional appropriations. When Congress finally made money received under the risk-corridors program available to fund money owed under the program, it also in the same bill made available an additional source of funding—HHS's $3.6 billion lump-sum program management budget. *Id.* At no point prior to 2014—when Congress amended the lump-sum program-management appropriation to bar risk-corridors payments from that source—was HHS *ever* subject to an appropriations bill that directed it to administer the risk-corridors program in a budget-neutral manner. The trial court's reasoning, if accepted, would not support a budget-neutral interpretation of the statute; it would instead mean that Congress did not intend to permit HHS to make *any* risk-corridors payments, since it made no initial appropriation at all. Because that interpretation would effectively nullify the risk-corridors program, the trial court's flawed reasoning must be rejected.

The trial court also rejected a plain-text interpretation of § 1342 because, it asserted, the Congressional Budget Office ("CBO") had "omitted any budgetary estimate for the risk-corridors program" in its analysis of the ACA's projected costs, which the trial court believed demonstrated the program was designed to be budget neutral. Appx23. As an initial matter, "the CBO's view—on which the Congress did not vote, and the President did not sign—cannot alter the meaning of enacted statutes." *Sharp v. United States*, 80 Fed. Cl. 422, 436 (2008) (quoting

Ameritech Corp. v. McCann, 403 F.3d 908, 913 (7th Cir. 2005)). Regardless, the CBO never said that the risk-corridors program was required to be budget neutral. The CBO Report on which the trial court relied undertook no analysis of the risk-corridors program at all—even though it included in that Report analyses of the ACA's other risk programs, and projected that *those* programs' respective collections and payments would be "budget neutral."

At most, the CBO omitted a budgetary analysis of the risk-corridors program because it "*assum[ed]* that 'collections would equal payments to plans in the aggregate.'" Appx7 (emphasis added). That assumption may have reflected the track of Medicare Part D's risk-corridors program, which had historically been revenue-positive for the Government. It amounted, at best, to an ultimately inaccurate *prediction* of the possible budgetary effect of the new program.

The CBO's first actual analysis of risk-corridors expenses recognized that risk corridors would *not* be budget neutral under the statute, and that the program *could* impose costs that were not offset by collections: "*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. 2014) (emphasis added); https://www.cbo.gov/Publications/45010. The CBO specified that, in contrast to the risk adjustment and reinsurance programs, "*payments and collections under the*

risk corridor program will not necessarily equal one another: If insurers' costs exceed their expectations, on average, the risk corridor program will impose costs on the federal budget; if, however, insurers' costs fall below their expectations, on average, the risk corridor program will generate savings for the federal budget." *Id.* at 110 (emphasis added). The CBO's inaccurate forecasts prior to this analysis—to the extent they are relevant at all—thus do not alter the Government's statutory obligation to make risk-corridors payments under § 1342.

2. The Statute Requires HHS To Make Payments Annually.

The text and purpose of Section 1342 also demonstrates that Congress intended for HHS to make any risk-corridors payments owed to eligible qualified health plans on an *annual* basis, as *Health Republic* recognized. *Health Republic* at 19. The ACA's plain text provides that risk-corridors payment obligations determined on an annual, or "plan year," basis. 42 U.S.C. § 18062(b)(1). As *Health Republic* explained, this means that "HHS must calculate separate risk corridors payments *for each of the three years* of the program," indicating that the program must be executed on an annual basis. *Health Republic* at 19. Simply put, once the payments due for a plan year have been *determined*, there is no statutory basis for delaying payment. Because the statutory conditions for payment have been met—*i.e.*, Lincoln has incurred costs that exceed 103% of the target amounts and has submitted a statement to HHS about what it is owed for 2014 and 2015—

Lincoln is entitled to risk-corridors payments under the Tucker Act for these "plan year[s]" now.

Indeed, everything about the risk-corridors program was designed to be annual. The program was based on Medicare Part D, which the Government does not dispute requires payments annually. *See, e.g.*, 42 U.S.C. § 1395w-115(e)(3)(A), and *see Health Republic* at 20-21. And as *Health Republic* confirms, "the purpose of, and interplay among, the three premium stabilization programs suggest that risk corridors payments should be made annually." *Health Republic* at 21. For risk corridors specifically, payments made on a non-annual timeline would not serve the purpose of risk mitigation in annual rate setting, since QHPs' losses would not be confined to the risk corridors on an annual basis. Absent timely payment of risk-corridors payments, QHPs would encounter potentially enormous and unbudgeted losses over a plan year, disrupting QHPs' accounting and budgeting (and, ultimately, administration of benefits) precisely when QHPs are at their most vulnerable—the exact scenario that the risk-corridors program was designed to avoid. *Health Republic* at 21-23. ("Congress created the temporary risk corridors program to provide relief to insurers who in the first three years of insurance market reforms underestimated their allowable costs and accordingly set their premiums too low. If those programs did not provide for prompt consideration to insurers upon the calculation of amounts due, insurers might lack

the resources to continue offering plans on the exchange."). Lincoln itself is a case in point: the government's failure to make timely risk-corridors payments contributed directly and substantially to Lincoln's liquidation and exit from the Illinois ACA exchange.

Even accepting *arguendo* that the text of Section 1342 is ambiguous, HHS itself interprets the ACA as requiring annual risk-corridors payments. HHS's July 2011 proposed rule that QHPs owed money should be paid promptly for risk-corridors, at the same time as QHPs must pay in risk corridors. Appx253; *Health Republic* at 24. The only payment deadline HHS ever proposed to make risk-corridors payments was the same as for payments in—within 30 days after HHS determines a payment should be made. HHS has made annual risk-corridors payments itself. As the court concluded in *Health Republic*, "there is no evidence that HHS understood that it could choose not to make annual risk-corridors payments. Thus, there can be no dispute that HHS construes its regulations to require annual risk-corridors payments." *Id.* at 25.

Were there any doubt that the ACA's plain language requires risk-corridors payments annually, annual payments would still be required under common-law principles because a longer payment period would be unreasonable. Courts read statutes and regulations to preserve common-law principles. *See United States v. Texas*, 507 U.S. 529, 534 (1993). It is axiomatic under the common law that, in

the absence of a specific timetable, payments must be made within a reasonable time. *Goodman v. Praxair, Inc.*, 494 F.3d 458, 465 (4th Cir. 2007) (observing, in context of statute of limitations discussion, that the elapse of a "commercially reasonable time for payment" is one event that could establish a breach of contract); *see also Eden Isle Marina, Inc. v. United States*, 113 Fed. Cl. 372, 493 (2013) (when there is not a specified timetable for performance, performance must occur within a reasonable time). The trial court and Government have identified nothing to suggest that it is reasonable to wait three years to pay amounts it owes, when such risk-corridors payments were understood *ab initio* to be critical to the stability and integrity of the Exchanges and where HHS itself said it should pay within 30 days.

The court below rejected this plain-text and common-sense reading of the statute, insisting that the ACA did not mandate annual risk-corridor payments because it omitted language from the Medicare Part D program requiring HHS to establish a risk corridor "for each plan year." Appx24-25. But the statute clearly does require a "program of risk *corridors*"—plural—for *each* of "calendar years 2014, 2015, and 2016." 42 U.S.C. § 18062(a) (emphasis added). The fact that the Part D program refers to "each year"—because the Part D program is permanent and therefore does not need to specify its duration—while the temporary ACA program refers to individual "calendar years 2014, 2015, and 2016" makes no

difference. 42 U.S.C. § 18062(a). They are *both* annual programs, which is the exact result Congress intended by modeling the ACA's risk-corridors program on the annual Part D program. *Id.*; *see also Health Republic* at 20-21.[4]

The Government's contrary reading of the statute—that because the statute does not state a specific date on which payments must be made, the Government may pay QHPs whenever it wishes—is also untenable. Congress's unconditional mandate that HHS "shall pay" QHPs means that the Government must pay *immediately* (or at minimum within a reasonable amount of time), not that the Government can create its own timing requirement that defeats the purpose and intended effect of the law. The Government's view perversely would mean that it has *more* leeway to decide when to fulfill its statutory obligations whenever Congress makes satisfaction of those obligations unconditional. That cannot be, and is not, the law.

[4] The court below asserted that "[t]he plural 'corridors'" does not mean multiple corridors corresponding to each plan year. Appx23. It based its conclusion on an implementing regulation—promulgated after the ACA was enacted—in which HHS defined "[r]isk corridors" as "any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount." 45 C.F.R. § 153.500. But that definition on its face has nothing to do with whether the plural "corridors" means separate corridors for each year. Even if HHS *had* defined "corridors" to mean a singular corridor over the entire program, that interpretation would be plainly contrary to the statute—which describes plural "corridors" by reference to "calendar years 2014, 2015, and 2016." 42 U.S.C. § 18062; *see Health Republic* at 20. The trial court's conclusion that "corridors" nevertheless is singular contravenes the statutory text, as well as Congress's intent to model the ACA's program on the annually administered Part D program.

C. The 2015 And 2016 Appropriations Bills Do Not Alter The Government's Obligation To Timely Pay Full Risk-Corridors Payments.

The regime requiring full, annual risk-corridors payments that Congress enacted in 2010 remains intact today, notwithstanding the 2015 and 2016 spending bills, which restricted CMS and HHS from using certain accounts to fund the risk-corridors payments the Government was obligated to pay under the ACA.

A cardinal rule of statutory construction is that repeals by implication are not favored. *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978) (quoting *Morton v. Mancari*, 417 U.S. 535, 549 (1974) (quoting *Posadas v. National City Bank*, 296 U.S. 497, 503 (1936)). Indeed, as has been often repeated for over 80 years, "the intention of the legislature to repeal must be clear and manifest." *Posadas v. National City Bank*, 296 U.S. 497, 503 (1936). That principle applies with even greater force to appropriations bills: the failure to appropriate funds for an existing obligation is strongly presumed not to modify the underlying obligation. *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978); *see also New York Airways*, 369 F.2d 743, 748 ("[I]t has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly owed obligations, by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute."); *see also* 1 GAO, *Principles of Federal Appropriations Law* at 2-49 (3d. Ed. 2004)

("mere failure to appropriate sufficient funds will not be construed as amending or repealing prior authorizing legislation.").

Strict adherence to the presumptions against implied repeal by appropriations bill is particularly appropriate here where QHPs relied on the expectation of risk-corridors payments to make crucial decisions about whether to enter and participate in the ACA exchanges and how to price their plans. If Congress's intention was to drastically modify the risk-corridors program—effectively eliminating any protections for losses incurred in 2015 and 2016 by requiring HHS to use payments in from those years to make remaining payments out for 2014—it had an obligation to make it manifestly clear to insurers that it was doing so, so that QHPs like Lincoln could adjust their decisions accordingly.

The 2015 and 2016 spending bills contain none of the "clear and manifest" indications of congressional intent needed to repeal risk-corridors by implication. Both bills left the risk-corridors statute, ACA § 1342 intact, while merely eliminating a single source of funding to make risk-corridors payments in a single year. The text of the 2015 and 2016 appropriations bills and their legislative history are also silent as to any intent to limit HHS's underlying obligations. Both bills were similarly signed by President Obama without any indication that he understood that by signing those bills, he was substantially paring back a program essential to the continued viability of the ACA.

Indeed, the language in the appropriations provision here limiting risk-corridors funding is similar to the appropriation provision in *Gibney*. *Compare Gibney*, 114 Ct. Cl. at 44 ("[N]one of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided [under specific statutes] . . . ."), *with* 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" risk-corridors payments). In *Gibney*, the Court of Claims found this language insufficient to overcome the presumption against implied repeal, and thus construed it as "a mere limitation on the expenditure of a particular fund" that "had no other effect" on the government's statutory requirement to pay. 114 Ct. Cl. at 44. The 2015 and 2016 spending bills' similar language must be given the same interpretation. The spending bills, therefore, had no effect on the amount owed to the Lincoln under the payment formula specified in Section 1342. The Court should enter judgment for Lincoln on Count I accordingly.

D. The Trial Court Erred In Deferring To HHS's Purported "Determination" That The Risk-Corridors Program Is Budget Neutral And Not Payable Annually.

Rather than give the risk-corridors statute its unambiguous meaning, the trial court purported to defer to HHS's "three-year, budget-neutral interpretation" of the statute, which it believed foreclosed relief under the Tucker Act. Appx26. The ruling misconstrues HHS's guidance, which to this day has consistently recognized QHPs' right to full, timely risk-corridor payments even while failing to make those payments. Even if HHS *had* reached a contrary conclusion, moreover, that conclusion would not be entitled to deference.

1. HHS Has Consistently Interpreted The Statute To Require Full And Timely Risk-Corridors Payments.

Before, during and even after each calendar year of the risk-corridors program, the relevant agency, HHS, has echoed Lincoln's views on the only question relevant to Lincoln's right to recover under the Tucker Act: it has recognized repeatedly that it has a current obligation to make the full amount of risk-corridors payments for each calendar year. HHS's decision to withhold full payment despite that recognized obligation is not relevant under the Tucker Act, and the trial court erred in concluding otherwise.

After Congress's enactment of the ACA in 2010, HHS repeatedly publically acknowledged and confirmed its statutory and regulatory obligations to make full and timely risk-corridors payments to QHPs. HHS's regulations implementing the

risk-corridors program have provided, since they were first enacted in 2012, that QHPs "will receive" payments in the amount specified under the statute. 45 C.F.R. § 153.510(b). The final rule implementing those regulations recognizes that QHPs "will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers." In March 2013, HHS again confirmed in a final rule that "the risk corridors program is not statutorily required to be budget neutral" and that [r]egardless of the balance of payments receipts, HHS *will remit* payments as required under Section 1342." Appx269 (emphasis added).

HHS did not alter this interpretation in May 2014 when it adopted its policy of administering the risk-corridor program on in a budget-neutral manner. Its May 2014 final rule left in place the 2012 regulation promising that QHPs "will receive" full payments, 45 C.F.R. § 153.510(b), and confirmed both that "Section 1342(b)(1) … establishes … the formula to determine … the amounts the Secretary *must pay* to the QHPs if the risk corridors threshold is met," Appx274 (emphasis added), and that "the [ACA] *requires* the Secretary to make *full payments* to issuers," including through "other sources of funding," if necessary. Appx291. HHS thus continued to assure QHPs throughout 2014 and 2015 that QHPs "*will receive* payments from HHS" in the amounts specified by statute, Appx278 (emphasis added) (June 2014); *see also* Appx286 (February 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make *full*

payments to issuers." (emphasis added)); Appx291 (November 2015) ("HHS recognizes that the Affordable Care Act *requires* the Secretary to make *full payments* to issuers." (emphasis added)). Even after this litigation was filed, HHS has made public announcements confirming full risk-corridors payments were an ongoing obligation of the Government. Appx523.

HHS thus agrees with Lincoln on the fundamental question of how much is owed under the risk-corridor payments and only contests when payment is due, not whether it is owed. Indeed, the only government entity that has ever suggested that HHS does not *owe* full, annual payments under the risk-corridors statute is the Department of Justice, which adopted that interpretation for the first time in its briefs in this case. The government's post-hoc "litigating position," however, is entitled to no deference. *Bowen v. Georgetown University Hosp.*, 488 U.S. 204, 213 (1988).

HHS nonetheless has failed to make the payments that it acknowledges are due only because it lacks sufficient funds to cover those payments as a result of Congress's failure to provide full funding. Because Lincoln's Tucker Act claim does not depend on the availability of a congressional appropriation, however, Congress's failure to appropriate funding is irrelevant to Lincoln's claims and does not preclude Lincoln from recovering what it is owed from the Judgment Fund. *See supra* 22-25.

2. The Contrary View That The Trial Court Attributed To HHS Is Not Entitled To *Chevron* Deference.

Even if HHS had interpreted the risk-corridors statute in a manner that foreclosed Lincoln's Tucker Act claims, that interpretation would not be entitled to deference under *Chevron*. *Chevron*'s "two-step framework" affords deference to "an agency's interpretation of a statute" when "the statute is ambiguous" and "the agency's interpretation is reasonable." *King*, 135 S. Ct. at 2488. But that framework applies only when it is "apparent from the agency's generally conferred authority and other statutory circumstances that Congress would expect the agency to be able to speak with the force of law when it addresses ambiguity in the statute." *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001); *e.g. King*, 135 S. Ct. at 2488 ("In extraordinary cases, however, there may be reason to hesitate before concluding that Congress has intended such an implicit delegation."). The central interpretative questions in this action are not, however, the type of questions that Congress would have delegated to HHS to decide, and even if they were, *Chevron* deference would not be warranted because the risk-corridor statute is not ambiguous and the interpretation that the trial court attributed to HHS is not reasonable.

a. Congress granted HHS no authority to change HHS's obligation to pay by withholding or delaying full risk-corridor payments.

The trial court's reliance on *Chevron* fails at the threshold because Congress could not have "intended" to "implicit[ly] delegat[e]" to HHS the broad authority that the trial court claims the agency exercised. *King*, 135 S. Ct. at 2488. Whether the obligation to make risk-corridors payments was intended to be limited in a budget-neutral manner is quintessentially a legislative matter that carries with it such "economic and political significance" that it would be odd, if not unconstitutional, for Congress to delegate it to an agency. *Id.* "[H]ad Congress wished," nonetheless, "to assign that question to an agency, it surely would have done so expressly." *Id.*

Chevron deference would be particularly inappropriate here because it would undermine the purpose of the risk-corridors program, which is to reduce uncertainty for QHPs about unexpected gains and losses as a result of participating in the ACA exchanges. If HHS can reinterpret its obligation under the program at any time—even *after* plans have agreed to participate in the exchanges and incurred obligations in reliance on HHS's express assurances of full, timely risk-corridor payments—then the program would only create *additional* uncertainty about how much QHPs can expect to gain or lose by participating in the exchanges.

Moreover, HHS itself is not a logical agency to which Congress would delegate a question of budget neutrality—it has no special expertise with budgeting policy—rendering it further unlikely that Congress would have delegated that question to HHS. *King* at 2488-89.

b. Deference is unwarranted because the statute is clear.

Even under a traditional *Chevron* analysis, deference would not be due to HHS's scheme to make partial payments, because the statute unambiguously requires full, annual payments. *See supra* at 26-38.

Chevron deference also cannot be used to overcome the presumption that Congress does not alter underlying obligations through appropriations bills. As the Supreme Court has recognized, rules of construction that require unambiguous evidence of congressional intent preclude *Chevron* deference. *E.g.*, *INS v. St. Cyr*, 533 U.S. 289, 320 n. 45 (2001) ("we only defer, however, to agency interpretation of statutes that, applying the normal 'tools of statutory construction,' are ambiguous. Because a statute that is ambiguous with respect to retroactive application is construed under our precedent to be unambiguously prospective, there is, for *Chevron* purposes, no ambiguity in such a statute for an agency to resolve."). Likewise, here, an ambiguous appropriations bill that fails to fund an obligation is construed to unambiguously leave that obligation in place, and there is no ambiguity for HHS to resolve.

c. Deference is not warranted because HHS did not provide a reasoned basis for the interpretation that the trial court attributed to it.

Even if the risk-corridors statute were ambiguous and Congress had delegated its interpretation to HHS, the interpretation that the trial court attributed to HHS would fail at *Chevron* step two because it was not a "reasonable" decision resulting from reasoned statutory interpretation. In determining whether an "agency's statutory interpretation" is a "'reasonable' view of the Congress's intent," the trial court was required to "look to what the agency said *at the time of the rulemaking*—not to its lawyers' post-hoc rationalizations." *Council for Urological Interests v. Burwell*, 790 F.3d 212, 222 (D.C. Cir. 2015). Courts "must judge the propriety of [agency] action solely by the grounds invoked by the agency." *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947). The trial court was thus "powerless to affirm" HHS's purported interpretation "by substituting what it considers to be a more adequate or proper basis." *Id.*

These principles preclude *Chevron* deference here because HHS *did not engage in reasoned statutory interpretation* about how to meet its statutory obligations to operate the risk-corridors program. It did not even purport to *interpret* the language of that statute, much less do so by applying the traditional tools of statutory interpretation. *Cf. Shi Liang Lin v. U.S. Dep't of Justice*, 494 F.3d 296, 339-40 (2d Cir. 2007) ("Since the agency has yet to interpret the broad

language of that section, it is wrong for us to say … that the agency expressed views to which we owe deference. And this is so, regardless of whether such a ruling, had it been made, would have passed the requirements of *Chevron* Step Two."). *Many* aspects about the ACA on which the trial court relied in upholding the interpretation that it attributed to HHS—including the CBO report and Congress's purported failure to appropriate funds for risk-corridors payments—were never mentioned in the May 2014 final rule to which the trial court purported to defer. Appx26, *citing* 79 Fed. Reg. at 30,260, AR6195. Indeed, the two appropriations bills on which the government now relies were each enacted *after* that final rule. Under *Chenery*, therefore, the government cannot rely on any of those authorities to establish that the May 2014 rule, as construed by the trial court, was reasonable.

If HHS truly *had* adopted a new interpretation of its risk-corridors obligations in the May 2014 rule, it would have been required—as a condition for obtaining *Chevron* deference—to acknowledge and justify that change of position. When an agency interpretation creates "'serious reliance interests'"—as HHS's pre-2014 statements plainly did in encouraging QHPs to enter the ACA exchanges, *see supra* at 8-10—a subsequent change is facially arbitrary and capricious and "receives no *Chevron* deference" without a reasoned explanation from the agency for that change. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125-26

(2016); *see Pauley v. Beth-Energy Mines, Inc.*, 501 U.S. 680, 698 (1991) ("the case for judicial deference is less compelling with respect to agency positions that are inconsistent with previously held views."). HHS provided no such analysis here.

The new interpretation that the trial court attributed to HHS is particularly inappropriate because it is at odds with the text of HHS's existing regulation implementing the risk-corridors program—which continues to provide that QHPs "will receive" payments based on a formula identical to the statutory formula under Section 1342. 45 C.F.R. § 153.510(b). HHS has never repealed that regulation, so it is that regulation—and not HHS's subsequent statements in informal guidance or in the preamble to the May 2014 rule—that controls QHPs' right to payment.

The establishment of the health insurance exchanges is a central facet of the ACA, providing access to insurance that millions of Americans did not have before. *King*, 135 S. Ct. at 2485. The Government admits the 3R programs were designed to stabilize those exchanges in their early and very risky years, when insurers had little information about this new insured pool's demographics. Appx255, Appx396. HHS's about-face decision to pay risk-corridors amounts only at the end of the risky startup period, however, has caused widespread chaos and destroyed the very exchanges the risk-corridors program was meant to protect.

Even if *Chevron* applied, the interpretation is contrary to the statute's purpose, and it must be rejected as unreasonable.

The record shows that HHS chose only *to make* risk-corridors payments in a budget-neutral fashion over three years, yet HHS consistently recognized it has an ongoing obligation to make full, annual risk-corridors payments. HHS has never asserted its *obligation* to pay is budget-neutral over three years.

