No. 17-1994

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

MODA HEALTH PLAN, INC,
Plaintiff-Appellee,

v.

UNITED STATES OF AMERICA,
Defendant-Appellant.

Appeal from the U.S. Court of Federal Claims,
Case No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler

BRIEF OF *AMICUS CURIAE* ASSOCIATION FOR COMMUNITY AFFILIATED PLANS IN SUPPORT OF PLAINTIFF-APPELLANT MODA, AND AFFIRMANCE

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August 28, 2017

CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, counsel for *amicus curiae* Association for Community Affiliated Plans certifies the following:

1. The full name of every party or *amicus* represented by one or more of the undersigned counsel is: Association for Community Affiliated Plans

2. The name of the real party in interest (if the party in the caption is not the real party in interest) represented by one or more of the undersigned counsel is: None

3. All parent corporations and publicly held companies that own 10% or more of stock in the party: None

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court (and who have not or will not enter an appearance in this case) are: The attorneys who have entered appearances are: William L. Roberts, Jonathan W. Dettmann, Nicholas J. Nelson, and Kelly J. Fermoyle of Faegre Baker Daniels, LLP.

Dated: August 28, 2017

/s/ William L. Roberts
William L. Roberts

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Association for Community Affiliated Plans (ACAP) is a national trade association representing not-for-profit health plans, many of whom participated in health-insurance marketplaces under the Affordable Care Act (ACA).[1] Collectively, ACAP exchange and Medicaid plans