In summary, DOJ's *post hoc* budget-neutral three-year payment position is belied by, *inter alia*:

1. The ACA's text (*e.g.*, § 1342(b)(1) which states that the HHS Secretary "shall pay to the plan" a certain amount if the plan's allowable costs "*for any plan year*" exceed the target amount by a certain threshold);

2. The implementing regulations (*e.g.*, 45 C.F.R.; § 153.510(b) which states that risk-corridors payments will be made for "*any benefit year*");

3. The risk-corridors program's fundamental purpose to support the Exchanges by providing insurers with additional protection against uncertainty in claims costs during the first three years of the Exchanges;

4. Prior legislative history from Medicare Part D, on which § 1342 was expressly modeled (*e.g.*, 42 U.S.C. § 1395w-115(e)(3)(A): "*For each plan year* the Secretary shall establish a risk corridor for each prescription drug plan …."; 42 C.F.R. § 423.336: "*For each* year, CMS establishes a risk corridor for each Part D plan);

5. The Supreme Court's ACA precedent (*e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2492-93 (2015) ("[T]he statutory scheme compels us to reject petitioners' interpretation because it would destabilize the

individual insurance market … and likely create the very 'death spirals' that Congress designed the Act to avoid")));

6. HHS's own repeated statements that it continues to be liable for full risk-corridors payments regardless of appropriations. *E.g.* Appx297;

7. HHS's conduct *preceding* this lawsuit, *e.g.*, *actually making prorated annual risk-corridors payments to Lincoln and other QHPs in December 2015 to March 2016* for just under 12.6 percent of the amounts due for the CY 2014 plan year and scheduling further payments in late 2016; and in requiring QHP issuers to pay the Government *in full* every year under the program; if the program only required full payments at the end of 2016, then those QHP issuers could have held off and only paid then;

8. HHS's conduct post-dating this lawsuit (*e.g.*, CMS' September 9, 2016 announcement that "HHS will record risk-corridors payments due as an obligation of the United States Government for which full payment is required."); and

9. Other Government agencies' assessments, *e.g.*, the Congressional Budget Office ("CBO") stating that "[t]he risk corridors program … covers insurance issued for calendar years 2014 to 2016, and corresponding payments and collections will occur during fiscal years 2015 to 2017." CBO, *The Budget and Economic Outlook: 2015 to 2025*, at 121 n.8 (Jan. 2015); https.//www.cbo.gov/Publications/49892.

The Government's failure to pay risk-corridors amounts on an annual basis and in full for the 2014 and 2015 plan years has now placed over 50,000 Illinois residents' health insurance at risk. It currently owes Lincoln over $75 million promised by statute. Without the funds the Government owes, Lincoln was forced out of business for good, leaving a void that would not today exist had the Government abided by its promise to mitigate risk for QHP issuers offering such

plans in the new risky ACA exchange markets. The Tucker Act confers jurisdiction for exactly such a situation and Lincoln is thus entitled to judgment on the Administrative Record on Count I for breach of a clear statutory and regulatory obligation.

II. The Trial Court Erred in Dismissing Counts II-V Each of Which Stated a Properly Pled and Plausible Cause of Action.

A. The Trial Court Itself Properly Found Lincoln Stated A Cause of Action Under Counts II-V.

In ruling on the Government's Rule 12(b)(1) motion to dismiss for lack of jurisdiction below, the trial court concluded "that Lincoln has sufficiently made non-frivolous contract claims against the Government for monetary relief." Appx16. It concluded that Lincoln had adequately pled claims for money damages under an express contract, or alternatively, an implied in fact contract under applicable law. Appx16. It also found that Lincoln had plausibly claimed money damages under the taking clause of the Fifth Amendment. Appx16-17. It concluded it had jurisdiction over all of Lincoln's claims. Appx16-17.

Curiously, however, after the court ruled on the cross-motions for judgment on the Administrative Record on Count I, and concluded there was no current obligation to pay, it then found that Counts II through V did not state a cause of action under Rule 12(b)(6) on that basis. But that issue was not before the Court on those counts on the 12(b)(6) motion. The Government did not move for

judgment on the Administrative Record on Counts II through V. Lincoln did. Because, according to the trial court, Lincoln could not establish that risk-corridors payments were currently due, it did not state a valid cause of action under Counts II through V. Appx34-35. In reaching its conclusions as to the viability of Counts II through V, the Court did not follow the requirement that it make all reasonable inferences in Lincoln's favor. This was plain error. With respect to the Government's Rule 12(b)(6) motion, dismissal is only proper when a plaintiff can prove no set of facts in support of its claim which would entitle it to relief. *Leider v. United States*, 301 F.3d 1290, 1295 (Fed. Cir. 2002). In considering a 12(b)(6) motion, the court assumes all well-pled factual allegations in the complaint are true and all reasonable inferences in favor of the non-movant. *Adams v. United States*, 391 F.3d 1212, 1218 (Fed. Cir. 2004).

As the trial court itself concluded, Lincoln does state a plausible cause of action in Counts II through V and they should not have been dismissed.[5] Moreover, for the reasons discussed in Sections I and II above, full risk-corridors payments are currently due and thus again Counts II through V state viable actions.

[5] For example, as to Counts III (implied contract) and IV (implied covenant of good faith), the ACA states on its face that a QHP "shall be" paid risk-corridors payments. Once Lincoln complied with the law as a QHP (and there is no question it did) the Government impliedly agreed to pay. *See United States v. Winstar*, 518 U.S. 839 (1996) (compliance with earlier statutory reserve requirements created implied contract right that overrode later statutory change to reserve requirement and justified damages award).

The Court should vacate the dismissal of Counts II through V under 12(b)(6) and remand for further appropriate action in the trial court.

III. The Court Has Jurisdiction to Enter Declaratory Judgment for Fiscal Year 2016 Because Lincoln's Claim for Money Damages is Tied To And Subordinate To Money Judgment For The Prior Fiscal Years.

A. The Court Has Jurisdiction for a Related Declaratory Judgment.

As of the filing date for this brief, calendar year 2016 QHP obligations and the concomitant risk-corridors programs for 2016 have concluded. All that remains is for Lincoln to submit its numbers for 2016 and for HHS to approve those numbers, probably in late November 2017. At that time the Government will be obligated to make full risk-corridors payments for calendar year 2016. This is so for the reasons discussed in Sections I and II above. It is also so, because even under the Government's position below, the full three years of the risk-corridors programs under the ACA have concluded.

Lincoln requested below a collateral declaratory judgment that it is entitled to full payment of the approved risk-corridors amount for fiscal year 2016 when HHS confirms the numerical amount based on Lincoln's submitted data. The trial court concluded it did not have jurisdiction over this request because "although Lincoln is seeking declaratory relief that it contends is collateral to its request for monetary judgment, the relief sought is not necessarily derivative from or attendant to any money judgment that might issue, but rather would turn on future

developments." Appx17. It offered no explanation for this conclusion. The Federal Circuit has interpreted the Tucker Act to provide jurisdiction for declaratory relief where it is tied and subordinate to a prior money judgment. *See, e.g.*, *James v. Caldera*, 159 F.3d 573 (Fed. Cir. 1998). This is exactly the type of case for which such relief was designed. The trial court had and this Court has jurisdiction over Lincoln's claim with respect to the 2016 RCPs and the Court should declare Lincoln is entitled to judgment in the amount of such payment when it is determined by HHS in 2017.

CONCLUSION

For these reasons, Lincoln respectfully requests that the Court:

1. Vacate the judgment for the Government and against Lincoln on Count I and enter judgment for Lincoln against the Government on Count I for $75,758,669.50;
2. Vacate the dismissal of Counts II through V and remand Counts II-V for further proceedings; and
3. Enter a declaratory judgment for Lincoln that it is entitled to judgment for the risk-corridors payment amount determined by HHS in 2017 for calendar year 2016.

Dated: January 31, 2017

Respectfully submitted,

/s/ Daniel P. Albers

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Counsel for Plaintiff-Appellant Land of Lincoln Mutual Health Insurance Company

ADDENDUM

TABLE OF CONTENTS

Addendum Page

In the United States Court of Federal Claims

No. 16-744C

(Filed: November 10, 2016)

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LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY,	Claim by qualified health insurance plan participating in a federally-run state Exchange to damages based upon statutory or regulatory entitlement to receive "risk-corridors" payments; Section 1342 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18062; 45 C.F.R. § 153.510; claims for damages based upon alleged breach of an express contract, an implied-in-fact contract, or an implied covenant of good faith and fair dealing; takings claim
Plaintiffs,	
v.	
UNITED STATES,	
Defendant.	
**********	

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OPINION AND ORDER

LETTOW, Judge.

Since 2014, Land of Lincoln Mutual Health Insurance Company ("Lincoln") has provided qualified health insurance plans in Illinois under the Patient Protection and Affordable Care Act ("the Affordable Care Act" or "the Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010). In this action, Lincoln seeks damages under Section 1342 of the Act, codified at 42 U.S.C. § 18062, which establishes and governs a temporary program of "risk corridors" applicable to calendar years 2014, 2015, and 2016, where qualifying health plans ("QHPs") participating on

health insurance Exchanges pay money to or receive money from the Department of Health and Human Services ("HHS"), depending upon the ratio of premiums received to claimed costs.[1]

Lincoln is an Illinois not-for-profit company with its headquarters in Chicago that served nearly 50,000 customers on the Illinois Health Insurance Marketplace in 2014, 2015, and part of 2016. Compl. ¶ 13.[2] Lincoln suffered losses in 2014 and 2015 and thus is deemed eligible to receive payment from HHS under the risk-corridors program. HHS paid Lincoln approximately 12.6% of the amount Lincoln is due for 2014, and nothing for 2015. Compl. ¶ 8. As a general matter, the payments HHS owes to qualified health plan issuers under the program exceed the fees received by HHS under the program, and HHS has stated that it will make payments only from fees collected, to the extent such fees are available, on a proportional basis to those owed payment.

Lincoln filed its complaint on June 23, 2016, alleging that it had a statutory and regulatory entitlement to the full amount of the payments due it under the program for 2014 and 2015, totaling at least $72,859,053, and that the full entitlement was and is due on an annual basis. Compl. ¶¶ 9, 77. Additionally, Lincoln alleges that the government's actions breached an express or implied-in-fact contract, breached the implied covenant of good faith and fair dealing, and contravened the Takings Clause of the Fifth Amendment. Compl. ¶ 1. Shortly after the complaint was filed, Lincoln requested "expedite[d] disposition of this action" because, among other things, it otherwise lacked funds to survive as a continuing entity. Pl.'s Mot. for an Early Pretrial Conference Pursuant to Rule 16(a) at 1 (July 26, 2016), ECF No. 7. In that regard, Lincoln advised that "the State of Illinois Director of Insurance has obtained an Order of Rehabilitation against Lincoln dated July 14, 2016." *Id.* at 2. Absent an infusion of funds by September 30, 2016, the health insurance Lincoln was providing to citizens of Illinois would have to be cancelled. *Id.* Promptly thereafter, the court held a status conference with the parties, and, because the case involves a claim of statutory and regulatory entitlement, the court requested the government to file the administrative record of its regulations and its actions respecting Lincoln. *See* Hr'g Tr. 32:1-2 (Aug. 12, 2016). The court set an accelerated schedule for submission and briefing of potentially dispositive motions and calendared an early hearing. *See* Scheduling Order (Aug. 12, 2016), ECF No. 12. With one subsequent adjustment to the

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[1]The Act assigns HHS the responsibility for implementing many aspects of the Act. HHS delegates some of those responsibilities to the Centers for Medicare & Medicaid Services ("CMS"), including the responsibility to establish and administer the risk-corridors program. *See* Delegation of Authorities, 76 Fed. Reg. 53,903, 53,904 (Aug. 30, 2011). For purposes of this opinion, both HHS and CMS will be referred to as "HHS."

[2]Lincoln is a nonprofit issuer that provided health plans through the government's Consumer Operated and Oriented Plan program, which was intended to "foster the creation of qualified nonprofit health insurance issuers." *See* 42 U.S.C. § 18042(a); Pl.'s Mot. for Judgment on the Administrative Record and Mem. in Support ("Pl.'s Mot.") at 3, ECF No. 20. Nonetheless, as an Illinois health insurance provider, Lincoln must file its rates, along with other information, with the State of Illinois and receive approval from the State before it can issue health insurance. See 215 Ill. Comp. Stat. 5/355, 5/143 (2016).

schedule, *see* Amended Scheduling Order (Oct. 18, 2016), ECF No. 36, the parties have followed this procedural path.

BACKGROUND

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, to expand individual health insurance coverage. The Act requires health insurance providers offering health insurance in a particular state to accept all individuals and qualified employers applying for coverage in that state, subject to certain restrictions. 42 U.S.C. § 300gg-1(a). Further, the Act prohibits insurance providers from setting premiums based upon a particular person's health. *See King v. Burwell*, __ U.S., __, __, 135 S. Ct. 2480, 2486 (2015) (citing 42 U.S.C. § 300gg); *see also* 45 C.F.R. §§ 147.108-116.

Additionally, the Act establishes health insurance "Exchanges," *i.e.*, marketplaces within each state where individuals and qualified employers can purchase health insurance. *See* 42 U.S.C. § 18031. The Act provides that each individual state may administer its respective Exchange if it elects to do so, or, if the state elects not to establish an Exchange, "the Secretary shall . . . establish and operate such Exchange within the [s]tate." 42 U.S.C. § 18041(c)(1). Health insurance providers wishing to offer insurance coverage on an Exchange can only do so if they offer a "qualified health plan," which is defined within the Act and the implementing regulations. *See* 42 U.S.C. §§ 18021, 18031(b)(1)(A); 45 C.F.R. § 155.20. The Act requires insurers participating on the Exchanges to, among other requirements, be certified as qualified health plans. *See* 42 U.S.C. § 18031(d)(4)(A), (e); 45 C.F.R. § 155.20.

A. The Risk-Corridors Program

Because the Act enabled health insurance coverage to be made available to many individuals who were previously underinsured or uninsured, Lincoln alleges that health insurance providers "had no previous experience or reliable data to meaningfully assess the risks and set the premiums for this new population of insureds." Compl. ¶ 4. Recognizing this uncertainty, Congress established three stabilization programs, *see* 42 U.S.C. §§ 18061-18063, to mitigate the uncertainty and pricing risks for insurers, which programs have become commonly known as "reinsurance," "risk corridors," and "risk adjustment," respectively. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013), AR 1807;[3] Def.'s Mot. to Dismiss and Mot. for Judgment on the Administrative Record on Count I ("Def.'s Mot.") at 6, ECF No. 22. The risk-corridors program established under Section 1342 of the Act, which is the stabilization program pertinent to Lincoln's claims, was designed to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,411, AR 1807. The risk-corridors program is a three-year temporary program that pertains to the calendar years of 2014, 2015, and 2016. 42 U.S.C. § 18062(a). It applies only to qualified

[3] "AR__" refers to the administrative record certified by HHS and filed with this court in compliance with Rule 52.1(a) of the Rules of the Court of Federal Claims ("RCFC").

health plans offered through an Exchange. *Id.*; *see* 45 C.F.R. § 153.510.[4] The program was "based on" a similar program enacted under Part D of Title XVIII of the Social Security Act. 42 U.S.C. § 18062(a) (referring to Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified at 42 U.S.C. §§ 1395w-101 *et seq.*) ("the Medicare Program")).

The risk-corridors program calls upon HHS to provide a mechanism to even out the losses and gains of qualified health plans during the three-year phase-in period. *See* 42 U.S.C. § 18062(b); 45 C.F.R. § 153.510. When a qualified health plan issuer experiences a loss in a calendar year, such that the plan's "allowable costs" are more than 103 percent of the plan's "target amount" for that year, HHS is directed to pay the issuer a portion of that loss. 42 U.S.C. § 18062(b)(1); 45 C.F.R. § 153.510(b). Correlatively, when the issuer experiences a gain in a calendar year, such that the plan's "allowable costs" are less than 97 percent of the plan's "target amount" for that year, the issuer is directed to pay the HHS a certain amount of that gain. 42 U.S.C. § 18062(b)(2); 45 C.F.R. § 153.510(c). The "[p]ayments out" and "[p]ayments in" are specified by statute as follows:

> (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 –

[4] If a health insurer chooses not to offer coverage through an Exchange, then it is not subject to the risk-corridors program. *See* 45 C.F.R Part 155 ("Exchange Establishment Standards and Other Related Standards under the Affordable Care Act"), Subpart K ("Exchange Functions: Certification of Qualified Health Plans"), § 155.1000(b) ("The Exchange must offer only health plans which have in effect a certification issued or are recognized as plans deemed certified for participation in an Exchange as a QHP, unless specifically provided for otherwise.").

> (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(b).[5] Allowable costs include the costs incurred by the qualified health plan in providing benefits under the plan, other than administrative costs. 42

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[5]The HHS regulations implementing the payment-out methodology set forth "substantially similar terms" to those set out in the statute. Def.'s Mot. at 7 (citing 45 C.F.R. § 153.510(b)-(c)). As HHS explained:

> For example, a [qualified health plan] has a target amount of $10 million, and the [qualified health plan] has allowable costs of $10.5 million, or 105 percent of the target amount. Since 103 percent of the target amount would equal $10.3 million, the amount of allowable costs that exceed 103 percent of the target amount is $200,000. Therefore, HHS would pay 50 percent of that amount, or $100,000 to the [qualified health plan] issuer.

Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,943 (July 15, 2011), AR 11295. And further:

> For example, a [qualified health plan] has a target amount of $10 million. The [qualified health plan] has allowable costs of $11.5 million, or 115 percent of the target amount. Since 108 percent of the target amount would be $10.8 million, the amount of allowable costs that exceed 108 percent of the target amount is $700,000. Therefore, HHS pays 2.5 percent of the target amount, or $250,000, plus 80 percent of $700,000, or $560,000, for a total of $810,000.

Id.

The regulations follow the Act in setting forth the obverse methodology when a qualified health plan issuer reports gains in a calendar year, but the issuer is required to make payments rather than receive payments. The issuer is required to pay HHS under the same formulas, but the allowable cost-to-target amount ratios are 97 and 92 percent, rather than 103 and 108 percent. *See* 45 C.F.R. § 153.510(b), (c).

U.S.C. § 18062(c)(1)(A).[6] The target amount consists of the total amount of premiums received under the plan, reduced by any administrative costs. 42 U.S.C. § 18062(c)(2).[7]

The Act does not include a time limit by which payments must be made to, or received from, HHS, *see* 42 U.S.C. § 18062, but the implementing regulations do include a deadline for when qualified health plan issuers must pay HHS. If a qualified health plan's allowable costs are sufficiently below the target amount such that the issuer is required to make payments to HHS, the issuer must do so "within 30 days after notification of such charges." 45 C.F.R. § 153.510(d). In March 2012, before HHS implemented this regulation, HHS noted that it had considered a 30-day deadline for paying qualified health plan issuers because "issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and [qualified health plan] issuers." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,238 (Mar. 23, 2012), AR 969. Even so, this deadline was only considered by HHS; it was not included in the proposed or final rule. *Id.* And, the implementing regulation did not refer to any time limit for HHS to make payments. *See* 45 C.F.R. § 153.510. Instead, HHS explained through a guidance bulletin issued on April 11, 2014, that if it failed to make sufficient payments for 2014, it would use the program's collected fees from 2015, and then 2016 if necessary, to satisfy amounts due. CMS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014), AR 108-09. HHS explained that it would be administering the risk-corridors payments "over the three-year life of the program, rather than annually." Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014), AR 6195.

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[6]Allowable costs are also reduced by "any risk adjustment and reinsurance payments received" by the qualified health plan issuer under Sections 1341 and 1343 of the Act. 42 U.S.C. § 18062(c)(1)(B).

[7]HHS had no direct role in the premiums Lincoln charged for its health insurance coverage, either for individuals or for small groups. Hr'g Tr. 47:4-8 (Nov. 7. 2016) ("HHS has no legal say in what any QHP charges in its premiums.") (The date will be omitted from subsequent citations to the transcript of the hearing held on Nov. 7, 2016.). Rather, by providing coverage (and participating on the federally-run Exchange for Illinois), Lincoln agreed to offer qualifying plans (*e.g.*, platinum, gold, silver, bronze) and to accept applications notwithstanding pre-existing conditions. Hr'g Tr. 47:12 to 48:19; *see also* 42 U.S.C. § 18022(d) (levels of coverage). The premium rates for those plans were subject to regulation by the State of Illinois' Department of Insurance. *See supra*, at 2 n. 2; Hr'g Tr. 47:5-8.

Federal law and regulations require plans seeking premium increases to provide justification for the increases and to post the justification on the issuers' website. *See* 42 U.S.C. § 18031(e)(2); 45 C.F.R. § 155.1020. The regulations require consideration of specified factors in determining rate increases. 45 C.F.R. § 155.1020(b); *see also* Hr'g Tr. 13:22 to 14:25. An Exchange can take the justification into account in deciding whether to make a plan available through the Exchange. 42 U.S.C. § 18031(e)(2).

B. Funding of the Risk-Corridors Program

Paragraphs 1342(b)(1) and (2) of the Act provide that HHS "shall pay" and plans "shall pay" amounts due out and due in under the payment methodology described in Subsection 1342(b), but the Subsection is otherwise silent regarding deficits or excess funds under the risk-corridors program. *See* 42 U.S.C. § 18062(b); Def.'s Mot. at 8 ("Congress did not include in the [Act] either an appropriation or an authorization of funding for risk corridors."). The Government Accountability Office ("GAO") reached this same conclusion in 2014 in response to a congressional inquiry. *See* The Honorable Jeff Sessions, the Honorable Fred Upton, B-325630, 2014 WL 4825237, at *2 (Comp. Gen. Sept. 30, 2014), AR 116 ("Section 1342, by its terms, did not enact an appropriation to make the payments specified in [S]ection 1342(b)(1).") ("*GAO Op.*").[8] Similarly, the implementing regulation states that qualified health plans will receive payments from HHS without any reference to any source of funding or appropriations apart from the "payments in." *See* 45 C.F.R. § 153.510(b).

On July 15, 2011, HHS noted in a proposed rule that prior to enactment of the Affordable Care Act, the Congressional Budget Office ("CBO") analyzed the estimated costs that would be attributable to passage, but "did not score the impact of risk corridors," under the assumption that "collections would equal payments to plans in the aggregate." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. at 41,948, AR 11300; *see* Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, Table 2 (Mar. 20, 2010), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf ("March 2010 CBO Letter") (providing an estimate of the spending and revenue impact for the Act's two other stabilization programs, reinsurance and risk adjustment, but not for the risk-corridors program). Despite this budget-scoring circumstance and the lack of specific authorization for appropriations, on March 11, 2013, HHS stated in adopting a final rule that "[t]he risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will

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[8]GAO drew upon its prior appropriation precedents for its reasoning:

> At issue here is whether appropriations are available to the Secretary of HHS to make the payments specified in section 1342(b)(1). Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. 1, § 9, cl. 7; 31 U.S.C. § 1341(a)(1); B-300192, Nov. 13, 2002, at 5. Appropriations may be provided through annual appropriations acts as well as through permanent legislation. *See e.g.*, 63 Comp. Gen. 331 (1984). *The making of an appropriation must be expressly stated in law.* 31 U.S.C. § 1301(d). *It is not enough for a statute to simply require an agency to make a payment.* B-114808, Aug. 7, 1979. Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1). In such cases, we next determine whether there are other appropriations available to an agency for this purpose.

GAO Op., 2014 WL 4825237, at *2, AR 116 (emphasis added).

remit payments as required under section 1342 . . . ." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,473, AR 1869. Then, one year later, HHS issued a final rule stating that the risk-corridors program would be implemented "in a budget neutral manner," while also noting the possibility of "future adjustments . . . to the extent necessary." HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014), AR 4929.

In its guidance of April 11, 2014, HHS explained that under the budget-neutral criterion for administration of the program, fees collected by HHS through the program would be the only funds used to pay the qualified health plans eligible for payment. *Risk Corridors and Budget Neutrality*, AR 108; *see* 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014) (noting that budget neutral means "the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect"). Thus, qualified health plans with allowable costs less than 97 percent of the target amount for the year would supply the funds used to pay qualified health plans with allowable costs greater than 103 percent of the target amount for the year. In its guidance of April 2014, HHS went on to state:

> [I]f risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments.

Risk Corridors and Budget Neutrality, AR 108. HHS has adhered to this budget-neutral implementation in subsequent rules and guidance. *See e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015), AR 8153.

In establishing this payment plan, HHS recognized the "unlikely" possibility that HHS would not receive sufficient collection fees to make all necessary payments for the 2016 calendar year, the final year of the program. HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,779, AR 8153. If such a situation did occur, however, HHS stated it would "use other sources of funding for the risk corridors payments, subject to the availability of appropriations." *Id.*

In September 2014, GAO responded to a congressional inquiry by finding that HHS, and more specifically CMS, was permitted to draw from its general lump-sum 2014 program-management appropriation of $3.6 billion to make payments under the risk-corridors program. *GAO Op.*, 2014 WL 4825237, at *2-5, AR 116-20.[9] GAO nonetheless noted that for general funds to be available in 2015, the year HHS had stated it would begin making risk-corridors

[9]The parties have reported that CMS's program-management appropriation for 2014 was spent. Hr'g Tr. 8:8-19.

payments, the 2015 CMS appropriation would have to "include language similar to the language" in the 2014 CMS appropriation. *Id.* at *5, AR 120.[10] Shortly thereafter, in December 2014, Congress enacted the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014), which differed from the 2014 appropriation act by explicitly prohibiting HHS from using any of its lump-sum appropriation for payments under the risk-corridors program in the 2015 fiscal year.[11] An identical provision appeared in the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015), for the 2016 fiscal year.

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[10]The appropriation for 2014 specifically provided:

> For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019.

Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, Div. H, Title II, 128 Stat. 5, 374 (2014). GAO found that the appropriation "made funds available to CMS to carry out its responsibilities, which, with the enactment of [S]ection 1342, include the risk corridors program." *GAO Op.*, 2014 WL 4825237, at *3, AR 117.

Notably, the Consolidated Appropriations Act, 2014, allowed "such sums as may be collected from authorized user fees and the sale of data" to "remain available until September 30, 2019." Pub. L. No. 113-76, Div. H, Title II, 128 Stat. 374. To be subject to that limited continuing authorization, however, the user fees had to be collected in fiscal year 2014. *See* Hr'g Tr. 56:23 to 58:25.

[11]The 2015 Appropriations Act specifically stated:

> 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).

Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014).

In these circumstances, HHS has acknowledged its statutory obligation to make full payments to qualifying health plan issuers under Section 1342, subject to the availability of funds. *See* Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,779, AR 8153 (noting that CMS would draw upon "risk corridors collections" and might be able to "use other sources of funding for the risk corridors payments, subject to the availability of appropriations"); Def.'s Mot. App. at A47 (CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016)) (same).[12]

C. Lincoln is a Qualified Health Plan Issuer That Has Not Yet Received All Payments Owed to It Under the Risk-Corridors Program

In September 2013, Lincoln sought to become a qualified health plan issuer and entered into an agreement with HHS, acting through CMS. Compl. ¶¶ 35-36, Ex. 2. The agreement remained valid until December 31, 2014. Compl. Ex. 2, Section III.a. Lincoln entered into similar agreements with "materially and substantially identical" terms for the calendar years of 2015 and 2016. Compl. ¶¶ 41, 45, Exs. 3-4.[13] Each agreement provides that the qualified health plan issuer will abide by certain standards when using "CMS Data Services Hub Web Services," such as performing certain testing and formatting transactions appropriately. Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. Each agreement also states that "CMS will recoup or net payments due" to the qualified health plan issuer with respect to the "payment of [f]ederally-facilitated Exchange user fees." Compl. Ex. 2, Section II.c; Ex. 3, Section III.b; Ex. 4, Section III.b.

Thus, Lincoln was certified as a qualified health plan issuer under the risk-corridors program for the calendar years of 2014, 2015, and 2016. Lincoln alleges that it relied upon the protections offered by the risk-corridors program when it agreed to become a qualified health plan issuer, and that it set premiums for its qualified health plans at lower rates than it otherwise

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[12]Like plaintiff's motion, defendant's motion is accompanied by a sequentially paginated appendix, but one that consists of only two documents, *viz.*, CMS's "Standard Companion Guide Transaction Information[:] Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally [F]acilitated Exchange (FFE)[- -] Comparison Guide Version Number: 1.5[,] March 22, 2013," Def.'s Mot. App. at A1-A46, and a memorandum from CMS dated September 9, 2016 styled "Risk Corridors Payments for 2015," *id.* at A47-A48. The index to the appendix notes that this memorandum is incorrectly dated September 9, 2015.

[13]Notably, the title of the agreement changed from "Agreement Between Qualified Health Plan Issuer and [CMS]" in 2014 to "Qualified Health Plan Certification Agreement and Privacy and Security Agreement Between Qualified Health Plan Issuer and [CMS]" in the 2015 and 2016 agreements. *See* Compl. Exs. 2, 3, 4.

would have if the program had not been in place. Compl. ¶ 28; Pl.'s Mot. at 5; *cf.* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,413, AR 1809 ("The risk corridors program will protect [qualified health plan] issuers . . . against inaccurate rate setting and will permit issuers to lower rates . . . .").

Lincoln suffered losses in 2014, and as a result Lincoln was due $4,492,243.80 for 2014 under the risk-corridors program's payment methodology. AR 270. In October 2015, however, HHS announced that it received $362 million in fees under the risk-corridors program, but owed $2.87 billion in payments. CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), AR 1254. Due to the budget-neutral criterion, HHS paid qualified health plan issuers 12.6% of the payments they were owed. *Id.* As a result, HHS paid Lincoln $566,825.32, but still owes Lincoln $3,925,418.48 in risk-corridors payments for 2014. AR 270; Pl.'s Mot. at 7. HHS explained that it will pay the remainder of the 2014 payments with fees collected from the 2015 risk-corridors program, and the 2016 program if necessary. AR 293.

Lincoln also claims that it is entitled to $71,833,251 from HHS under the risk-corridors program for losses Lincoln suffered in 2015. Pl.'s Mot. at 7-8 & App. 8 at A56 to A59.[14] HHS has not announced final collections and payments for 2015, but HHS stated in September 2015 that it anticipates "all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." Def.'s Mot. App. at A47. HHS has since indicated that it plans to begin making further payments for 2014 in December 2016, but it has not yet specified the amount of fees it collected in 2015. *See* AR 1498; Def.'s Mot. at 13-14.

D. Lincoln's Action in This Court

Lincoln filed this action on June 23, 2016. It alleges that it is entitled to damages from the government on the grounds that the government violated its risk-corridors "payment obligations" under Section 1342 of the Act and the implementing federal regulations (Count I), breached an express contract or, alternatively, an implied-in-fact contract (Counts II, III), breached the implied covenant of good faith and fair dealing (Count IV), and contravened the Fifth Amendment by taking Lincoln's property for public use without just compensation (Count V). *See generally* Compl. Lincoln demands $75,758,669.48 from the government for payments Lincoln is allegedly owed to date under the risk-corridors program, consisting of $3,925,418.48 for 2014 and $71,833,251 for 2015. Pl.'s Mot. at 2.[15] Lincoln additionally requests that the

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[14]In 2015, Lincoln's experience deteriorated to the point that its adjusted risk-corridors ratio for individual coverage was 183.5% and that for small-group coverage was 177.7%, Pl.'s Mot. App. 8 at A59, far removed from the target amounts.

[15]Lincoln requested an amount of "at least $72,859,053" when it filed its complaint in June 2016, Compl. at 44-45, but Lincoln subsequently adjusted that figure in September 2016 to reflect Lincoln's final 2015 costs. *See* Pl.'s Mot. at 2; Pl.'s Reply in Support of Mot. for Judgment on the Administrative Record ("Pl.'s Reply") at 6 n.4, ECF No. 37.

court require the government to fulfill its risk-corridors payment obligations for 2015 and 2016 within 30 days of determining payments owed. Compl. at 45.

On September 23, 2016, Lincoln filed a motion for judgment on the administrative record, and the government filed a motion to dismiss Lincoln's claims and a motion for judgment on the administrative record with respect to Count I. *See generally* Pl.'s Mot.; Def.'s Mot. The government argues that the court should dismiss Lincoln's claims for lack of jurisdiction pursuant to RCFC 12(b)(1), or, alternatively, that it is entitled to judgment on the administrative record under Count I and that the court should dismiss Counts II, III, IV, and V for failure to state a claim pursuant to RCFC 12(b)(6). *See generally* Def.'s Mot. Lincoln opposed the government's motion and filed a cross-motion for judgment on the administrative record with respect to Counts II-V, *see* Pl.'s Resp. in Opp'n to Def.'s Mot. to Dismiss and Mot. for Judgment on the Administrative Record and Cross-Mot. for Judgment on the Administrative Record on Counts II-V ("Pl.'s Resp. and Cross Mot."), ECF No. 29, which the government opposed, *see* Def.'s Opp'n to Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V ("Def.'s Opp'n to Pl.'s Cross Mot."), ECF No. 43. The competing motions were addressed at a hearing held on November 7, 2016.

JURISDICTION

A. The Court Has Subject Matter Jurisdiction Over Lincoln's Claims for Money Damages, but Not Over Lincoln's Request for Declaratory Relief

1. Claim for money damages under Section 1342 and the implementing regulations.

As plaintiff, Lincoln has the burden of establishing jurisdiction. *See Reynolds v. Army & Air Force Exch. Serv.*, 846 F.2d 746, 748 (Fed. Cir. 1988). Under the Tucker Act, this court has jurisdiction "to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." 28 U.S.C. § 1491(a)(1). The Tucker Act waives sovereign immunity, which allows a plaintiff to sue the United States for money damages. *United States v. Mitchell*, 463 U.S. 206, 212 (1983). It does not, however provide a plaintiff with any substantive rights. *United States v. Testan*, 424 U.S. 392, 398 (1976). Rather, to establish jurisdiction, "a plaintiff must identify a separate source of substantive law that creates the right to money damages." *Fisher v. United States*, 402 F.3d 1167, 1172 (Fed. Cir. 2005) (en banc in relevant part) (citing *Mitchell*, 463 U.S. at 216; *Testan*, 424 U.S. at 398); *Jan's Helicopter Serv., Inc. v. Federal Aviation Admin.*, 525 F.3d 1299, 1309 (Fed. Cir. 2008) (noting that the source of substantive law must be "money-mandating" to support jurisdiction under the Tucker Act). This jurisdictional inquiry is separate from the merits of the case and "does not require a determination that the plaintiff has a claim on the merits." *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 875 (Fed. Cir. 2007); *see also Engage Learning, Inc. v. Salazar,* 660 F.3d 1346, 1353 (Fed. Cir. 2011) ("We have held that jurisdiction under [the Contract Disputes Act, 41 U.S.C. § 7102(a), like the Tucker Act,] requires no more than a non-frivolous *allegation* of a contract with the government.") (emphasis in original) (citations omitted); *Jan's Helicopter*

Serv., 525 F.3d at 1309 ("There is no further jurisdictional requirement that the court determine whether the additional allegations of the complaint state a nonfrivolous claim on the merits.").

In short, the court will have jurisdiction when a plaintiff invokes a money-mandating source and makes a "non-frivolous assertion" that the plaintiff is entitled to relief under that source. *Jan's Helicopter Serv.*, 525 F.3d at 1307 n.8; *Greenlee Cnty.*, 487 F.3d at 876-77 (citations omitted). A source is money-mandating when "it can fairly be interpreted as mandating compensation" by the government. *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472 (2003) (citing *Mitchell*, 463 U.S. at 217). Under this standard, a source will be money-mandating when it is "reasonably amenable to the reading that it mandates a right of recovery in damages." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 19 (2011) (quoting *White Mountain Apache Tribe*, 537 U.S. at 473). In contrast, a source is not money-mandating when it provides the government with "complete discretion" regarding whether it will make payments. *Doe v. United States*, 463 F.3d 1314, 1324 (Fed. Cir. 2006) (citations omitted); *see ARRA Energy Co. I*, 97 Fed. Cl. at 19 (noting that the determination of whether a source is money-mandating "generally turns on whether the government has discretion to refuse to make payments under that [source]").

While the word "may" in a statute creates a presumption of government discretion, *Doe*, 463 F.3d at 1324 (citing *McBryde v. United States,* 299 F.3d 1357, 1362 (Fed. Cir. 2002)), the Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Greenlee Cnty.*, 487 F.3d at 877 (quoting *Agwiak v. United States,* 347 F.3d 1375, 1380 (Fed. Cir. 2003)). For example, in *Agwiak*, the Federal Circuit found that a statute and its implementing regulations were money-mandating because both stated that certain employees "shall be paid" by the government. 347 F.3d at 1380; *see also Greenlee Cnty.*, 487 F.3d at 877 (finding that the relevant statute was "reasonably amenable" to a money-mandating interpretation because it provided that "the Secretary of the Interior shall make a payment . . ."); *Lummi Tribe of the Lummi Reservation v. United States*, 99 Fed. Cl. 584, 594 (2011) (finding a statute to be money-mandating because the use of the word "shall" bound the government "to pay a qualifying tribe the amount to which it is entitled under the [statutory] formula"). Even if the word "shall" is not present, a statute can still be money-mandating when the government is required to make payments after certain statutory requirements are met. *See Fisher*, 402 F.3d at 1174-75; *see also United States v. Larionoff*, 431 U.S. 864, 869 (1977) (construing and applying a statute providing a reenlistment bonus for active duty soldiers); *Laughlin v. United States*, 124 Fed. Cl. 374, 383-85 (2015) (addressing a statute governing the Dental Office Multiyear Retention Bonus applicable to the military), *appeal filed*, No. 16-1627 (Fed. Cir.) (to be argued Dec. 8, 2016); *Hale v. United States*, 107 Fed. Cl. 339, 345-46 (2012) (applying statutes providing military service members with special and incentive bonuses), *aff'd*, 497 Fed. Appx. 43 (Fed. Cir. 2013).

Here, Section 1342 of the Act provides that when a qualified health plan's allowable costs exceed the target amount by more than 103 percent, "the Secretary *shall* pay to the plan" an amount set forth in Section 1342, depending on whether the costs exceed the target amount by more than 103 or 108 percent. 42 U.S.C. § 18062(b)(1) (emphasis added). Further, the implementing regulation states that qualified health plan issuers "will receive payment from HHS" under the criteria and formulas described in Section 1342. 45 C.F.R. § 153.510(b).

Neither the statute nor the regulation use the word "may" or provide any indication that HHS has discretion to refuse risk-corridors payments if funds are available. Regardless of whether the program is budget neutral or whether full payments are required annually, which topics are addressed *infra*, it is evident that HHS is obliged to make payments to qualified health plans when certain criteria are satisfied and funds are available. HHS has acknowledged this requirement. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."). Thus, Section 1342 and the implementing regulation are money-mandating sources of law.

Nonetheless, the government argues that the court does not have jurisdiction over Lincoln's claims because the payments that HHS owes are not "presently due." Def.'s Mot. at 16. To support its argument, the government cites *Todd v. United States*, where the Federal Circuit held that this court has jurisdiction under the Tucker Act only when the money damages are "actual" and "presently due." 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (quoting *Testan*, 424 U.S. at 398 (in turn quoting *United States v. King*, 395 U.S. 1, 3 (1969))). This court has found jurisdiction lacking under the "presently due" standard when, for example, a plaintiff brought suit against the government to receive a lump sum set forth in a settlement agreement between the two parties, but the agreement provided for periodic payments. *See Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 179-80 (2009). Because the government was current on its periodic payments and further payments were not presently due, the plaintiff was not entitled to bring suit for the entire sum. *Id.* The government contends that a similar analysis applies to Lincoln's claims because HHS has established a three-year framework and payments under the risk-corridors programs will not be due until the end of the program in 2016, to the extent funds are available, even for losses that qualified health plans incurred in 2014 and 2015. Def.'s Mot. at 16-17. The government argues that the "fair inference" standard, discussed *supra*, must be analyzed in conjunction with this "presently due" requirement. *See* Def.'s Opp'n to Pl.'s Mot. for Judgment on the Administrative Record ("Def.'s Opp'n to Pl.'s Mot.") at 11, ECF No. 30.

The government's argument reaches too far. The court's jurisdictional analysis differs depending on whether the plaintiff relies on a money-mandating statute. *See Bevevino v. United States*, 87 Fed. Cl. 397, 408 (2009) (noting that the Federal Circuit has "distinguished cases brought under money-mandating statutes, and those brought under statutes that are not money-mandating") (citing *Dysart v. United States,* 369 F.3d 1303, 1315 n.9 (Fed. Cir. 2004)); *Speed v. United States*, 97 Fed. Cl. 58, 66-68 (2011) (distinguishing between the jurisdictional analysis for claims arising out of a money-mandating statute and claims arising out of a contract). The cases upon which the government relies, such as *Todd* and *Annuity Transfers*, relate to allegations based upon contracts, rather than money-mandating statutes. *See Todd*, 386 F.3d at 1094; *Annuity Transfers*, 86 Fed. Cl. at 179-80. In rejecting the government's jurisdictional challenge, the court in *Bevevino* explained that the government's reliance on *Todd* was "misplaced" because the claims in *Todd* were premised on contractual obligations, whereas the claims in *Bevevino* were based upon a money-mandating statute. 87 Fed. Cl. at 407-08. Similarly, Lincoln's claim in Count I is based upon Section 1342 of the Act and its implementing regulation, which can be fairly interpreted as money-mandating sources of law. Thus, the court has jurisdiction over Lincoln's claim. In this instance, the government concedes that at least

some money was due and more may be due shortly, even though all of Lincoln's claimed amounts might not be payable on a current basis.[16]

2. *Claims for money damages under an express contract or, alternatively, an implied-in-fact contract theory.*

This court has jurisdiction "to render judgment upon any claim against the United States founded . . . upon any express or implied contract with the United States." 28 U.S.C. § 1491(a)(1). Thus, as discussed *supra*, a contract can serve as the substantive source for a plaintiff's claim to monetary relief under the Tucker Act. *See Speed*, 97 Fed. Cl. at 64 (citing *Ransom v. United States*, 900 F.2d 242, 244 (Fed. Cir. 1990)).

Similar to the court's jurisdictional analysis of Lincoln's claim based upon Section 1342, the merits of Lincoln's contract claims must be separated from the court's assessment of its power to rule on these claims. *See Engage Learning*, 660 F.3d at 1353-54. The court has jurisdiction over express and implied contract claims as long as a plaintiff makes a "non-frivolous allegation of a contract with the government." *Id.* (citing *Lewis v. United States,* 70 F.3d 597, 602, 604 (Fed. Cir. 1995); *Gould, Inc. v. United States,* 67 F.3d 925, 929-30 (Fed. Cir. 1995)). However, the claim must still be for "actual, presently due money damages." *Speed*, 97 Fed. Cl. at 66 (citing *King*, 395 U.S. at 3).

Here, Lincoln seeks risk-corridors payments of $3,925,418.48 for 2014 and $71,833,251 for 2015. Pl.'s Mot. at 2. Lincoln argues that it is entitled to these payments under an express contract theory because prior to each year of the risk-corridors program Lincoln offered a qualified health plan, and it allegedly entered into written agreements with HHS that allegedly required HHS to make full payment for the upcoming year. *See* Compl. ¶¶ 166-78; Pl.'s Resp. and Cross-Mot. at 31-35, 39-43. Alternatively, Lincoln argues that the course of conduct

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[16]The government embellishes its contention that the court lacks jurisdiction over Count I by referring to HHS's three-year framework for applying "payments in" and "payments out," urging that no further payments for 2014 are now due, and averring that the "presently due" standard consequently has not been satisfied. As the government would have it, the decision by HHS to apply a three-year framework is entitled to deference under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). *See* Def.'s Mot. at 17-18; Hr'g Tr. 70:6-9. This argument is misplaced. The government's argument addresses the merits of whether and when Lincoln is entitled to recover money under the statute, which does not correspond to the jurisdictional inquiry of whether the statute itself is money-mandating. *See Greenlee Cnty.*, 487 F.3d at 876 (explaining that the money-mandating analysis only requires the court to ask "whether the plaintiff is within the class of plaintiffs entitled to recover under the statute if the elements of a cause of action are established") (citing *Fisher*, 402 F.3d at 1172-73). The *Chevron* prongs apply to the merits of the case, as discussed *infra*. *See generally Adair v. United States*, 497 F.3d 1244 (Fed. Cir. 2007) (applying the "reasonably amendable" standard without reference to *Chevron* deference in finding jurisdiction through a money-mandating source of law, and then applying a *Chevron* analysis to the merits of the case); *Sharp v. United States*, 80 Fed. Cl. 422, 427 (2008) (same).

between the government and Lincoln gave rise to an implied-in-fact contract that would also entitle Lincoln to full annual payments from HHS. Compl. ¶¶ 180-97; Pl.'s Resp. and Cross-Mot. at 39 ("[T]he [g]overnment's promise to make payment can induce behavior that constitutes a mutuality of intent to contract.").

The court concludes that Lincoln has sufficiently made non-frivolous contract claims against the government for monetary relief. Lincoln has established that it entered into written agreements with HHS certifying Lincoln as a qualified health plan provider under the risk-corridors program for all three years of the program. *See* Compl. Exs. 2-4. Further, the government engaged in conduct that indicated an intent to make at least some payments under the risk-corridors program to qualified health plans. *See, e.g.*, HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,411, AR 1807 ("The risk corridors program will protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains.").

Thus, the court has jurisdiction over Lincoln's express and implied contract claims to the extent that the 2014 and 2015 risk-corridors payments are presently due. Under Lincoln's alleged 2014 contract with HHS, payment was due in 2015 after HHS determined the amount of payment it owed to Lincoln. HHS paid approximately 12% of that amount, *see Risk Corridors Payment Proration Rate for 2014*, AR 1254, and the remaining balance is allegedly due. Additionally, Lincoln alleges that HHS repudiated its 2015 contract obligations when HHS stated that it did not anticipate making any 2015 payments during 2016. *See* Pl.'s Resp. and Cross-Mot. at 11-12; Def.'s Mot. App. at A47. Lincoln chose to treat that repudiation as a present breach. Pl.'s Resp. and Cross-Mot. at 11-12; *see Franconia Assocs. v. United States*, 536 U.S. 129, 143-44 (2002) (noting that a plaintiff may treat the other party's repudiation as a present breach by bringing suit); *Kasarsky v. Merit Sys. Prot. Bd.*, 296 F.3d 1331, 1338 (Fed. Cir. 2002) (same) (citing *Franconia Associates*, 536 U.S. at 143-44). Under Lincoln's alleged anticipatory breach claim, HHS's stated intention not to pay constitutes a present breach and the 2015 payments owed to Lincoln are due as well.[17]

3. Claim for money damages under the Takings Clause of the Fifth Amendment.

The court has jurisdiction via the Tucker Act over claims brought under the Takings Clause of the Fifth Amendment. *See, e.g.*, *Preseault v. Interstate Commerce*, 494 U.S. 1, 12 (1990); *Jan's Helicopter Serv.*, 525 F.3d at 1309 (citing *Moden v. United States*, 404 F.3d 1335,

[17]This conclusion is not inconsistent with the holdings of *Todd* and *Annuity Transfers*, as relied upon by the government. Lincoln is requesting monetary relief attributable to HHS's alleged anticipatory breach. In contrast, the plaintiff in *Todd* was seeking non-monetary relief, *see* 386 F.3d at 1094, and the plaintiff in *Annuity Transfers* was not alleging an anticipatory breach, but was instead seeking to change the contract, *see* 86 Fed. Cl. at 179. This court has repeatedly exercised its jurisdiction over anticipatory breach claims seeking monetary relief. *See, e.g.*, *Tamerlane, Ltd. v. United States*, 81 Fed. Cl. 752 (2008); *Franconia Assocs. v. United States*, 61 Fed. Cl. 718 (2004).

1341 (Fed. Cir. 2005)). A takings claim need only be non-frivolous for this court to find jurisdiction under the Tucker Act. *Moden*, 404 F.3d at 1341. Here, Lincoln has presented a non-frivolous claim that the government took the payments that Lincoln is entitled to under Section 1342 and the implementing regulation. Thus, the court has jurisdiction over Lincoln's takings claim.

4. Request for declaratory relief.

Additionally, Lincoln requests that, incidental to a monetary judgment, the court declare that the government must fulfill and fully satisfy its risk-corridors payment obligations for 2015 and 2016 within 30 days of determining payments owed. Compl. at 45; Pl.'s Resp. and Cross-Mot. at 30-31. The court does not have jurisdiction over such a request.

The Tucker Act provides the court with jurisdiction to grant equitable or declaratory relief in three circumstances. *See Annuity Transfers*, 86 Fed. Cl. at 181. First, the court may "issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records" as an "incident of and collateral to" a monetary judgment. 28 U.S.C. § 1491(a)(2). Second, the court has jurisdiction to hear nonmonetary disputes arising under the Contract Disputes Act, 28 U.S.C. § 1491(a)(1) (last sentence), and third, it has juridical power to grant equitable relief in bid protests. 28 U.S.C. § 1491(b)(2). None of these three circumstances apply here. Although Lincoln is seeking declaratory relief that it contends is collateral to its request for monetary judgment, the relief sought is not necessarily derivative from or attendant to any money judgment that might issue, but rather would turn on future developments. Thus, the court does not have jurisdiction over Lincoln's request for declaratory relief.

B. Lincoln's Claims Are Ripe For Judicial Review

The justiciability doctrines of Article III apply in this court, including the ripeness requirement. *Square One Armoring Serv., Inc. v. United States*, 123 Fed. Cl. 309, 321 (2015); *see Fisher*, 402 F.3d at 1176. The government argues that Lincoln's claims are not ripe for judicial consideration because HHS has not determined the final payment amounts under the risk-corridors program and will not do so until the end of the three-year period the program is in effect. Def.'s Mot. at 20-22; Def.'s Opp'n to Pl.'s Mot. at 11-12.

The ripeness doctrine "prevent[s] the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also . . . protect[s] the agencies from judicial interference." *Abbott Labs. v. Gardner*, 387 U.S. 136, 148 (1967), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977). An unripe claim is dismissed without prejudice. *Pernix Grp., Inc. v. United States*, 121 Fed. Cl. 592, 599 (2015) (citing *Shinnecock Indian Nation v. United States,* 782 F.3d 1345, 1350 (Fed. Cir. 2015)). In determining whether an action is ripe, the court evaluates (1) "the fitness of the issues for judicial decision" and (2) "the hardship to the parties of withholding court consideration." *Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc.*, 527 F.3d 1278, 1294-95 (Fed. Cir. 2008) (citing *Abbott Labs.*, 387 U.S. at 149).

A case will generally be fit for judicial review when "further factual development would not 'significantly advance [a court's] ability to deal with the legal issues presented.'" *Caraco Pharm. Labs.*, 527 F.3d at 1295 (citing *National Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 812 (2003)). Contrastingly, a claim will not be fit if it is "contingent upon future events that may or may not occur." *Systems Application & Techs., Inc. v. United States*, 691 F.3d 1374, 1383 (Fed. Cir. 2012) (citing *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985)). The court must also consider whether its involvement "would inappropriately interfere with further administrative action." *Ohio Forestry Ass'n, Inc. v. Sierra Club*, 523 U.S. 726, 733 (1998).

Respecting hardship, the court must consider whether withholding court consideration would have an "immediate and substantial impact" on the plaintiff. *Caraco Pharm. Labs.*, 527 F.3d at 1295 (quoting *Gardner v. Toilet Goods Ass'n*, 387 U.S. 167, 171 (1967)). This element of the doctrine requires a lesser showing compared to that required of a plaintiff seeking injunctive relief, which calls upon a plaintiff to show irreparable harm. *See Systems Application & Techs.*, 691 F.3d at 1385. Even so, the mere possibility of harm is not sufficient to establish hardship. *See Confederated Tribes & Bands of The Yakama Nation v. United States*, 89 Fed. Cl. 589, 616 (2009) ("[A] possible financial loss is not by itself a sufficient interest to sustain a judicial challenge to governmental action.") (quoting *Abbott Labs.*, 387 U.S. at 153); *Pernix Grp.*, 121 Fed. Cl. at 599 ("Abstract, avoidable or speculative harm is not enough to satisfy the hardship prong.").

1. Section 1342 and the implementing regulation.

In evaluating fitness for review, the parties focus on Lincoln's claim for damages under Section 1342 of the Act and the implementing regulation. Lincoln asserts that qualified health plans satisfying the conditions of Section 1342 are entitled to payment under the risk-corridors program, and the government accepts this assertion in substantial part. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."). That said, the parties differ in interpreting Section 1342 and the implementing regulations. Lincoln asserts that both the statute and regulations require HHS to make full payment annually, *see* Pl.'s Mot. at 9-11; Pl.'s Resp. and Cross-Mot. at 12-23, while the government contends that payments are not due until the end of the program, depending upon the availability of funds, *see* Def.'s Mot. at 23-25; Def.'s Opp'n to Pl.'s Mot. at 18-22. The dispute centers on an issue of statutory interpretation and is therefore fit for judicial review. *See Coalition for Common Sense in Gov't Procurement v. Sec'y of Veterans Affairs*, 464 F.3d 1306, 1316 (Fed. Cir. 2006) ("[W]e find that the issues presented by the parties deal largely with legal issues of statutory construction, which we have previously held fit for pre-enforcement judicial review.") (citing *National Org. of Veterans' Advocates, Inc. v. Sec'y of Veterans Affairs*, 330 F.3d 1345, 1347 (Fed. Cir. 2003)). No further factual development is necessary in determining the meaning and application of Section 1342 and the implementing regulation.

The possibility of the government's making some or all of the risk-corridors payments in the future does not change this calculus. In *Confederated Tribes & Bands of The Yakama Nation*, the government argued that plaintiffs' breach of trust and fiduciary duties claims were

not fit for judicial review because the government still had the means to obtain and provide the money requested by plaintiffs. 89 Fed. Cl. at 614-15. The government asserted that those future efforts would alter the facts of the case. *See id.* at 615. The court rejected that argument and found the claims fit for judicial review, explaining that the government's as-yet indeterminate further actions might be relevant to determining the plaintiffs' damages award, but had "no bearing on the accrual and fitness of plaintiffs' claim." *Id.* Regardless of future events, the facts underlying plaintiffs' claim of breach of trust were "fixed." *Id.* at 616. Similarly, the facts underlying Lincoln's claim are fixed as well. As Lincoln would have it, HHS allegedly breached its statutory and regulatory obligations by failing to make full payments annually. Subsequent HHS payments might bear on Lincoln's ability to receive amounts due, but they will not affect Lincoln's underlying claim.

Lincoln has also demonstrated hardship. Lincoln is allegedly due nearly $4 million for losses it suffered in 2014. AR 270; Pl.'s Mot. at 7. Further, Lincoln is allegedly due more than $70 million for losses in 2015, *see* Pl.'s Mot. at 7-8 & App. 8 at A59, but HHS has stated that it does not anticipate making any 2015 payments this year. Def.'s Mot. App. at A47. Lincoln's excess of claims paid compared to premiums received is not uncertain or speculative; as previously noted, Lincoln's adjusted risk-corridors ratios for coverages in 2015 were more than 175% over its target for 2015 and Lincoln suffered substantial losses as a result. *See supra*, at 11 n. 14. Lincoln did not have reserves to cover the deficit, and it was placed in liquidation proceedings as of October 1, 2016. *See* Def.'s Mot. to Strike Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V at 3-4 & Attach., ECF No. 31; Pl.'s Resp. to Def.'s Mot. to Strike Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V at 4-5, ECF No. 34.[18] Coupled with Lincoln's premium-setting policies, HHS's failure to make timely payments at least contributed to this insolvency and liquidation. *See 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). Thus, Lincoln's claim under Section 1342 and the implementing regulations is ripe for judicial review.

2. *Express and implied contract claims.*

Ordinarily, a breach of contract claim ripens when the breach occurs. *See Barlow & Haun, Inc. v. United States*, 118 Fed. Cl. 597, 615-16 (2014) (citing *Nager Elec. Co. v. United States*, 368 F.2d 847, 851-52 (Ct. Cl. 1966)), *aff'd*, 805 F.3d 1049 (Fed. Cir. 2015). If a party repudiates a contract, the claim "ripens when performance becomes due or when the other party to the contract opts to treat the repudiation as a present total breach." *Id.* at 616 (citations omitted); *see also Franconia Associates*, 536 U.S. at 143 (noting that when a party repudiates a contract by renouncing a contractual duty before performance is due, the repudiation "ripens into a breach . . . if the promisee elects to treat it as such") (internal quotation marks and citations omitted).

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[18] *See* Agreed Order of Liquidation with a Finding of Insolvency, *Illinois v. Land of Lincoln Mut. Health Ins. Co.*, No. 16 CH 09210 (Ill. Cir. Ct., Cook Cnty., Chancery Div. Sept. 29, 2016), appended as the attachment to Def's Mot. to Strike Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V, ECF No. 31-1.

Lincoln alleges that HHS had a contractual obligation to make full and annual payments under the risk-corridors program. Again, HHS made payments for the 2014 year, but did not pay in full. Further, as Lincoln would have it, HHS allegedly committed an anticipatory breach of the 2015 contract when it announced that it would not be making 2015 payments this year, and Lincoln has treated HHS's so-called repudiation as a present and total breach. *See* Pl.'s Resp. and Cross-Mot. at 11-12. Lincoln's contract claims for 2014 and 2015 consequently also are ripe for review.

3. Takings claim.

Generally, a regulatory takings claim is ripe when the "government entity charged with implementing the regulations has reached a final decision regarding the application of the regulations to the property at issue." *Morris v. United States*, 392 F.3d 1372, 1376 (Fed. Cir. 2004) (quoting *Williamson Cnty. Reg'l Planning Comm'n v. Hamilton Bank,* 473 U.S. 172, 186 (1985)). An agency action is final when (1) it constitutes the "consummation of the agency's decisionmaking process" such that it is not "of a merely tentative or interlocutory nature," and (2) it is a decision where "rights or obligations have been determined" or from which "legal consequences will flow." *Barlow & Haun*, 118 Fed. Cl. at 616 (citing *Bennett v. Spear*, 520 U.S. 154, 177-78 (1997)) (internal quotation marks omitted). Additionally, a party must have first taken "reasonable and necessary steps" to allow the regulatory agency to exercise its "full discretion." *Washoe Cnty., Nev. v. United States*, 319 F.3d 1320, 1324 (Fed. Cir. 2003) (quoting *Palazzolo v. Rhode Island,* 533 U.S. 606, 620-21 (2001)).

Lincoln submitted timely accounts of its losses and entitlement to payment for 2014 and 2015, but it has received less than full payment from the government. While HHS has stated that it intends to fulfill its 2014 payment obligations as funds become available, it did not make full payments annually. This was not a tentative decision by HHS, but rather reflected the agency's budget-neutral scheme and determined Lincoln's rights as a qualified health plan issuer. HHS's actions represent a final decision on behalf of the agency, and the legal consequences of those actions have directly affected Lincoln. Lincoln's takings claim is also ripe.

STANDARDS FOR DECISION

A. Rule 12(b)(6)

Under RCFC 12(b)(6), a complaint must "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). The facts alleged must be sufficient to "raise a right to relief above the speculative level, on the assumption that all the allegations in the complaint are true (even if doubtful in fact)." *Kam-Almaz v. United States*, 682 F.3d 1364, 1367-68 (Fed. Cir. 2012) (quoting *Twombly*, 550 U.S. at 555). In evaluating a motion to dismiss pursuant to RCFC 12(b)(6), the court draws all "reasonable inferences" in favor of the non-moving party. *Bowers Inv. Co., LLC v. United States*, 104 Fed. Cl. 246, 253 (2011) (quoting *Sommers Oil Co. v. United States*, 241 F.3d 1375, 1378 (Fed. Cir. 2001)), *aff'd*, 695 F.3d 1380 (Fed. Cir. 2012). However, the court is not required to accept legal conclusions, even if placed

within factual allegations. *See Rack Room Shoes v. United States*, 718 F.3d 1370, 1376 (Fed. Cir. 2013) (citing *Iqbal*, 556 U.S. at 678); *Kam-Almaz*, 682 F.3d at 1367-68 (citing *Twombly*, 550 U.S. at 555).

B. Judgment on the Administrative Record

In a case dependent upon the administrative record, a party is permitted to move for judgment on the administrative record pursuant to RCFC 52.1(c). The court reviews decisions of a federal agency under the standards set forth in the Administrative Procedure Act ("APA"), codified in pertinent part at 5 U.S.C. § 706(2)(A). *See Weeks Marine, Inc. v. United States*, 575 F.3d 1352, 1358 (Fed. Cir. 2009); *Meyer v. United States*, 127 Fed. Cl. 372, 381 (2016). Under the APA, a court shall set aside an agency action if the action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see Centech Grp., Inc. v. United States*, 554 F.3d 1029, 1037 (Fed. Cir. 2009); *Paralyzed Veterans of Am. v. Sec'y of Veterans Affairs*, 345 F.3d 1334, 1339 (Fed. Cir. 2003). In this instance, Lincoln argues that only the "contrary to law" aspect of the standard applies, *see* Pl.'s Reply in Support of Cross-Mot. for Judgment on the Administrative Record on Counts II-V ("Pl.'s Reply in Support of Cross-Mot.") at 9, ECF No. 44, and the court will apply that criterion.

ANALYSIS

I. THE STATUTORY ENTITLEMENT COUNT

Land of Lincoln's fundamental claim is that HHS has misconstrued Section 1342 of the Act and that the statute when properly interpreted establishes an entitlement to "payments out" on an annual basis and in full, even in the absence of an authorization for, or appropriation of, specific funding beyond the "payments in" due under the statute.

When a party challenges an agency's interpretation of a statute administered by the agency, the court applies the two-step process established in *Chevron*, 467 U.S. at 842-43. *See White v. United States*, 543 F.3d 1330, 1333 (Fed. Cir. 2008). Under step one, the court must determine whether "Congress has directly spoken to the precise question at issue." *Chevron*, 467 U.S. at 842. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. An agency must apply an unambiguous statute according to its terms as expressed by Congress, and in that circumstance no deference is accorded an agency's interpretation. *White*, 543 F.3d at 1333 (citations omitted).

But, if Congress has not spoken to the precise issue, the court turns to step two and applies the "*Chevron* standard of deference." *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005) ("[T]he *Chevron* standard of deference applies if Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'") (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001)); *see White*, 543 F.3d at 1333 (noting that courts "must defer to an agency's interpretation of a statute if the statute is ambiguous or contains a gap that

Congress has left for the agency to fill through regulation") (citing *Federal Express Corp. v. Holowecki*, 552 U.S. 389, 395 (2008)).

In supporting its position, Lincoln relies upon a variant of the plain-meaning doctrine applicable to *Chevron* step one, while the government contends that Section 1342 is ambiguous because of gaps in the language and urges the court to defer to the agency's interpretation under *Chevron* step two.

A. Section 1342 Provides No Specific Authorization for Use of Appropriated Funds and is Ambiguous as to Whether HHS Is Required to Make Payments Annually

Under step one of *Chevron*, "the precise question at issue" here is whether Congress intended for HHS to make full payments annually under Section 1342, regardless of the amount of fees collected under the risk-corridors program. The court begins with the language of the statute. *Sursely v. Peake*, 551 F.3d 1351, 1355 (Fed. Cir. 2009) (citing *Santa Fe Indus., Inc. v. Green*, 430 U.S. 462, 472 (1977)); *see Alexander v. Sandoval*, 532 U.S. 275, 288 (2001) ("We therefore begin . . . our search for Congress's intent with the text and structure of [the statute]."). Statutory terms are interpreted "in accordance with [their] ordinary or natural meaning." *Sursely*, 551 F.3d at 1355 (citing *Microsoft Corp. v. AT & T Corp.*, 550 U.S. 437, 449 (2007)) (internal quotation marks omitted). When interpreting statutory terms, the court may consider the text, structure, legislative history, and canons of construction. *Delverde, SrL v. United States*, 202 F.3d 1360, 1363 (Fed. Cir. 2000).

Paragraph 1342(b)(1) provides that if a qualified health plan reports allowable costs for "any plan year" that sufficiently exceed the plan's target amount, "the Secretary shall pay to the plan" a percentage of those costs. 42 U.S.C. § 18062(b)(1). Lincoln emphasizes the "shall pay" language and the year-by-year reporting and calculus of its cost-revenue experience. Although Paragraph 1342(b)(1) contemplates that qualified health plans will be reporting costs on an annual basis via the phrase "any plan year," that arrangement reflects the year-by-year transitory aspect of the temporary risk-corridors program.[19] The "[p]ayments out" and "[p]ayments in " methodology in Subsection 1342(b) governs the amounts that HHS must pay to and receive from qualified health plans, but it does not establish when these payments are to be made. Similarly, Subsection 1342(a) states that the Secretary "shall establish and administer" the program "for calendar years 2014, 2015, and 2016," but it does not specify the timing of the various payments over those three years.[20]

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[19]Lincoln also points to several other annual aspects of the program to support its argument that HHS is required to make full payments annually, *see* Pl.'s Resp. and Cross-Mot. at 14-15; Pl.'s Reply at 4, but those aspects concern HHS's requirement that qualified health plans must submit data to HHS annually, *see* 45 C.F.R. § 153.530(d), and must be certified annually, *see* 45 C.F.R. § 155.1045; Compl. Exs. 2-4. Those provisions for annual qualification for participation and for consideration of data over a calendar year do not control what is to happen with the data submitted by qualified plans and do not refer to payments to and from issuers.

[20]Lincoln argues that the plural "corridors," as opposed to "corridor," demonstrates that Congress intended to implement multiple risk corridors for each calendar year, with separate

Additionally, the only statutory source of funding for the risk-corridors program is Paragraph 1342(b)(2), which refers to "[p]ayments in" from qualified health plans. 42 U.S.C. § 18062(b)(2); *see GAO Op.*, 2014 WL 4825237, at *2, AR 116 ("Section 1342, by its terms, did not enact an appropriation to make the payments specified in [S]ection 1342(b)(1)."). No other source of funds is mentioned or specified. *See supra*, at 7-9 & nn. 8-10 for a discussion of GAO's consideration of other appropriated CMS program-management funds that might have been available during fiscal year 2014. In March 2010, while Congress was considering the bills that eventually become the Affordable Care Act, the CBO provided Congress with an estimate of how the Act would affect future government spending and revenue. *See generally* March 2010 CBO Letter. The CBO explicitly provided revenue and spending estimates for the Act's two other stabilization programs, reinsurance and risk adjustment, but it omitted any budgetary estimate for the risk-corridors program. *See id.*, Table 2. That circumstance is significant. Congress explicitly relied upon the CBO's findings when enacting the Affordable Care Act. *See* Affordable Care Act § 1563.[21] Congress also provided appropriations or authorizations of funds

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payments for each year. Pl.'s Resp. and Cross-Mot. at 14. The implementing regulations define "risk corridors" as "any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount." 45 C.F.R. § 153.500. Subsection 1342(b) sets forth multiple payment adjustment systems, depending on whether a qualified health plan's allowable costs fall above or below the target amount by specified percentages. The plural "corridors" reflects that more than one payment adjustment system exists within the program.

[21]Section 1563 of the Act is entitled "Sense of the Senate Promoting Fiscal Responsibility." It provides:

> Sec. 1563. Sense of the Senate Promoting Fiscal Responsibility
>
> (a) FINDINGS. – The Senate makes the following findings:
>
> (1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the federal deficit between 2010 and 2019.
> (2) CBO projects this Act will continues to reduce budget deficits after 2019.
> (3) Based on CBO estimates, this Act will extend the solvency the Medicare HI Trust Fund.
> (4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.
> (5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.
>
> (b) SENSE OF THE SENATE. – It is the sense of the Senate that –

for other programs within the Act, but it never has done so for the risk-corridors program. *See, e.g.*, 42 U.S.C. §§ 18031(a)(1), 18054(i); *see also National Fed'n of Indep. Bus. v. Sebelius*, __ U.S. __, __, 132 S. Ct. 2566, 2583 (2012) ("Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally.") (citing *Russello v. United States*, 464 U.S. 16, 23 (1983)).[22]

Lincoln additionally emphasizes that the risk-corridors program is explicitly "based on" Part D of the Medicare Program, *see* 42 U.S.C. § 18062(a), which requires full payments annually and is not budget neutral. Pl.'s Mot. at 12; Pl.'s Resp. and Cross-Mot. at 15-16, 18-19. However, the Medicare Program is not helpful to Lincoln's argument. The Medicare Program sets forth a risk-corridors payment program between HHS and qualified prescription drug plans. *See* 42 U.S.C. § 1395w-115. While Section 1342 is "based on" the Medicare Program and the

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> (1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and
> (2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spend in this Act for other purposes.

Affordable Care Act § 1563, 124 Stat. 270-71.

[22]In post-enactment reports, the CBO's observations related to the risk-corridors program have been inconsistent. *See, e.g.*, Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, at Tables 2, 4 (July 2012), https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/43472-07-24-2012-CoverageEstimates.pdf (providing spending and revenue estimates for reinsurance and risk adjustment, but not risk corridors); Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, at 59 (Feb. 2014), https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf (estimating the spending and revenue of the risk-corridors program and noting that "risk corridor collections . . . will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit"); Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act–CBO's January 2015 Baseline*, Table B-1 (Jan. 2015), https://www.cbo.gov/sites/default/files/51298-2015-01-ACA.pdf ("The risk corridors program is now recorded in the budget as a discretionary program.").

These post-enactment observations by CBO are of limited utility for statutory interpretation. For purposes of determining the congressional intent underpinning Section 1342, the CBO's March 2010 estimate is the only pertinent report because that is what Congress relied upon in passing the Act. *See United States v. Fausto*, 484 U.S. 439, 455, 461 n.9 (1988) (Stevens, J., dissenting) ("If we construe a statute in a different legal environment than that in which Congress operated when it drafted and enacted the statute, we significantly increase the risk that we will reach an erroneous interpretation."), *superseded by statute as stated in Kaplan v. Conyers*, 733 F.3d 1148, 1160-61 (Fed. Cir. 2013).

two programs share many similarities, they are not identical. The Medicare Program specifically requires that "*[f]or each plan year*, the Secretary shall establish a risk corridor . . . ." 42 U.S.C. § 1395w-115(e)(3)(A) (emphasis added). In contrast, Congress chose to omit "for each plan year" in Section 1342 and instead required that "[t]he Secretary shall establish and administer a program of risk corridors." 42 U.S.C. § 18062(a). The only mention of "any plan year" is in reference to the qualified health plan's reported costs, rather than HHS's obligation to pay. *See* 42 U.S.C. § 18062(b)-(c). Additionally, unlike Section 1342, the Medicare Program explicitly provides for authorization of appropriations. *See* 42 U.S.C. § 1395w-115(a)(2) ("This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section."). "When Congress omits from a statute a provision found in similar statutes, the omission is typically thought deliberate." *Turtle Island Restoration Network v. Evans*, 284 F.3d 1282, 1296 (Fed. Cir. 2002) (noting that Congress's failure to include an embargo in the statute, when it did so in similar statutes, suggested that Congress did not intend to impose an embargo) (citing *Immigration & Naturalization Serv. v. Phinpathya*, 464 U.S. 183, 190 (1984)). Here, the differences between the two statutes suggest that Section 1342 does not require HHS to make full payments annually.

In short, Section 1342 is ambiguous in terms of the "payments in" and "payments out" arrangement for risk-corridors payments because it does not contain an express authorization for appropriations to make up any shortfall in the "payments in" to cover all of the "payments out" that may be due.[23] And, it does not explicitly require "payments out" to be made on an annual basis, whether in full or not. *Chevron* step two thus seemingly comes into play.

Lincoln nonetheless argues that *Chevron* deference is inappropriate because (1) HHS's interpretation of Section 1342 is a *post hoc* rationalization that the government has merely advanced for purposes of litigation, and (2) deference is not appropriate in the context of the Affordable Care Act. *See* Pl.'s Resp. and Cross-Mot. at 21-22.

HHS initially outlined its three-year, budget-neutral interpretation of Section 1342 in 2014, several years before this suit began. *See, e.g.*, HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. at 13,787, AR 4929; Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195. HHS's interpretation thus is not merely a "convenient litigation position." *See Parker v. Office of Pers. Mgmt.*, 974 F.2d 164, 166 (Fed. Cir. 1992); *see also Auer v. Robbins*, 519 U.S. 452, 462 (1997) (rejecting petitioners' argument that the agency's interpretation was undeserving of deference merely because it was presented through a legal brief, and holding that there was "no reason to suspect that the interpretation [did] not reflect the agency's fair and considered judgment on the matter in question"). Rather, HHS's interpretation reflects the agency's deliberations and efforts through the rulemaking process. The fact that the agency may have taken inconsistent positions prior to 2014 does not alter the analysis. *See Chevron*, 467 U.S. at 863-64 ("The fact that the agency has from time to time changed its interpretation of the term 'source' does not, as

[23]Correlatively, the statute does not indicate the disposition of any potential *excess* of "payments in" over "payments out" for any given year, but that rather unlikely scenario is perhaps only of academic interest.

respondents argue, lead us to conclude that no deference should be accorded the agency's interpretation of the statute . . . . [T]he fact that the agency has adopted different definitions in different contexts adds force to the argument that the definition itself is flexible . . . .").

In resisting deference, Lincoln also relies on *King v. Burwell*, __ U.S. at __, 135 S. Ct. at 2488-89, where the Supreme Court did not give deference to the Internal Revenue Service's ("IRS") interpretation of the Affordable Care Act. The Court reasoned that deference was not appropriate because that "extraordinary case[]" involved tax credits that were "central" to the Act's statutory scheme, implicated "billions of dollars" that would affect health insurances prices, and related to an implicit delegation of authority from Congress to the IRS, which did not have expertise in health insurance policy. *Id.* Here, in contrast, Congress delegated the responsibilities of administering the risk-corridors program to HHS, which addresses health insurance policy in a variety of different contexts. Lincoln has failed to demonstrate that this setting is sufficiently "extraordinary" to obviate reference to *Chevron* deference.

B. HHS's Three-Year, Budget-Neutral Interpretation of Section 1342 is Reasonable Under the Chevron *Step-Two Standard of Deference*

Under step two of *Chevron*, the court must defer to HHS's interpretation of Section 1342 as long as that interpretation is reasonable. HHS's interpretation was reflected in its final rule on May 27, 2014, when it stated that it intended "to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually." Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195. "[A] court must defer to an agency's reasonable interpretation of a statute and must not substitute its own judgment for that of the agency even if the court might have preferred another interpretation and even if the agency's interpretation is not the only reasonable one." *Wheatland Tube Co. v. United States*, 495 F.3d 1355, 1360-61 (Fed. Cir. 2007); *see also Federal Express Corp.*, 552 U.S. at 395 (holding that when an agency interprets an ambiguous statute through a regulation, the court must defer to the agency's reasonable interpretation).

Section 1342 directs HHS to establish the risk-corridors program and sets forth the amounts that HHS must receive and pay under the payment methodology subsection, but it does not obligate HHS to make annual payments or authorize the use of any appropriated funds. HHS's interpretation is consistent with the CBO's 2010 report, Congress's decision explicitly to authorize funds for other sections of the Act but not Section 1342, and Congress's choice to omit from Section 1342 the critical appropriation language used in the Medicare Program, as discussed *supra*. HHS's three-year, budget-neutral interpretation reasonably reflects these circumstances.

Lincoln argues that HHS's interpretation is unreasonable because HHS's failure to make full payments annually defeats the purpose of the risk-corridors program, which is to provide stability and protection for qualified health insurance plans. *See* Pl.'s Resp. and Cross-Mot. at 19-20. In this vein, HHS has repeatedly acknowledged its obligation to pay qualified health plans that are eligible for payment under the risk-corridors program. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."). That said, HHS's payments in due course, not necessarily annually, to the extent

funds are available from "payments in" without resort to appropriated funds, can still serve the program, albeit not to the extent Lincoln urges. Importantly, Lincoln's argument based on broad purposes is not persuasive. "[P]olicy considerations cannot override our interpretation of the text and structure of [a statute], except to the extent that they may help to show that adherence to the text and structure would lead to a result so bizarre that Congress could not have intended it." *Chamberlain Grp., Inc. v. Skylink Techs., Inc.*, 381 F.3d 1178, 1192 (Fed. Cir. 2004) (quoting *Central Bank, N.A. v. First Interstate Bank, N.A.*, 511 U.S. 164, 188 (1994)); *see also Sharp*, 80 Fed. Cl. at 433 ("While the outcome of granting more money to married people than to similarly situated single people may seem odd, it is entirely reasonable to assume a scenario in which various factions within Congress, each of which had different policy goals, were motivated to–and did–compromise in order to pass the Veterans Benefits Act of 2003.").[24] HHS's interpretation does not lead to such a "bizarre" result. Congress directed HHS to establish the risk-corridors program and make payments as necessary and appropriate, but it gave HHS discretion in administering the program.

The primary implementing regulation for the risk-corridors program, 45 C.F.R. § 153.510, sets forth substantially similar terms to Section 1342. As to "payments out," the regulation provides:

> (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.

45 C.F.R. § 153.510(b). Correlatively to Section 1342, the regulation omits any reference to when payment from HHS is due or how HHS is to fund the program. There is no deadline for

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[24] As the Supreme Court observed in *Board of Governors of Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 373-74 (1986), "[a]pplication of 'broad purposes' of legislation at the expense of specific provisions ignores the complexity of the problems Congress is called upon to address and the dynamics of legislative action." The Court commented that "Congress may be unanimous in its intent to stamp out some vague social or economic evil; however, because its members may differ sharply on the means for effectuating that intent, the final language of the legislation may reflect hard-fought compromises." *Id.* at 374; *see also America Online, Inc., v. United States*, 64 Fed. Cl. 571, 579 (2005) (quoting and relying on *Dimension Financial* in construing an excise tax statute).

HHS to make payments to the qualified health plan issuers. *See generally* 45 C.F.R. § 153.510. The only relevant difference is that the regulation explicitly provides a deadline for qualified health plan issuers to remit overages to HHS. *See* 45 C.F.R. § 153.510(d). Thus, for the reasons discussed *supra*, the court finds HHS's interpretation of the ambiguous statute to be reasonable. HHS's decision not to make full payments annually cannot be considered contrary to law. The government's motion for judgment on the administrative record with respect to Count I is granted.

II. THE CONTRACT COUNTS

A. Count II: Lincoln Has Failed to Allege a Valid Express Contract Because the Agreements Between Lincoln and HHS Do Not Establish Any Contractual Commitment Pertaining to the Risk-Corridors Program

Lincoln alleges that it entered into three one-year contracts with HHS when it agreed to be a qualified health plan issuer for 2014, 2015, and 2016 and that HHS breached those contracts by failing to make full payments annually. *See* Compl. ¶¶ 166-78, Exs. 2-4. The government responds that the agreements between Lincoln and HHS are not contracts and are unrelated to the risk-corridors program. *See* Def.'s Mot. at 31-37; Def.'s Opp'n to Pl.'s Cross-Mot. at 12-18. For the reasons set out below, the court concludes that Lincoln has failed to establish that an express contract exists between Lincoln and HHS respecting the risk-corridors program.

To establish a valid contract with the government, a plaintiff must demonstrate "(1) mutuality of intent to contract, (2) consideration, (3) lack of ambiguity in offer and acceptance, and (4) authority on the part of the government agent entering the contract." *Suess v. United States*, 535 F.3d 1348, 1359 (Fed. Cir. 2008) (citations omitted). In evaluating an alleged contract, the court begins with the language of the agreement. *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1038 (Fed. Cir. 2003) (citing *Foley Co. v. United States*, 11 F.3d 1032, 1034 (Fed. Cir. 1993)). When the terms of the agreement are "clear and unambiguous, they must be given their plain and ordinary meaning." *Bell/Heery v. United States*, 739 F.3d 1324, 1331 (Fed. Cir. 2014) (quoting *McAbee Constr., Inc. v. United States*, 97 F.3d 1431, 1435 (Fed. Cir. 1996)) (internal quotation marks omitted). Additionally, the agreement is "construed as a whole and 'in a manner that gives meaning to all of its provisions and makes sense.'" *Id.* (quoting *McAbee Constr.*, 97 F.3d at 1435); *see also Jowett, Inc. v. United States*, 234 F.3d 1365, 1368 (Fed. Cir. 2000).

Here, Lincoln entered into one-year agreements with HHS for 2014, 2015, and 2016. *See* Compl. Exs. 2-4.[25] The agreements certified Lincoln as a qualified health plan issuer, as required by the Affordable Care Act and the implementing regulations. *See* 42 U.S.C. § 18031(d)(4)(A), (e); 45 C.F.R. § 155.20. The substance of each agreement is contained in the "Acceptance of Standard Rules of Conduct," where the qualified health plan issuer agrees to use HHS's internet services in accord with the conduct outlined in the agreement. *See* Compl. Ex. 2,

[25]The three agreements are not identical, but they are substantially similar and contain the same language in pertinent part.

Section II.b; Ex. 3, Section II.b; Ex. 4 Section II.b. The conduct specifically relates to the qualified health plan's communications through the government's internet service. The qualified health plan agrees to properly test and format transactions, submit test transactions, and abide by certain transaction standards, among other internet service-related requirements. *See* Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The agreements do not explicitly refer to the risk-corridors program. *See generally* Compl. Exs. 2-4. Rather, they reflect Lincoln's agreement to comply with HHS's standards and the government's acceptance of Lincoln into the Affordable Care Act's Exchange program. Because Illinois elected not to establish an Exchange under the provisions of 42 U.S.C. § 18031(d), HHS stepped in to provide a federally-run Exchange in Illinois pursuant to 42 U.S.C. § 18041(c). The plain language of the agreements does not indicate any contractual commitment on behalf of HHS to make risk-corridors payments.[26]

Lincoln presents several arguments as to why the agreements represent a contractual obligation to pay qualified health plans under the risk-corridors program, including that: (1) the agreements provide that HHS will "undertake all reasonable efforts to implement systems and processes" to support the qualified health plan issuers, (2) the agreements state that they are "governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated by HHS," and (3) the agreements state that HHS "will recoup or net payments due" to qualified health plan issuers "against amounts owed" to HHS with respect to the "payment of [f]ederally-facilitated Exchange user fees." *See* Compl. Exs. 2-4; Pl.'s Resp. and Cross-Mot. at 33-34. These arguments do not constitute persuasive support to Lincoln's position for the reasons set forth below.

First, HHS's obligation "to implement systems and processes," *see* Compl. Ex. 2, Section II.d; Ex. 3, Section III.a; Ex. 4, Section III.a, must be read in the context of the agreements as a whole. The agreements explicitly relate to the qualified health plan's use of HHS's "Data Services Hub Web Services." *See* Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The qualified health plan agrees to abide by certain requirements so that it can be certified to offer insurance through this internet service. Given this context, "systems and processes" must relate to the electronic system that HHS and the qualified health plan will be using, and the processes that support this electronic system. This interpretation is reinforced by the language of the "Companion Guide," which is explicitly cited within the agreement. *See, e.g.*, Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The guide identifies the various processes that are implicated by HHS's internet service, such as the testing process and validation process.

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[26]The government also notes that Lincoln's express contract claim, if accepted, would result in an "artificial policy distinction" between the qualified health plans using federally-facilitated Exchanges and the qualified health plans using state-established Exchanges. *See* Def.'s Mot. at 36-37. The risk-corridors program applies to all qualified health plans. *See generally* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. However, only qualified health plans under the federally-facilitated Exchanges, not the state-established Exchanges, enter into the types of agreements with HHS that are at issue here. *See* Def.'s Mot. at 36-37. Thus Lincoln's express contract theory, if adopted, would create an inconsistent and unintended result where some qualified health plans have an allegedly express contractual basis for risk-corridors payments, but others do not.

See Def.'s Opp'n to Pl.'s Cross-Mot. at 13-14, App. at A1-A5. The "systems and processes" language does not give rise to any risk-corridors obligations.

Second, the general reference to "the laws and common law of the United States, including . . . such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies," Compl. Ex 2, Section V.g; Ex. 3, Section V.g; Ex. 4, Section V.g, does not incorporate the risk-corridors program into the agreement. For a contract to incorporate a document, "the incorporating contract must use language that is *express* and *clear*, so as to leave no ambiguity about the identity of the document being referenced, nor any reasonable doubt about the fact that the referenced document is being incorporated into the contract." *Northrop Grumman Info. Tech., Inc. v. United States*, 535 F.3d 1339, 1344 (Fed. Cir. 2008) (emphasis in original). A reference to the laws of the United States, or to statutes or regulations generally, will typically not suffice to incorporate a specific statutory provision or regulation. *See, e.g.*, *St. Christopher Assocs., L.P. v. United States*, 511 F.3d 1376, 1384 (Fed. Cir. 2008) (holding that a general reference to the agency's regulations did not incorporate a specific regulation promulgated by the agency or a specific section of the agency's handbook); *Smithson v. United States*, 847 F.2d 791, 794-95 (Fed. Cir. 1988) (holding that a contract did not incorporate an agency's regulations, despite the statement in the contract that it was "subject to the present regulations of the [agency] and to its future regulations not inconsistent with the express provisions hereof"); *Dobyns v. United States*, 118 Fed. Cl. 289, 315-16 (2014) (holding that an agreement's reference to "all laws regarding or otherwise affecting the Employee's employment" did not incorporate specific agency provisions). As the Federal Circuit explained in *Smithson*, holding otherwise would allow a private party to "choose among a multitude of regulations as to which he could claim a contract breach" and impose entirely new obligations on the government through implication. 847 F.2d at 794 (internal quotation marks and citations omitted). Here, the general reference to federal law and HHS regulations does not expressly or clearly incorporate the specific risk-corridors provisions upon which Lincoln relies.

Third, HHS's obligations regarding "[f]ederally-facilitated Exchange user fees," *see* Compl. Ex. 2, Section II.c; Ex. 3, Section III.b; Ex. 4, Section III.b, do not relate to the risk-corridors program. Neither Section 1342 of the Act nor Section 153.510 of the regulations refer to such fees. *See* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. Rather, the term "user fees" is included in Section 1311 of the Act, which permits the Exchanges "to charge assessments or user fees to participating health insurance issuers." 42 U.S.C. § 18031(d)(5)(A).[27] The implementing regulations, under a provision entitled "Requirement for [f]ederally-facilitated Exchange user fee," explain that participating health insurance issuers offering plans through a federally-facilitated Exchange "must remit a user fee to HHS." 45 C.F.R. § 156.50(c)(1), (2).[28] HHS is

[27]The cited Subparagraph relates to state-established Exchanges, but as noted *supra*, at 3, 6 n. 7, HHS provided an Exchange in Illinois when the State did not.

[28]In 2014, HHS and GAO described risk-corridors payments as "user fees." *See* Letter from William B. Schultz, Gen. Counsel, HHS, to Julia C. Matta, Assistant Gen. Counsel, GAO (May 20, 2014) ("Schultz-Matta Letter"), AR 1482-84; *GAO Op.*, 2014 WL 4825237, at *3-5, AR 117-19. These characterizations were made, however, in the context of analyzing the 2014

obligated to adjust or reduce the user fee if the issuer satisfies certain conditions, such as making payments for a contraceptive service. *See id.* § 156.50(d). Thus, the agreements between HHS and Lincoln simply acknowledge that Lincoln will pay the user fee set forth in Section 156.50 of the implementing regulations. The reference to HHS's recouping or netting payments reflects the agency's obligations described in Section 156.50(d), which states when an adjustment to the user fee is applicable. The risk-corridors program is not mentioned as a basis for an adjustment. *See generally* 45 C.F.R. § 156.50(d).

Thus, Lincoln has failed to allege that the agreements between Lincoln and HHS created a valid express contract pertaining to risk-corridors payments. The government's motion to dismiss Lincoln's claim of breach of an express contract is granted.

B. Count III: Lincoln Has Failed to Allege a Valid Implied-in-Fact Contract Because Mutuality of Intent and Offer and Acceptance are Lacking, and Even if an Implied-in-Fact Contract Did Exist, the Scope of the Contract Would be Limited by the Implementing Regulations

Lincoln alleges that it formed an implied-in-fact contract with the government and that the government implicitly agreed to make full risk-corridors payments annually, which it has failed to do. *See* Compl. ¶¶ 180-97; Pl.'s Resp. and Cross-Mot. at 35-39. The government responds that Section 1342 and the implementing regulations and the course of conduct of the parties do not establish the existence of any contract between the government and qualified health plans. *See* Def.'s Mot. at 37-42.

An implied-in-fact contract is based upon a meeting of the minds, which is inferred from the conduct of the parties and the surrounding circumstances. *Night Vision Corp. v. United States*, 469 F.3d 1369, 1375 (Fed. Cir. 2006) (citing *Hanlin v. United States*, 316 F.3d 1325, 1328 (Fed. Cir. 2003)). The requirements for a binding contract are the same for express and implied contracts. *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997); *see Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986) (noting that to find an implied-in-fact contract, "all of the elements of an express contract must be shown by the facts or circumstances surrounding the transaction . . . so that it is reasonable, or even necessary, for the court to assume that the parties intended to be bound").[29] Plaintiff has the

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appropriation act's reference to "sums as may be collected from authorized user fees." *See* Schultz-Matta Letter, AR 1482-84; *GAO Op.*, 2014 WL 4825237, at *2-5, AR 116-19. Here, in contrast, the agreements between Lincoln and HHS do not simply contain the term "user fees," but instead refer to "*[f]ederally-facilitated Exchange* user fees." *See* Compl. Ex. 2, Section II.c; Ex. 3, Section III.b; Ex. 4, Section III.b (emphasis added). In this setting, Section 156.50 of the implementing regulations is instructive rather than HHS's and GAO's past characterizations, because Section 156.50 explicitly addresses a "[f]ederally-facilitated Exchange user fee." *See* 45 C.F.R. § 156.50(c), (d).

[29]To support its implied contract claim, Lincoln argues that it relied on the government's alleged offer to make risk-corridors payments when Lincoln chose to participate on the Illinois Exchange. *See* Pl.'s Resp. and Cross-Mot. at 36. However, detrimental reliance is not an

burden of proving that a valid contract exists. *Harbert/Lummus Agrifuels Projects v. United States*, 142 F.3d 1429, 1434 (Fed. Cir. 1998); *see Hanlin*, 316 F.3d at 1328 (noting that plaintiff has the burden of establishing an implied-in-fact contract); *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321, 328-29 (2012) (granting the government's motion to dismiss when plaintiff failed to allege the necessary elements for a valid contract with the government).

"[A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued . . . ." *National R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry.*, 470 U.S. 451, 465-66 (1985) (citing *Dodge v. Bd. of Educ.*, 302 U.S. 74, 79 (1937)) (internal quotation marks omitted); *see AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 ("Only when statutes or regulations have clearly expressed the Government's intent to enter into a contractual arrangement with program participants have courts found an implied-in-fact contract.") (citations omitted). For example, in *Hanlin*, the Federal Circuit rejected plaintiff's claim that the relevant statute and regulation gave rise to an implied-in-fact contract. 316 F.3d at 1329-30. There, the statute provided that the agency "may direct" payment of attorneys' fees under certain circumstances, but the regulation stated that such fee arrangements "will be honored" by the agency only when specific conditions were met. *Id.* at 1328-29. The Federal Circuit explained that "[t]he statute and the regulation set forth the [agency's] authority and obligation to act, rather than a promissory undertaking . . . . The statute is a directive from the Congress to the [agency], not a promise from the [agency] to the [plaintiff]." *Id.* at 1329; *see also AAA Pharmacy*, 108 Fed. Cl. at 328-29 (dismissing plaintiff's breach of contract theory based on the government's alleged failure to abide by Medicare regulations because the regulations represented the government's independent obligations and did not indicate an intent to contract).

Here, similarly, Section 1342 and the implementing regulations do not provide any express or explicit intent on behalf of the government to enter into a contract with qualified health plan issuers. Although the provisions may mandate payment from HHS, albeit not annually, when a qualified health plan satisfies statutory and regulatory conditions, that alone does not demonstrate intent to contract. *See ARRA Energy Co. I*, 97 Fed. Cl. at 28 (dismissing plaintiffs' implied-in-fact contract claim because the statute failed to indicate an unambiguous offer or intent to contract, even though the government may have had a statutory obligation to make an award to the plaintiffs); *see also Hanlin*, 316 F.3d at 1331 (noting that an agency "may indeed be obligated to follow a statute and regulation regardless of whether it also has a contractual duty to perform"). HHS's obligation to make risk-corridors payments when certain conditions are met represents the agency's independent authority and obligation as directed by

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element of an implied-in-fact contract claim. *Steinberg v. United States*, 90 Fed. Cl. 435, 444 (2009), *appeal dismissed*, 451 Fed. Appx. 915 (Fed. Cir. 2010). It is an element of an implied-in-law claim, over which this court does not have jurisdiction. *See, e.g.*, *International Data Prods. Corp. v. United States*, 492 F.3d 1317, 1325 (Fed. Cir. 2007); *Baistar Mech. Inc., v. United States*, __Fed. Cl. __, __, 2016 WL 5404169, at *7 (2016); *XP Vehicles, Inc. v. United States*, 121 Fed. Cl. 770, 782-83 (2015).

Congress, not any promissory undertaking or offer to qualified health plans issuers such as Lincoln. Thus there is no apparent mutuality of intent to contract.

To support its implied contract claim, Lincoln primarily relies on *Radium Mines, Inc. v. United States*, where the court construed a regulation as an offer that invited acceptance by performance. 153 F. Supp. 403, 405-06 (Ct. Cl. 1957). Lincoln contends that HHS's obligation to make payments under the risk-corridors program constituted an offer, which Lincoln accepted by participating in the Exchange as a qualified health plan and complying with the various statutory and regulatory requirements. *See* Pl.'s Resp. and Cross-Mot. at 39-41. However, in *Radium Mines*, the regulation explicitly provided that the government would contract with uranium producers that offered to sell uranium to the government, as long as certain conditions were met. *See* 153 F. Supp. at 405-06. For example, one provision in the regulation stated that "the Commission will forward to the person making the offer a form of contract containing applicable terms and conditions ready for his acceptance." *Id.* at 405. And similarly, in *Grav v. United States*, 14 Cl. Ct. 390, 391-93 (1988), *aff'd*, 886 F.2d 1305 (Fed. Cir. 1989), the court held that a statute gave rise to an implied-in-fact contract between the government and private parties because it stated that "the Secretary shall offer to enter into a contract . . . ." Here, unlike the regulation in *Radium Mines* and the statute in *Grav*, Section 1342 and the implementing regulations make no explicit reference to an offer or contract. *See AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 (finding that a regulation providing for payment from the government did not create an implied-in-fact contract because, unlike in *Radium Mines*, the regulation did "not include any language manifesting either an offer or an intent to enter into contract"); *ARRA Energy Co. I*, 97 Fed. Cl. at 27-28 (finding that a statute did not create an implied-in-fact contract because, unlike in *Radium Mines*, it did not clearly express an intent to contract).

Additionally, Lincoln relies on *New York Airways, Inc. v. United States*, 369 F.2d 743, 745 (Ct. Cl. 1966), where the relevant statute provided that the "Postmaster General shall make payments out of appropriations for the transportation of mail by aircraft . . . as is fixed and determined by the [Civil Aeronautics] Board . . . ." The Board promulgated an order that fixed the monthly compensation for mail transporters, including plaintiffs. *Id.* at 744. In finding an implied-in-fact contract, the court stated that the Board's order constituted "an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer." *Id.* at 751. The facts of *New York Airways*, however, are distinguishable from Lincoln's implied-in-fact contract claim. In *New York Airways*, the plaintiffs' were entitled to fixed monthly compensation from the Board in exchange for transporting mail; no further action was necessary because the Board's order invited acceptance by performance. *Id.* That invitation and acceptance were deemed to form a binding obligation even though the appropriations that had been made for the mail service had been exhausted. *Id.* at 746-49. In contrast, qualified health plans are not entitled to compensation solely by offering health insurance on the Exchange. The only health plans eligible for payment are those that suffer sufficiently high losses and submit those losses to the government. *See* 45 C.F.R. §§ 153.510(b), (g), 156.430(c). Even then, HHS has some discretion in determining when payments will be made because the risk-corridors program does not require full payments annually, as discussed *supra*. Thus, Section 1342 and the implementing regulations do not constitute an offer or invite acceptance by performance alone. *See Baker v. United States*, 50 Fed. Cl. 483, 495 (2001) (holding that a regulation did not constitute an offer

inviting acceptance by performance because further action from the agency was necessary before the private party was entitled to the benefits provided in the regulation).

Alternatively, even assuming Lincoln could show that Section 1342 and the implementing HHS regulations constituted a contractual offer relating to risk-corridors payments that Lincoln accepted, thus giving rise to an implied-in-fact-contract,[30] Lincoln cannot establish that HHS breached a contractual obligation. *See Anderson v. United States*, 73 Fed. Cl. 199, 201 (2006) ("For plaintiff to recover on her breach of contract claim, she must establish the existence of a valid contract with defendant and a breach of a duty created by that contract.") (citing *San Carlos Irrigation & Drainage Dist. v. United States*, 877 F.2d 957, 959 (Fed. Cir. 1989); *Cornejo-Ortega v. United States*, 61 Fed. Cl. 371, 373 (2004)). If a valid implied contract obligated HHS to make risk-corridors payments, HHS's contractual obligations would be defined by Section 1342 and the implementing regulations pertaining to the risk-corridors program. As discussed *supra*, neither Section 1342 of the Act nor Section 153.510 of the regulations dictate when HHS must make payments. Additionally, subsequent to Lincoln's 2014 qualified health plan certification but prior to Lincoln's 2015 certification, HHS expressly stated that it would be implementing a three-year, budget-neutral scheme for risk-corridors payments. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195. Lincoln cannot establish that HHS breached any implied contract because the three-year, budget-neutral risk-corridors program has not ended.

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[30]Assuming that Lincoln could show mutuality of intent and offer and acceptance, consideration and authority to contract would not bar Lincoln's 2014 and 2015 contract claims, but the latter element would bar a claim for 2016. As consideration for HHS's payments, Lincoln provided health insurance on the government Exchange and complied with various regulatory requirements. *See* Pl.'s Resp. and Cross-Mot. at 39-40. Additionally, HHS may have had authority to contract when it entered into the 2014 and 2015 agreements with Lincoln. One caveat to that observation is that the Anti-Deficiency Act prevents an agency from authorizing an expenditure that exceeds available appropriations or contracting for a monetary payment in advance of available appropriations, unless authorized by law. 31 U.S.C. § 1341(a)(1)(A), (B); *see Hercules Inc. v. United States*, 516 U.S. 417, 427 (1996). An alleged contract with the government that does not comply with the Anti-Deficiency Act will be void *ab initio*, *see Springfield Parcel C, LLC v. United States*, 124 Fed. Cl. 163, 190 (2015), due to lack of contracting authority, *see, e.g.*, *Rick's Mushroom Serv., Inc. v. United States*, 521 F.3d 1338, 1346 (Fed. Cir. 2008). However, if the agency has authority when the contract is formed, the Anti-Deficiency Act is not triggered and a subsequent government action that restricts available funds will not negate the formation of that contract. *See Wetsel-Oviatt Lumber Co. v. United States*, 38 Fed. Cl. 563, 570 (1997). Here, the 2014 and 2015 agreements certifying Lincoln as a qualified health plan were signed before December 2014, *see* Compl. Exs. 2-3, when Congress enacted the 2015 appropriations bill that restricted risk-corridors payments to fees collected under the program. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. at 2491. Prior to the appropriations bill, the GAO determined that HHS had the authority to use general CMS appropriations to make risk-corridors payments. *GAO Op.*, 2014 WL 4825237, at *2-5, AR 116-20. Thus, HHS may have had sufficient appropriations to make a contract regarding risk-corridors payments prior to December 2014 without triggering the Anti-Deficiency Act, but not thereafter.

Thus, the government's motion to dismiss Lincoln's breach of implied-in-fact contract claim is granted.

C. Count IV: Lincoln Failed to Allege a Breach of the Implied Covenant of Good Faith and Fair Dealing Because No Valid Contract Exists

Lincoln alleges that the government breached the implied covenant of good faith and fair dealing by failing to make full risk-corridors payments annually. *See* Compl. ¶¶ 199-209. Every contract contains an implied "duty of good faith and fair dealing in its performance and enforcement." *Metcalf Constr. Co. v. United States*, 742 F.3d 984, 990 (Fed. Cir. 2014) (quoting *Restatement (Second) of Contracts* § 205 (1981)). However, this implied duty only attaches to a valid contract and will not otherwise apply. *See, e.g.*, *HSH Nordbank AG v. United States*, 121 Fed. Cl. 332, 341 (2015) ("[S]ince Plaintiff failed to establish either an express or implied contract . . . , its dependent claim for a breach of implied covenant of good faith and fair dealing also must be dismissed."), *aff'd*, 644 Fed. Appx. 1004 (Fed. Cir. 2016); *Westlands Water Dist. v. United States*, 109 Fed. Cl. 177, 205 (2013) ("[T]here is no contractual . . . duty to which the implied duty of good faith and fair dealing can attach."). Because Lincoln failed to allege a valid express or implied contract with the government, the dependent implied covenant claim does not appertain. The government's motion to dismiss Lincoln's breach of implied covenant of good faith and fair dealing is granted.

III. THE TAKINGS COUNT

Lincoln alleges that HHS's failure to make full risk-corridors payments annually violated the Fifth Amendment because it resulted in a taking of Lincoln's property for public use without just compensation. *See* Compl. ¶¶ 211-17. The Takings Clause of the Fifth Amendment provides that private property shall not be taken without just compensation. U.S. Const. amend. V, cl. 4. In evaluating a takings claim, the court must first determine whether the plaintiff has a cognizable interest in the property at issue. *Karuk Tribe of Cal. v. Ammon*, 209 F.3d 1366, 1374 (Fed. Cir. 2000) (citations omitted). Absent a valid property interest, a plaintiff's takings claim will fail as a matter of law. *Earman v. United States*, 114 Fed. Cl. 81, 112 (2013), *aff'd*, 589 Fed. Appx. 991 (Fed. Cir. 2015). If the plaintiff does have a property interest, only then will the court determine whether the government's actions constituted a taking of that interest. *Adams v. United States*, 391 F.3d 1212, 1218 (Fed. Cir. 2004).

Here, Lincoln does not have a valid property interest in receiving full risk-corridors payments annually. Lincoln's statutory entitlement claim does not give rise to a takings claim because Lincoln is not entitled to full payments annually, and because a statutory right to payment is not a recognized property interest. *See Adams*, 391 F.3d at 1225 (holding that appellants' right to unpaid compensation under the Fair Labor Standards Act did not create a property interest); *Hicks v. United States*, 118 Fed. Cl. 76, 85 (2014) ("Even if plaintiff's demand represented a genuine obligation of the government, the failure to pay such a monetary obligation would not amount to a taking.") (citations omitted); *Meyers v. United States*, 96 Fed. Cl. 34, 62 (2010) (dismissing plaintiffs' takings claim based on the Conservation Security Program because the program's monetary benefits did not provide plaintiff with a property

interest), *appeal dismissed*, 420 Fed. Appx. 967 (Fed. Cir. 2011). Additionally, although contracts are property, Lincoln's contract claims do not establish a property interest because Lincoln failed to allege the elements of a valid express or implied-in-fact contract related to risk-corridors payments. *See, e.g.*, *Piszel v. United States*, 121 Fed. Cl. 793, 803 (2015) ("[T]his [c]ourt has long recognized that *valid* contracts are property.") (emphasis added), *aff'd*, 833 F.3d 1366 (Fed. Cir. 2016). Thus, the government's motion to dismiss Lincoln's takings claim is granted.

CONCLUSION

For the reasons stated above, the government's motion for judgment on the administrative record is GRANTED with respect to Count I, and the government's motion to dismiss plaintiff's complaint pursuant to RCFC 12(b)(6) is GRANTED with respect to Counts II, III, IV, and V. Plaintiff's motion and cross-motion for judgment on the administrative record are DENIED. The clerk will enter judgment in accord with this disposition.

No costs.

It is so ORDERED.

s/ Charles F. Lettow
Charles F. Lettow
Judge

In the United States Court of Federal Claims

No. 16-744 C

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY

JUDGMENT

v.

THE UNITED STATES,

Pursuant to the court's Opinion and Order filed November 10, 2016,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that the defendant's motion for judgment on the administrative record is granted with respect to Count I, and the defendant's motion to dismiss plaintiff's complaint pursuant to RCFC 12(b)(6) is granted with respects to Counts II, III, IV, and V. Plaintiff's motion and cross-motion for judgment on the administrative record are denied. No costs.

Lisa L. Reyes
Acting Clerk of Court

November 10, 2016 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.

STATUTORY ADDENDUM

TABLE OF CONTENTS

Statutory Addendum Page

In the United States Court of Federal Claims

No. 16-259C
(Filed: January 10, 2017)

HEALTH REPUBLIC INSURANCE COMPANY,	*	Section 1342 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18062; 45 C.F.R. pt. 153; Risk Corridors Program; RCFC 12(b)(1) Motion to Dismiss; Subject Matter Jurisdiction; Money-Mandating Statute and Regulation; Presently Due Money Damages; Ripeness; Agency Interpretation of Its Own Regulations; Requirement of Annual Risk Corridors Payments
Plaintiff,	*	
v.	*	
THE UNITED STATES,	*	
Defendant.	*	

Stephen Swedlow, Chicago, IL, for plaintiff.

Charles E. Canter, United States Department of Justice, Washington, DC, for defendant.

OPINION AND ORDER

SWEENEY, Judge

Plaintiff Health Republic Insurance Company contends, for itself and on behalf of those similarly situated, that defendant United States has not fully paid the risk corridors payments to which it and other insurers are entitled under the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010), and its implementing regulations. Defendant moves to dismiss plaintiff's complaint for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) of the Rules of the United States Court of Federal Claims ("RCFC"). As explained below, the court grants in part and denies in part defendant's motion.

I. BACKGROUND

A. The Affordable Care Act

Congress enacted the Affordable Care Act in March 2010. 124 Stat. at 119. The Act includes "a series of interlocking reforms designed to expand coverage in the individual health insurance market." King v. Burwell, 135 S. Ct. 2480, 2485 (2015).

> First, the Act bars insurers from taking a person's health into account when deciding whether to sell health insurance or how much to charge. Second, the Act

> generally requires each person to maintain insurance coverage or make a payment to the Internal Revenue Service. And third, the Act gives tax credits to certain people to make insurance more affordable.

Id.; accord 26 U.S.C. §§ 36B, 5000A (2012); 42 U.S.C. § 300gg-1 (2012). "These three reforms are closely intertwined. . . . Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement. And the coverage requirement would not work without the tax credits." King, 135 S. Ct. at 2487 (citation omitted).

In conjunction with these three reforms, the Affordable Care Act required the establishment of an American Health Benefit Exchange ("exchange") in each state by January 1, 2014, to facilitate the purchase of "qualified health plans" by individuals and small businesses. 42 U.S.C. §§ 18031, 18041; accord King, 135 S. Ct. at 2485 (describing an exchange as "a marketplace that allows people to compare and purchase insurance plans"). Among other requirements, each "qualified health plan" offered on an exchange must provide a package of "essential health benefits." 42 U.S.C. § 18021(a)(1).

Thus, when enacted, the Affordable Care Act provided benefits and risks for health insurance companies ("insurers"). On the one hand, insurers would have access to a market of previously uninsured individuals, which could result in the insurers attracting more customers. See King, 135 S. Ct. at 2485; accord 42 U.S.C. § 18091(2)(C) ("The requirement [to maintain insurance coverage], together with the other provisions of this Act, will add millions of new consumers to the health insurance market . . . ."). On the other hand, because insurers lacked data "to predict the needs of the newly-insured" individuals, they would be hampered in their ability to "price [qualified health] plans to reflect the medical costs associated with this new and untested marketplace." Compl. ¶ 2; accord id. ¶ 26 ("[I]nsurers generally have less experience in how to accurately price policies in the individual market rather than the group market, and no relevant experience estimating benefit utilization, risk pool composition, and medical spending costs for insurance policies to the post-[Affordable Care Act] market, which included a new demographic and new mandatory coverage requirements."). To mitigate the risk faced by insurers, the Affordable Care Act included three premium stabilization programs: a transitional reinsurance program, a permanent risk adjustment program, and a temporary risk corridors program. See id. ¶¶ 4, 20; 42 U.S.C. §§ 18061-18063.

The transitional reinsurance program required insurers to fund, for the three-year period beginning January 1, 2014, reinsurance entities that would make payments to insurers that covered high-risk individuals "for any plan year beginning" in the three-year period. 42 U.S.C. § 18061. The permanent risk adjustment program requires each state to "assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) . . . if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year" and "provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) . . . if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the

average actuarial risk of all enrollees in all plans and coverage in such State for such year . . . ." Id. § 18063.

The third program–the one at issue in this case–is the temporary risk corridors program. Pursuant to section 1342 of the Affordable Care Act:

> The Secretary [of the Department of Health and Human Services ("HHS")] 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 U.S.C. 1395w-101 et seq.].

42 U.S.C. § 18062(a) (first alteration added). Section 1342 describes the methodology for collecting and making payments that HHS was required to adopt:

> (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.

Id. § 18062(b). "The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan," minus "any risk adjustment and reinsurance payments received under section[s] 18061 and 18063 . . . ." Id. § 18062(c)(1). And, the "target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan." Id. § 18062(c)(2). Neither section 1342 of the Affordable Care Act nor any of the Act's other provisions appropriated funds specifically for the risk corridors program. See generally Pub. L. No. 111-148, 124 Stat. at 119-1024.

B. Regulations Implementing the Risk Corridors Program

As contemplated by the Affordable Care Act, the Secretary of HHS established a risk corridors program. Proposed regulations first appeared in the Federal Register on July 15, 2011. See Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930 (to be codified at 45 C.F.R. pt. 153). HHS explained that the temporary risk corridors program was, in general, "designed to provide QHP issuers with greater payment stability as insurance market reforms are implemented" and would "protect against uncertainty in setting rates in the Exchange by limiting the extent of issuer losses (and gains)."[1] Id. at 41,931; accord id. at 41,948. In addition, HHS noted that although the proposed regulations did not contain any deadlines for qualified health plans to remit charges to HHS or for HHS to make risk corridors payments to qualified health plans, such deadlines were under consideration:

> For example, a QHP issuer required to make a risk corridor payment may be required to remit charges within 30 days of receiving notice from HHS. Similarly, HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers.

Id. at 41,943. Finally, with respect to the expected cost of the risk corridors program, HHS stated, in a summary of its preliminary regulatory impact analysis:

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[1] HHS frequently abbreviates "qualified health plan" as "QHP" in its regulations.

> [The Congressional Budget Office ("CBO")] estimated program payments and receipts for reinsurance and risk adjustment. . . . CBO did not score the impact of risk corridors, but assumed collections would equal payments to plans in the aggregate. The payments and receipts in risk adjustment, reinsurance, and risk corridors are financial transfers between issuers.

Id. at 41,948. But see id. at 41,942 ("Risk corridors create a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers.").

After a notice-and-comment period, HHS published a final rule on March 23, 2012. See Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Premium Stabilization Rule"), 77 Fed. Reg. 17,220 (to be codified at 45 C.F.R. pt. 153). In this final rule, HHS reiterated the explanatory remarks set forth in its proposed rule. See id. at 17,221, 17,236, 17,238. In addition, because HHS had separately issued a final regulatory impact analysis, see Def.'s App. 2 at 2-53,[2] it updated its discussion of the expected cost of the risk corridors program:

> CBO estimated program payments and receipts for reinsurance and risk adjustment. . . . 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.

77 Fed. Reg. at 17,244; accord Def.'s App. 2 at 11 ("CBO did not score the impact of risk corridors and assumed collections would equal payments to plans and would therefore be budget neutral."), 40 ("CBO did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers."). HHS also indicated that it had received several comments regarding deadlines for risk corridors remittances and payments:

> Three commenters agreed that 30 days was a reasonable timeframe for both payments and charges, and one commenter recommended that payments and charges be paid once per year. One commenter suggested requiring issuers of QHPs to submit risk corridors data within 30 days after submission of a request for payment to HHS or receipt of demand for payment from HHS.

77 Fed. Reg. at 17,239. In response to these comments, HHS indicated that it "plan[ned] to address the risk corridors payment deadline in the HHS notice of benefit and payment parameters." Id. Thus, the final regulation establishing the risk corridors and describing the payment methodology, 45 C.F.R. § 153.510, provided only:

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[2] Because defendant did not paginate its appendices, the court uses the page numbers assigned by its electronic case filing system.

(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.

77 Fed. Reg. at 17,251; see also id. ("A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters." (codified at 45 C.F.R. § 153.530(a) (2012))).

The notice of benefit and payment parameters mentioned in the Premium Stabilization Rule was published as a proposed rule by the Centers for Medicare and Medicaid Services

("CMS"), an agency of HHS, on December 7, 2012.[3] See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118 (to be codified at 45 C.F.R. pts. 153, 155-158). In the proposed rule's prefatory remarks, CMS stated:

> The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. . . . The risk corridors program, which is a Federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains. . . .
>
> In the Premium Stabilization Rule (77 FR 17220), we laid out a regulatory framework for these . . . programs. In that rule, we stated that the specific payment parameters for those programs would be published in this proposed rule. In this proposed rule, we expand upon these standards, and propose payment parameters for these programs.

Id. at 73,119. With respect to the risk corridors program, CMS further explained: "The temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016. In this proposed rule, we propose . . . an annual schedule for the program and standards for data submissions." Id. at 73,121. More specifically, CMS provided:

> We propose to add paragraph (d) to § 153.510, which would specify the due date for QHP issuers to remit risk corridors charges to HHS. Under this provision, an issuer would be required to remit charges within 30 days after notification of the charges.
>
> We propose a schedule for the risk corridors program, as follows. By June 30 of the year following an applicable benefit year, . . . issuers of QHPs will have

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[3] The Secretary of HHS had delegated to the Administrator of CMS her authority–granted in section 1342 of the Affordable Care Act–

> to establish and administer a program of risk corridors 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 health plan to the health plan's aggregate premiums based on the program for regional participating provider organizations under part D of Title XVIII of the Social Security Act.

Delegation of Authorities, 76 Fed. Reg. 53,903-04 (Aug. 30, 2011).

> been notified of risk adjustment payments and charges for the applicable benefit year. By that same date, . . . QHP issuers also would have been notified of all reinsurance payments to be made for the applicable benefit year. As such, we propose in § 153.530(d) that the due date for QHP issuers to submit all information required under § 153.530 of the Premium Stabilization Rule is July 31 of the year following the applicable benefit year.

Id. at 73,164; accord id. at 73,200 ("In this proposed rule, HHS also specifie[s] the annual schedule for the risk corridors program, including dates for claims run-out, data submission, and notification of risk corridors payments and charges."). CMS remarked that it did not expect that these proposed changes would "significantly alter CBO's estimates of the budget impact of the" risk corridors program. Id. at 73,196.

After a notice-and-comment period, CMS published a final rule on March 11, 2013. See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410 (to be codified at 45 C.F.R. pts. 153, 155-158). In this final rule, CMS reiterated the prefatory remarks set forth in the proposed rule. See id. at 15,411-12, 15,515. CMS also indicated that it received several comments regarding payments, charges, and receipts for the risk corridors program. Id. at 15,473. For example, "[o]ne commenter . . . asked for clarification on HHS's plans for funding risk corridors if payments exceed receipts." Id. In response, CMS stated: "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." Id. In addition, several commenters provided "supportive comments on [CMS's] proposal to require issuers to submit risk corridors information by July 31 of the year following the applicable benefit year," leading CMS to finalize that proposal. Id.; see also id. at 15,520 ("In this final rule, HHS also specifies the annual schedule for the risk corridors program, including dates for claims run-out, data submission, and notification of risk corridors payments and charges."). Thus, 45 C.F.R. § 153.510 was amended by adding the following subsection: "(d) Charge submission deadline. A QHP issuer must remit charges to HHS within 30 days after notification of such charges." Id. at 15,531. And, 45 C.F.R. § 153.530 was amended by adding the following subsection: "(d) Timeframes. For each benefit year, a QHP issuer must submit all information required under this section by July 31 of the year following the benefit year." Id.

On December 2, 2013, CMS published a proposed notice of benefit and payment parameters for 2015. See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,322 (to be codified at 45 C.F.R. pts. 144, 147, 153, 155-156). It noted that on November 14, 2013, the federal government announced that it would allow individuals, between January 1 and October 1, 2014, to renew insurance coverage that did not comply with the "2014 market rules." Id. at 72,324. CMS suspected that this "transitional" policy "could increase an issuer's average expected claims cost for plans that comply with the 2014 market rules" and therefore lead to "unexpected losses." Id. As a result,

CMS proposed "modifications to a number of programs," including the risk corridors program. Id. Among other changes, CMS proposed modifying the risk corridors formula for 2014:

> As mentioned elsewhere in this proposed rule, for the 2014 benefit year, we are proposing an adjustment to the risk corridors formula that would help to further mitigate potential QHP issuers' unexpected losses that are attributable to the effects of the transition policy. This proposed adjustment may increase the total amount of risk corridors payments that the Federal government will make to QHP issuers, and reduce the amount of risk corridors receipts; however, we are considering a number of approaches that would limit the impact of the policy on the Federal budget. Because of the difficulty associated with predicting State enforcement of 2014 market rules and estimating the enrollment in transitional plans and in QHPs, we cannot estimate the magnitude of this impact on aggregate risk corridors payments and charges at this time.

Id. at 72,379-80.

After a notice-and-comment period, CMS issued a final rule on March 11, 2014. See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744 (to be codified at 45 C.F.R. pts. 144, 147, 153, 155-156). It stated:

> In our proposed rule, we considered an adjustment to the risk corridors formula for the 2014 benefit year that would help to further mitigate any unexpected losses for issuers of plans subject to risk corridors attributable to the effects of the transitional policy, and noted that we were considering approaches that would limit the impact of the policy on the Federal budget. . . .
>
> . . . .
>
> We are finalizing the risk corridors adjustment policy as proposed. . . . We project that these changes, in combination with the changes to the reinsurance program finalized in this rule, will result in net payments that are budget neutral in 2014. We intend to implement this program in a budget neutral manner, and may make future adjustments, either upward or downward to this program (for example, as discussed below, we may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal.

Id. at 13,786-87. CMS expanded upon the economic impact of its modifications to the risk corridors program:

> The Affordable Care Act created a temporary risk corridors program for the years 2014, 2015, and 2016 that applies to QHPs . . . . HHS intends to implement this program in a budget neutral manner.

> As mentioned elsewhere in this rule, for the 2014 benefit year, we are making an adjustment to the risk corridors formula that would help mitigate potential QHP issuers' unexpected losses that are attributable to the effects of the transitional policy. . . . Because of the difficulty associated with predicting State enforcement of the 2014 market rules and estimating the enrollment in transitional plans and in QHPs, it is difficult to estimate the precise magnitude of this impact on aggregate risk corridors payments and charges at this time.
>
> Our initial modeling suggests that this adjustment for the transitional policy could increase the total risk corridors payment amount made by the Federal government and decrease risk corridors receipts, resulting in an increase in payments. However, we estimate that even with this change, the risk corridors program is likely to be budget neutral or, will result in net revenue to the Federal government. . . . [W]hile the transitional risk corridors adjustment will result in higher risk corridors payments than would occur if no transitional adjustment were in place, we believe that the risk corridors program as a whole will be budget neutral or, will result in net revenue to the Federal government in FY 2015 for the 2014 benefit year. We note that even with an estimated increase in outlays, CBO still projects the Premium Stabilization programs to reduce the deficit by approximately $8 billion over the budget window. HHS intends to implement this program in a budget neutral manner.

Id. at 13,829; accord id. at 13,826 ("[W]e were uncertain of the exact magnitude of the effect of the proposed adjustments to the risk corridors and reinsurance programs as a result of the transitional policy . . . ."), 13,827 ("For risk corridors, CBO now estimates the Federal government will pay $8 billion to issuers from [fiscal years] 2015-2017, but that collections for this program will total $16 billion, for a net yield of $8 billion to the Federal government.").

One month after publishing this final rule, on April 11, 2014, CMS issued a two-page memorandum with the subject line "Risk Corridors and Budget Neutrality." Def.'s App. 2 at 54-55. The memorandum contained four sets of questions and answers, three of which are relevant here:

> Q1: In the HHS Notice of Benefit and Payment Parameters for 2015 final rule (79 FR 13744) . . . , HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?
>
> A1: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors

payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

. . . .

Q2: What happens if risk corridors collections do not match risk corridors payments in the final year of risk corridors?

A2: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program. However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program.

. . . .

Q4: In the 2015 Payment Notice, HHS stated that it might adjust risk corridors parameters up or down in order to ensure budget neutrality. Will there be further adjustments to risk corridors in addition to those indicated in this FAQ?

A4: HHS believes that the approach outlined in this FAQ is the most equitable and efficient approach to implement risk corridors in a budget neutral manner. However, we may also make adjustments to the program for benefit year 2016 as appropriate.

Id.

C. Appropriations Acts for Fiscal Years 2015 and 2016

On December 16, 2014, Congress enacted the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, to fund the federal government

for the fiscal year ending September 30, 2015, id. § 5, 128 Stat. at 2133. In the division of the Act appropriating funds for HHS, Congress included the following provision:

> 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).

Id. at div. G, tit. II, § 227, 128 Stat. at 2491. In an explanatory statement that was published in the Congressional Record, the chairman of the House Committee of Appropriations remarked:

> 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).

One year later, on December 18, 2015, Congress enacted the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242, to fund the federal government for the fiscal year ending September 30, 2016, id. § 5, 129 Stat. at 2244. That Act provided:

> 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).

Id. at div. H, tit. II, § 225, 129 Stat. at 2624. The Act also provided:

> 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.

Id. at div. H, tit. II, § 226, 129 Stat. at 2625. In a June 25, 2015 report accompanying the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2016, the Senate Committee on Appropriations explained: "The Committee continues bill language requiring the administration to operate the Risk Corridor program in a budget neutral manner by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as payments for the Risk Corridor program." S. Rep. No. 114-74, at 12.

D. The Risk Corridors Program in Practice

Plaintiff "is a nonprofit corporation organized under the laws of the State of Oregon" that provided health insurance on Oregon's exchange in 2014 and 2015. Compl. ¶ 16. Based on the data submitted by plaintiff, HHS determined that plaintiff was entitled to a risk corridors payment for 2014 of $7,884,886.15. Def.'s App. 2 at 80. However, because the risk corridors payments owed to insurers ($2.87 billion) greatly exceeded the risk corridors charges due from insurers ($362 million), HHS announced, on October 1, 2015, that it would prorate the risk corridors payments. Id. at 58. Each insurer that was entitled to a risk corridors payment for 2014 would receive only 12.6% of what it was owed. Id.; Compl. ¶ 16. CMS subsequently advised insurers that HHS would begin making risk corridors payments in December 2015. Def.'s App. 2 at 58.

When it filed its complaint in early 2016, plaintiff estimated that it was owed a risk corridors payment for 2015 of approximately $15 million. Compl. ¶ 16. Subsequently, on September 9, 2016, HHS announced preliminary information regarding risk corridors payments for 2015. See Def.'s Reply Ex. "[B]ased on [its] preliminary analysis, HHS anticipate[d] that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." Id. at 1. HHS confirmed that conclusion in a November 18, 2016 memorandum. See Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf. In that same memorandum, HHS indicated that plaintiff was entitled to a risk corridors payment of $13,000,493.30 for 2015, id. at 10, that plaintiff could expect to receive $261,922.66 towards its 2014 risk corridors payment, id., and that it would begin making risk corridors payments in December 2016, id. at 2. Thus, as of the date of this decision, plaintiff has not received its full risk corridors payment for 2014 or any part of its risk corridors payment for 2015.

E. Procedural History

Plaintiff filed suit on February 24, 2016, alleging, in its sole claim for relief, that defendant has not fully paid the risk corridors payments to which it and other insurers are entitled

under section 1342 of the Affordable Care Act and its implementing regulations.[4] It seeks the following relief: unpaid risk corridors payments; consequential, special, or other damages resulting from defendant's nonpayment; declaratory and injunctive relief; prejudgment and postjudgment interest; and attorneys' fees and costs.

On June 24, 2016, defendant moved to dismiss plaintiff's complaint for lack of subject matter jurisdiction pursuant to RCFC 12(b)(1). In its motion, defendant contends that (1) plaintiff does not have a claim for presently due money damages; (2) plaintiff's claim is not ripe; and (3) the court lacks jurisdiction to award certain relief requested by plaintiff, including consequential damages, special damages, interest, declaratory relief, and injunctive relief. Plaintiff filed its response in opposition on August 15, 2016, and defendant filed its reply on September 9, 2016.[5] In addition, the parties filed short briefs regarding the decision in Land of Lincoln Mutual Health Insurance Co. v. United States, 129 Fed. Cl. 81 (2016), appeal docketed, No. 17-1224 (Fed. Cir. Nov. 16, 2016). The court deems oral argument unnecessary.

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[4] Subsequently, fourteen other suits to recover unpaid risk corridors payments were filed in this court. See First Priority Life Ins. Co. v. United States, No. 16-587C (filed May 17, 2016); Moda Health Plan, Inc. v. United States, No. 16-649C (filed June 1, 2016); Blue Cross & Blue Shield of N.C. v. United States, No. 16-651C (filed June 2, 2016); Land of Lincoln Mut. Health Ins. Co. v. United States, No. 16-744C (filed June 23, 2016); Me. Cmty. Health Options v. United States, No. 16-967C (filed Aug. 9, 2016); N.M. Health Connections v. United States, No. 16-1199C (filed Sept. 26, 2016); BCBSM, Inc. v. United States, No. 16-1253C (filed Oct. 3, 2016); Blue Cross of Idaho Health Serv., Inc. v. United States, No. 16-1384C (filed Oct. 24, 2016); Minuteman Health Inc. v. United States, No. 16-1418C (filed Oct. 27, 2016); Mont. Health Co-op v. United States, No. 16-1427C (filed Oct. 28, 2016); Alliant Health Plans v. United States, No. 16-1491C (filed Nov. 14, 2016); Blue Cross & Blue Shield of S.C. v. United States, No. 16-1501C (filed Nov. 14, 2016); Neighborhood Health Plan Inc. v. United States, No. 16-1659C (filed Dec. 19, 2016); Health Net, Inc. v. United States, No. 16-1722C (filed Dec. 30, 2016). Each of the plaintiffs in these cases alleges a failure to pay risk corridors payments in violation of section 1342 of the Affordable Care Act and its implementing regulations. In addition, some of the plaintiffs allege breach of an express contract, breach of an implied-in-fact contract, breach of the implied duty of good faith and fair dealing, anticipatory breach of contract, and/or an uncompensated taking in violation of the Fifth Amendment to the United States Constitution.

[5] Subsequently, on October 5, 2016, plaintiff filed motions for class certification and for the appointment of interim class counsel. The court granted latter motion on October 25, 2016, and the former motion on January 3, 2017.

II. DISCUSSION

A. Standard of Review

In ruling on a motion to dismiss a complaint pursuant to RCFC 12(b)(1), the court generally assumes that the allegations in the complaint are true and construes those allegations in the plaintiff's favor. Trusted Integration, Inc. v. United States, 659 F.3d 1159, 1163 (Fed. Cir. 2011). The allegations in the complaint must include "the facts essential to show jurisdiction." McNutt v. Gen. Motors Acceptance Corp., 298 U.S. 178, 189 (1936). If such jurisdictional facts are challenged in a motion to dismiss, the plaintiff "must support them by competent proof." Id.; accord Land v. Dollar, 330 U.S. 731, 735 & n.4 (1947) ("[W]hen a question of the District Court's jurisdiction is raised, . . . the court may inquire by affidavits or otherwise, into the facts as they exist." (citations omitted)). Ultimately, the plaintiff bears the burden of proving, by a preponderance of the evidence, that the court possesses subject matter jurisdiction. Trusted Integration, 659 F.3d at 1163. If the court finds that it lacks subject matter jurisdiction, it must, pursuant to RCFC 12(h)(3), dismiss the complaint.

B. The Court Possesses Subject Matter Jurisdiction to Entertain Plaintiff's Claim for Unpaid Risk Corridors Payments

Whether the court has jurisdiction to decide the merits of a case is a threshold matter. See Steel Co. v. Citizens for a Better Env't, 523 U.S. 83, 94-95 (1998). "Without jurisdiction the court cannot proceed at all in any cause. Jurisdiction is power to declare the law, and when it ceases to exist, the only function remaining to the court is that of announcing the fact and dismissing the cause." Ex parte McCardle, 74 U.S. (7 Wall.) 506, 514 (1868). The parties or the court sua sponte may challenge the court's subject matter jurisdiction at any time. Arbaugh v. Y & H Corp., 546 U.S. 500, 506 (2006).

The ability of the United States Court of Federal Claims ("Court of Federal Claims") to entertain suits against the United States is limited. "The United States, as sovereign, is immune from suit save as it consents to be sued." United States v. Sherwood, 312 U.S. 584, 586 (1941). The waiver of immunity "cannot be implied but must be unequivocally expressed." United States v. King, 395 U.S. 1, 4 (1969).

The Tucker Act, the principal statute governing the jurisdiction of this court, waives sovereign immunity for claims against the United States that are founded upon the Constitution, a federal statute or regulation, or an express or implied contract with the United States. 28 U.S.C. § 1491(a)(1) (2012). However, the Tucker Act is merely a jurisdictional statute and "does not create any substantive right enforceable against the United States for money damages." United States v. Testan, 424 U.S. 392, 398 (1976). Instead, the substantive right must appear in another source of law, such as a "money-mandating constitutional provision, statute or regulation that has been violated, or an express or implied contract with the United States." Loveladies Harbor, Inc. v. United States, 27 F.3d 1545, 1554 (Fed. Cir. 1994) (en banc).

In this case, plaintiff contends that section 1342 of the Affordable Care Act, 42 U.S.C. § 18062, and the regulation implementing section 1342's payment requirements, 45 C.F.R. § 153.510(b), are money-mandating provisions that entitle it, and other similarly situated insurers, to seek money damages from the United States. Defendant does not dispute that these two provisions mandate the payment of money to plaintiff and other similarly situated insurers. Indeed, it would be folly to do so. Section 1342 provides that the Secretary of HHS "shall pay" specified amounts to eligible qualified health plans, 42 U.S.C. § 18062(b)(1), and the regulation implementing this requirement provides that the Secretary of HHS "will pay" specified amounts to issuers of eligible qualified health plans, 45 C.F.R. § 153.510(b). Such language creates the necessary money mandate. See Britell v. United States, 372 F.3d 1370, 1378 (Fed. Cir. 2004) ("[T]his type of mandatory language, e.g., 'will pay' or 'shall pay,' creates the necessary 'money-mandate' for Tucker Act purposes."); see also United States v. White Mountain Apache Tribe, 537 U.S. 465, 473 (2003) ("It is enough, then, that a statute creating a Tucker Act right be reasonably amenable to the reading that it mandates a right of recovery in damages."); Mitchell v. United States, 463 U.S. 206, 219 (1983) (noting that a court must "examine whether [sources of substantive law] can fairly be interpreted as mandating compensation for damages sustained as a result of a breach of the duties they impose"); Eastport S.S. Corp. v. United States, 372 F.2d 1002, 1007 (Ct. Cl. 1967) (explaining that a plaintiff must allege "that the particular provision of law relied upon grants the claimant, expressly or by implication, a right to be paid a certain sum").

Defendant instead argues that the court lacks subject matter jurisdiction to entertain plaintiff's complaint because the Tucker Act's waiver of sovereign immunity is limited to claims for presently due money damages, and plaintiff has not established that its damages are presently due. In support of this contention, defendant primarily relies upon the decision of the United States Supreme Court ("Supreme Court") in United States v. King. In that case, the plaintiff alleged

> that the Secretary of the Army's action in rejecting his disability retirement was arbitrary, capricious, not supported by evidence, and therefore unlawful, and asked for a judgment against the United States for an amount of excess taxes he had been compelled to pay because he had been retired for longevity instead of disability.

395 U.S. at 2. The United States Court of Claims ("Court of Claims"), a predecessor of this court and the United States Court of Appeals for the Federal Circuit ("Federal Circuit"), concluded that the plaintiff's claim "was basically one for a refund of taxes and was therefore barred by [the plaintiff's] failure to allege that he had filed a timely claim for refund" with the Internal Revenue Service. Id. However, the Court of Claims concluded that it could instead "exercise jurisdiction under the Declaratory Judgment Act." Id. (citation omitted). The Supreme Court, upon examining its precedent, disagreed. Id. at 3. It held "that neither the Act creating the Court of Claims nor any amendment to it grants that court jurisdiction of" the plaintiff's case, explaining:

> That is true because [the plaintiff's] claim is not limited to actual, presently due money damages from the United States. Before he is entitled to such a judgment he must establish in some court that his retirement by the Secretary of the Army for longevity was legally wrong and that he is entitled to a declaration of his right to have his military records changed to show that he was retired for disability. This is essentially equitable relief of a kind that the Court of Claims has held throughout its history, up to the time this present case was decided, that it does not have the power to grant.

Id. (emphasis added). In other words, the plaintiff could not recover the money damages he sought without first obtaining a declaratory judgment, a type of equitable relief that the Court of Claims could not provide. Accordingly, the Supreme Court was distinguishing between money damages that could be paid immediately, and money damages that could not be paid until other, nonmonetary relief had been awarded. Accord Todd v. United States, 386 F.3d 1091, 1094 (Fed. Cir. 2004) ("[A]ppellants are not seeking presently due money damages, but instead seek the equitable remedy of a reclassification of [a] facility and a salary increase based on that reclassification."); Nat'l Air Traffic Controllers Ass'n v. United States, 160 F.3d 714, 716 (Fed. Cir. 1998) (per curiam) ("Although the Tucker Act has been amended to permit the Court of Federal Claims to grant equitable relief ancillary to claims for monetary relief over which it has jurisdiction, there is no provision giving the Court of Federal Claims jurisdiction to grant equitable relief when it is unrelated to a claim for monetary relief pending before the court. It is not enough that the court's decision may affect the disposition of a monetary claim pending elsewhere, or that the court's decision will ultimately enable the plaintiff to receive money from the government." (citations omitted)); Overall Roofing & Constr. Inc. v. United States, 929 F.2d 687, 689 (Fed. Cir. 1991) (noting that historically, a "claim" in the Court of Federal Claims is a request for presently due money damages rather than a request for a declaratory judgment), superseded on other grounds by statute, Federal Courts Administration Act of 1992, Pub. L. No. 102-572, § 907(b), 106 Stat. 4506, 4519; Wood v. United States, 214 Ct. Cl. 744, 745 (1977) ("[T]he court can only enter judgment for monies presently due and owing from the United States, and, lacking declaratory judgment jurisdiction, cannot adjudicate future rights and obligations."); Johnson v. United States, 105 Fed. Cl. 85, 95-96 (2012) (holding that the plaintiff's claim for the cancellation of his educational debt was not a request for presently due money damages but was instead a request for declaratory relief that was beyond the court's jurisdiction); Annuity Transfers, Ltd. v. United States, 86 Fed. Cl. 173, 179-83 (2009) (holding that the plaintiffs had not alleged a claim for presently due money damages because (1) the contracts at issue provided for the periodic payment of money by the United States; (2) the plaintiffs did not allege that the United States was not making the periodic payments or had otherwise breached the contracts; and (3) the plaintiffs were actually seeking an order allowing for the alteration of the terms of the contracts–declaratory relief–rather than money damages).

The distinction drawn by the Supreme Court in King is not applicable in this case; an insurer's entitlement to unpaid risk corridors payments is not dependent upon the insurer first obtaining a declaratory judgment. Moreover, taken in isolation, the requirement that money

damages be presently due speaks more to the ripeness of a claim than to whether the court has subject matter jurisdiction to entertain the claim in the first instance. Indeed, it is well settled that once the court determines that a source of law implicated in a plaintiff's complaint mandates the payment of money damages for its violation and that "the plaintiff has made a nonfrivolous assertion that it is within the class of plaintiffs entitled to recover under the money-mandating source," the court must conclude that it possesses subject matter jurisdiction. Jan's Helicopter Serv., Inc. v. FAA, 525 F.3d 1299, 1307 (Fed. Cir. 2008); accord Greenlee Cty., Ariz. v. United States, 487 F.3d 871, 876 (Fed. Cir. 2007); Fisher v. United States, 402 F.3d 1167, 1173 (Fed. Cir. 2005) (en banc portion). Both section 1342 of the Affordable Care Act and the regulation implementing section 1342's payment requirements are money-mandating sources of law. Accord Land of Lincoln, 129 Fed. Cl. at 97. The court therefore has subject matter jurisdiction to entertain plaintiff's claim that the United States violated those provisions.

C. Plaintiff's Claim for Unpaid Risk Corridors Payments Is Ripe

Although the court possesses jurisdiction over the subject matter of this case, the court cannot exercise that jurisdiction unless plaintiff's claim for unpaid risk corridors payments is ripe for judicial review. To be ripe, a claim must not be contingent upon future events that may or may not occur. Thomas v. Union Carbide Agric. Prods. Co., 473 U.S. 568, 580-81 (1985). When a claim results from an "administrative determination," the ripeness doctrine "prevent[s] the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and . . . protect[s] the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties." Abbott Labs. v. Gardner, 387 U.S. 136, 148-49 (1967), overruled on other grounds by Califano v. Sanders, 430 U.S. 99 (1977); accord Shinnecock Indian Nation v. United States, 782 F.3d 1345, 1351 (Fed. Cir. 2015) ("Adherence to ripeness standards prevents courts from making determinations on the merits of a case before all the essential facts are in."). The doctrine derives from both "Article III limitations on judicial power and from prudential reasons for refusing to exercise jurisdiction." Reno v. Catholic Soc. Servs., Inc., 509 U.S. 43, 57 n.18 (1993); cf. Shinnecock Indian Nation, 782 F.3d at 1351 n.7 ("Although the Court of Federal Claims is an Article I tribunal, it generally adheres to traditional justiciability standards applicable to courts established under Article III.").

Defendant argues that plaintiff's claim for unpaid risk corridors payments is not ripe because HHS has not determined the total amount of payments due to plaintiff and other insurers under the risk corridors program. This argument is based on the fact that neither section 1342 of the Affordable Care Act nor the regulation implementing section 1342's payment requirements expressly includes a deadline for HHS to make risk corridors payments to insurers. In the absence of an explicit deadline, defendant asserts, HHS may defer payment to insurers until the conclusion of the three-year risk corridors program, or to whenever it has the funds available to make full payment. Accordingly, defendant contends that because HHS is not under any present obligation to make risk corridors payments, will not know the total amount owed to each insurer

until 2017,[6] and does not currently know whether plaintiff will receive the full amount of risk corridors payments it is owed, plaintiff's claim is premature.

The underlying premise of defendant's ripeness argument is that, contrary to plaintiff's contention, plaintiff and other insurers are not entitled to receive risk corridors payments on an annual basis. Specifically, defendant contends that in the absence of an explicit deadline in section 1342 of the Affordable Care Act or the regulation implementing section 1342's payment requirements, HHS possesses the discretion to establish a payment framework; that the two appropriations laws enacted by Congress confirm HHS's discretion; and that the framework adopted by HHS is therefore entitled to deference. Plaintiff responds that the plain language of section 1342 and the Affordable Care Act in general require annual risk corridors payments, that legislative history reveals congressional intent to require annual risk corridors payments, that HHS's failure to make annual risk corridors payments undermines the purpose of the risk corridors program, that HHS's payment framework is not entitled to deference, and that HHS currently owes plaintiff and other insurers risk corridors payments for 2014 and 2015.

1. Congress Intended That HHS Make Annual Risk Corridors Payments to Eligible Qualified Health Plans

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

[6] Of course, because plaintiff did not participate on an exchange in 2016, HHS would know the total amount of risk corridors payments due to plaintiff for 2014 and 2015 in 2016. Indeed, during the pendency of this suit, HHS published a memorandum indicating that plaintiff was entitled to a risk corridors payment for 2015 of $13,000,493.30. HHS had previously determined that plaintiff was entitled to a risk corridors payment for 2014 of $7,884,886.15. Thus, according to HHS, the total amount owed to plaintiff under the risk corridors program is $20,885,379.45.

statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give to it such a construction as will carry into execution the will of the Legislature . . . .'" (quoting Brown v. Duchesne, 60 U.S. 183, 194 (1856))); see also Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 843 n.9 (1984) ("If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."); Kilpatrick v. Principi, 327 F.3d 1375, 1384 (Fed. Cir. 2003) ("[I]n determining whether Congress has directly spoken to the point at issue, a court should attempt to discern congressional intent either from the plain language of the statute or, if necessary, by resort to the applicable tools of statutory construction[.]"); Timex V.I., Inc. v. United States, 157 F.3d 879, 882 (Fed. Cir. 1998) ("If . . . the statute's text does not explicitly address the precise question, we do not at that point simply defer to the agency. Our search for Congress's intent must be more thorough than that."). If congressional intent regarding the timing of risk corridors payments can be ascertained from evaluating the text of the Affordable Care Act, then the court's inquiry on this issue is complete. See Conn. Nat'l Bank, 503 U.S. at 254.

a. HHS Must Calculate Separate Risk Corridors Payments for Each of the Three Years of the Program

Section 1342 of the Affordable Care Act does not explicitly provide a deadline for HHS to make risk corridors payments to insurers. However, as plaintiff notes, Congress contemplated that HHS would calculate risk corridors payments separately for each year of the program. For example, Congress directed HHS to "establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," 42 U.S.C. § 18062(a), rather than a program for calendar years 2014 through 2016. In addition, Congress required HHS to calculate "[p]ayments in" and "[p]ayments out" for each year of the program. See id. § 18062(b)(1), (b)(2), (c)(1), (c)(2). Although the fact that Congress required HHS to make separate calculations for each calendar year does not necessarily mean that Congress intended for HHS to make annual payments, it does lend credence to such a construction.

b. HHS Is Required to Base the Risk Corridors Program on a Preexisting Program in Which It Makes Annual Payments to Eligible Insurers

Plaintiff contends that further support for construing section 1342 of the Affordable Care Act to contain an annual payment requirement is Congress's directive that the risk corridors program "be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w-101 et seq.]." Id. § 18062(a). In the statute creating the latter program, Congress directed HHS to establish a risk corridor for each prescription drug plan for each plan year. Id. § 1395w-115(e)(3)(A). The regulations implementing the program, which were issued in 2005, provided:

> (c) Payment methods. CMS makes payments after a coverage year after obtaining all of the cost data information in paragraph (c)(1) of this section

necessary to determine the amount of payment. CMS will not make payments under this section if the Part D sponsor fails to provide the cost data information in paragraph (c)(1) of this section.

(1) Submission of cost data. Within 6 months of the end of a coverage year, the Part D sponsor must provide the information that CMS requires.

(2) Lump sum and adjusted monthly payments. CMS at its discretion makes either lump-sum payments or adjusts monthly payments in the following payment year based on the relationship of the plan's adjusted allowable risk corridor costs to the predetermined risk corridor thresholds in the coverage year, as determined under this section.

42 C.F.R. § 423.336(c) (2009) (final emphasis added). Thus, in the program upon which the Affordable Care Act's risk corridors program was to be based, HHS–through CMS–would make payments in the year following the coverage year so long as it had received the necessary cost data. Indeed, for the first year of the program–2006–HHS paid funds owed to eligible plan sponsors in November and December 2007. See Office of Inspector Gen., Dep't of Health & Human Servs., Medicare Part D Reconciliation Payments for 2006-2007 14 (2009), https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf ("CMS paid most of the funds owed to sponsors for 2006 by increasing these sponsors' monthly prospective payments for November and December 2007."). Congress would have been aware of HHS's regulation and payment scheme when it enacted the Affordable Care Act in March 2010. 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."); cf. Lorillard v. Pons, 434 U.S. 575, 581 (1978) ("[W]here . . . Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute."). To be sure, Congress merely dictated that the Affordable Care Act's risk corridors program "be based on" the program described in 42 U.S.C. § 1395w-115(e); it did not require HHS to establish an identical program under the Affordable Care Act. Thus, taken alone, the reference to the earlier risk corridors program is not evidence of congressional intent to require annual risk corridors payments under the Affordable Care Act. At a minimum, however, the reference reflects Congress's approval of a risk corridors program that provides for annual payments.

c. The Purpose of, and Interplay Among, the Three Premium Stabilization Programs Suggest That Risk Corridors Payments Should Be Made Annually

Additional evidence of congressional intent is discernable from an examination of the purpose of, and interplay among, the three premium stabilization programs described in the Affordable Care Act. The transitional reinsurance program was designed to reimburse insurers that covered high-risk individuals during the three-year period beginning January 1, 2014. 42 U.S.C. § 18061(b)(1). For any plan year that began in the three-year period, insurers were

required to fund reinsurance entities, id., which are "not-for-profit organization[s]" tasked with "help[ing] stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest," id. § 18061(c)(1). Then, insurers who covered high-risk individuals would receive payments from the reinsurance entities for any plan year that began during the three-year period. Id.

Under the permanent risk adjustment program, each state determines the average actuarial risk for all designated enrollees in that state and then (1) assesses charges on the insurers whose enrollees have less actuarial risk than average and (2) provides payments to the insurers whose enrollees have more actuarial risk than average. Id. § 18063(a). In short, the program compensates insurers who enroll a disproportionate number of higher-risk individuals and penalizes insurers who enroll fewer than average higher-risk individuals. Id. To effectuate the program, states are required to make the calculations, assess the charges, and provide the payments on an annual basis. Id.

The risk corridors program is a temporary, three-year "payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." Id. § 18062(a). A plan's allowable costs are the total costs to provide the benefits covered by the plan "reduced by any risk adjustment and reinsurance payments received" by the plan, id. § 18062(c)(1), and a plan's aggregate premiums are the "total premiums . . . reduced by the administrative costs of the plan," id. § 18062(c)(2). Insurers with plans in which aggregate premiums exceed allowable costs by a certain threshold remit payments to HHS, and insurers with plans in which allowable costs exceed aggregate premiums by a certain threshold receive payments from HHS. Id. § 18062(b). Such a scheme both protects insurers who underestimate allowable costs and, as a result, charge inadequate premiums, and penalizes insurers who overestimate their costs and, as a result, charge excessive premiums. Id. Consequently, insurers have an incentive to adjust their premiums and costs to avoid paying a penalty to HHS and to ensure, once the risk corridors program concludes, that premiums will cover costs. Indeed, given the temporary nature of the risk corridors program, it is apparent that insurers are expected, by the end of three years, to be capable of more accurately estimating their allowable costs and setting their premiums.

The common thread among the three premium stabilization programs is a concern that insurers' costs would detrimentally exceed the premiums collected. In creating the transitional reinsurance program, Congress recognized that certain insurers might attract more than expected high-risk individuals during the first three years of insurance market reforms, increasing their costs beyond what they anticipated. Similarly, Congress created the permanent risk adjustment program to account for the fact that plans that enroll a disproportionate number of high-risk individuals would incur greater costs. And Congress created the temporary risk corridors program to provide relief to insurers who, in the first three years of insurance market reforms, underestimated their allowable costs and accordingly set their premiums too low. 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.[7] Further, if enough insurers left the exchanges, one of the goals of the Affordable Care Act–the creation of "effective health insurance markets," id. § 18091(2)(I)-(J)–would be unattainable. It is thus nonsensical to suggest that Congress, in enacting provisions meant to ensure the success of the Affordable Care Act, drafted those provisions to cause the opposite effect. 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."). Indeed, Congress did not do so. Reinsurance and risk adjustment payments are to be made on an annual basis. And, the risk corridors payment that HHS owes an eligible insurer for a particular year depends upon the amount of reinsurance and risk adjustment payments that insurer received for that same year. It seems probable, therefore, that Congress intended for risk corridors payments, like the reinsurance and risk corridors payments upon which they depend, to be paid annually.

d. Summary

None of the factors described above (the requirement of separate calculations for each year, the reference to a preexisting program in which annual payments are made, the purpose of the premium stabilization programs, and the interplay among the premium stabilization programs), taken individually, conclusively establishes congressional intent. However, when the factors are considered together, congressional intent becomes apparent: HHS is required to make annual risk corridors payments to eligible qualified health plans. Because HHS has ascertained plaintiff's entitlement to risk corridors payments for 2014 and 2015–the only years for which plaintiff asserts its claim–plaintiff's claim for unpaid risk corridors payments is ripe for adjudication.

2. Even if the Affordable Care Act Is Construed as Ambiguous, HHS Interprets the Act as Requiring Annual Risk Corridors Payments to Eligible Qualified Health Plans

The court's conclusion that plaintiff's claim is ripe would be no different had it determined that the Affordable Care Act was ambiguous as to whether HHS was required to make annual risk corridors payments.

As previously noted, Congress directed HHS to "establish and administer" the Affordable Care Act's risk corridors program. 42 U.S.C. § 18062(a). Thus, HHS and CMS published several proposed and final rules setting forth how they intended to administer the program. The regulations adopted in the final rules do not specify a deadline for HHS to make risk corridors payments. However, in the first proposed rule, issued on July 15, 2011, HHS indicated that it was considering such a deadline:

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[7] Alternatively, an insurer whose costs greatly exceeded its premiums might, in the face of uncompensated losses, opt to discontinue offering plans on the exchanges even if it possessed sufficient resources to sustain those losses and remain on the exchanges.

> For example, a QHP issuer required to make a risk corridor payment may be required to remit charges within 30 days of receiving notice from HHS. Similarly, HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers.

76 Fed. Reg. at 41,943. Such deadlines would help effectuate the goal of the risk corridors program–"to provide QHP issuers with greater payment stability as insurance market reforms are implemented" and "protect against uncertainty in setting rates in the Exchange by limiting the extent of issuer losses (and gains)." Id. at 41,931; accord 77 Fed. Reg. at 73,119.

In addition to these proposed and final rules, CMS published a memorandum to explain how HHS would make and fund the risk corridors payments. In this memorandum, dated April 11, 2014, CMS indicates that it would use risk corridors payments it receives from insurers required to pay into the program to make risk corridors payments to insurers entitled to payment from the program, and

> if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Def.'s App. 2 at 54.

"When a court reviews an agency's construction of the statute which it administers" and determines that "Congress has not directly addressed the precise question at issue, . . . the question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron, 467 U.S. at 842-43 (footnote omitted). Further, if an agency's regulations do not directly address the question at issue, the court "must necessarily look to the administrative construction of the regulation . . . , which becomes of controlling weight unless it is plainly erroneous or inconsistent with the regulation." Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 413-14 (1945); accord Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994) ("We must give substantial deference to an agency's interpretation of its own

regulations."); see also Cathedral Candle Co. v. U.S. Int'l Trade Comm'n, 400 F.3d 1352, 1363-64 (Fed. Cir. 2005) ("Deference to an agency's interpretation of its own regulations is broader than deference to the agency's construction of a statute, because in the latter case the agency is addressing Congress's intentions, while in the former it is addressing its own.").

There can be no dispute that the regulations promulgated by HHS to establish the risk corridors program are based on a permissible construction of section 1342 of the Affordable Care Act–neither the Act nor the regulations contain an explicit deadline for HHS to make risk corridors payments. Thus, the court turns to HHS's construction of its own regulations.

Two documents–the July 11, 2011 proposed rule and the April 11, 2014 memorandum–reflect that HHS construed its regulations to require annual risk corridors payments. In the July 11, 2011 proposed rule, HHS stated that the purpose of the risk corridors program was to assist insurers during the implementation of the insurance market reforms required by the Affordable Care Act. In furtherance of this purpose, HHS stated that it was considering setting identical deadlines for insurers to remit payment to HHS and for HHS to make payments to insurers–thirty days after determining the amounts due–because it believed that insurers would want prompt payment and that the payment deadlines for HHS and insurers should be the same. In other words, HHS recognized that to be effective, the risk corridors program should provide for regular payments, both to and from insurers, throughout the existence of the program. See also 78 Fed. Reg. at 15,531 (adopting regulations requiring insurers to submit risk corridors information annually (by July 31 of the year following each benefit year) and then remit payment to HHS within thirty days of being notified of the amount due). Additionally, in the April 11, 2014 memorandum, CMS represented that HHS intended to make whatever payments it could after each of the three years of the risk corridors program. In other words, HHS intended to make annual risk corridors payments with the funds it had available. Indeed, HHS has, in actual practice, has made annual risk corridors payments to insurers. Moreover, there is no evidence that HHS understood that it could choose not to make annual risk corridors payments to insurers. Thus, there can be no dispute that HHS construes its regulations to require annual risk corridors payments.

Because HHS determined that plaintiff is entitled to a $7,884,886.15 risk corridors payment for 2014 and a $13,000,493.30 risk corridors payment for 2015, the only remaining issue is whether plaintiff was entitled to full payment for 2014 in December 2015 and full payment for 2015 in December 2016. This issue is not abstract or hypothetical, and its resolution does not rest upon contingent future events (such as HHS's determination concerning whether it will be able to fully compensate insurers entitled to risk corridors payments). Accord Land of Lincoln, 129 Fed. Cl. at 101 ("The possibility of the government's making some or all of the risk-corridors payments in the future does not change this calculus. . . . HHS allegedly breached its statutory and regulatory obligations by failing to make full payments annually. Subsequent HHS payments might bear on [the plaintiff]'s ability to receive amounts due, but they will not affect [the plaintiff]'s underlying claim."); see also Duke Power Co. v. Carolina Envtl. Study Grp., Inc., 438 U.S. 59, 81-82 (1978) (remarking that waiting for a regulation-triggering event to

occur "would not . . . significantly advance [the court's] ability to deal with the legal issues presented nor aid [the court] in their resolution"). Rather, resolution of this issue will require the court to determine, on the merits, whether HHS is permitted to make partial annual risk corridors payments under section 1342 of the Affordable Care Act and its implementing regulations. Accordingly, even had the court concluded that section 1342 of the Affordable Care Act was ambiguous with respect to the timing of risk corridors payments, plaintiff's claim for unpaid risk corridors payments for 2014 and 2015 would be ripe for adjudication.

D. The Court Lacks Jurisdiction to Provide Some of the Relief Requested by Plaintiff

Defendant raises one final issue in its motion to dismiss: whether the Court of Federal Claims possesses subject matter jurisdiction to entertain plaintiff's requests for relief aside from the unpaid risk corridors payments. Specifically, defendant argues that the court lacks subject matter jurisdiction to award, as plaintiff requests, consequential, special, or other damages resulting from defendant's failure to make full risk corridors payments; declaratory and injunctive relief; and prejudgment and postjudgment interest. With respect to its requests for consequential, special, or other damages; equitable relief; and prejudgment interest, plaintiff does not dispute defendant's contention.

Plaintiff's decision not to contest the bulk of defendant's position is sound. First, the Court of Federal Claims may only award money damages if a money-mandating source of law provides for such an award. See Loveladies Harbor, Inc., 27 F.3d at 1554; see also Clean Fuel LLC v. United States, 110 Fed. Cl. 415, 418 (2013) ("This court has no jurisdiction over a claim for one type of money damages if the 'money-mandating' statute the plaintiff cites pertains only to a different type of money damages."). Plaintiff has not identified any source of law entitling it to any type of money damages other than unpaid risk corridors payments. Accordingly, the court lacks subject matter jurisdiction to entertain plaintiff's request for consequential, special, or other damages.

Second, except in a limited number of statutorily defined circumstances, the Court of Federal Claims cannot entertain claims for nonmonetary equitable relief. See Bowen v. Massachusetts, 487 U.S. 879, 905 & n.40 (1988); Gonzales Bonds & Ins. Agency, Inc. v. Dep't of Homeland Sec., 490 F.3d 940, 943 (Fed. Cir. 2007); Kanemoto v. Reno, 41 F.3d 641, 645 (Fed. Cir. 1994). None of those circumstances applies here. See 28 U.S.C. § 1491(a)(2) (providing the court with jurisdiction to issue, "as incident of and collateral to" an award of money damages, "orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records"); id. (providing the court with jurisdiction to render judgment in nonmonetary disputes arising under the Contract Disputes Act of 1978); id. § 1491(b)(2) (providing the court with jurisdiction to award declaratory and injunctive relief in bid protests); id. § 1507 (providing the court with jurisdiction to issue declaratory judgments under 26 U.S.C. § 7428). Thus, the court does not possess subject matter jurisdiction to entertain plaintiff's request for declaratory and injunctive relief.

Third, the Court of Federal Claims may not award interest in suits against the United States "in the absence of an express waiver of sovereign immunity from an award of interest." Library of Cong. v. Shaw, 478 U.S. 310, 311 (1986), superseded on other grounds by statute, Civil Rights Act of 1991, Pub. L. No. 102-166, § 114, 105 Stat. 1072, 1079 (codified at 42 U.S.C. § 2000e-16(d)). Pursuant to 28 U.S.C. § 2516(a), "[i]nterest on a claim against the United States shall be allowed in a judgment of the United States Court of Federal Claims only under a contract or Act of Congress expressly providing for payment thereof." Plaintiff does not allege a breach of contract or identify any federal statutes that would entitle it to prejudgment interest. As a result, the court lacks subject matter jurisdiction to entertain plaintiff's request for prejudgment interest.

Plaintiff does, however, argue that the Court of Federal Claims may, in appropriate circumstances, award postjudgment interest. In support of this contention, plaintiff relies on 28 U.S.C. § 1961(c)(3), which allows for the payment of interest "on judgments of the United States Court of Federal Claims only as provided in . . . any other provision of law"; 28 U.S.C. § 1961(c)(2), which allows for the payment of interest "on all final judgments against the United States in the United States Court of Appeals for the [F]ederal Circuit"; and 28 U.S.C. § 2516(b), which allows for the payment of interest "on a judgment against the United States affirmed by the Supreme Court after review on petition of the United States . . . ." The latter two provisions are not applicable in this case; 28 U.S.C. § 1961(c)(2) relates to final judgments of the Federal Circuit and 28 U.S.C. § 2516(b) becomes operative only when the United States unsuccessfully appeals a judgment to the Supreme Court. See generally Mobil Oil Co. v. United States, 374 F.3d 1123 (Fed. Cir. 2004). Thus, plaintiff cannot make a nonfrivolous assertion that it is within the class of plaintiffs entitled to recover postjudgment interest under these provisions. See Jan's Helicopter Serv., 525 F.3d at 1307. Moreover, plaintiff has not, pursuant to 28 U.S.C. § 1961(c)(3), identified any statute allowing for the payment of interest on judgments of the Court of Federal Claims. Accordingly, the court lacks subject matter jurisdiction to entertain plaintiff's request for postjudgment interest.

III. CONCLUSION

In sum, the court possesses subject matter jurisdiction to entertain plaintiff's claim that HHS, by failing to make full risk corridors payments for 2014 and 2015, violated section 1342 of the Affordable Care Act and the regulation implementing section 1342's payment requirements, but lacks subject matter jurisdiction to entertain plaintiff's requests for consequential, special, or other damages resulting from defendant's failure to make full risk corridors payments; declaratory and injunctive relief; and prejudgment and postjudgment interest. In addition, plaintiff's claim for unpaid risk corridors payments for 2014 and 2015 is ripe for adjudication.

The court therefore **GRANTS IN PART** and **DENIES IN PART** defendant's motion to dismiss. Defendant shall file an answer in accordance with the RCFC.

IT IS SO ORDERED.

s/ Margaret M. Sweeney
MARGARET M. SWEENEY
Judge

42 U.S. Code § 18062 - Establishment of risk corridors for plans in individual and small group markets

(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 U.S.C. 1395w–101 et seq.].

(b) Payment methodology
(1) Payments outThe 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 inThe 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.

(c) Definitions In this section:
(1) Allowable costs
(A) In general
The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.
(B) Reduction for risk adjustment and reinsurance payments
Allowable costs shall [1] reduced by any risk adjustment and reinsurance payments received under section [2] 18061 and 18063 of this title.
(2) Target amount
The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

(Pub. L. 111–148, title I, § 1342, Mar. 23, 2010, 124 Stat. 211.)

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on this 31st day of January, 2017, I caused this Brief of Appellant to be filed electronically with the Clerk of the Court using the CM/ECF System, which will send notice of such filing to the following registered CM/ECF users:

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Upon acceptance by the Clerk of the Court of the electronically filed document, the required number of copies of the Brief of Appellant will be hand filed at the Office of the Clerk, United States Court of Appeals for the Federal Circuit in accordance with the Federal Circuit Rules.

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CERTIFICATE OF COMPLIANCE

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Dated: January 31, 2017

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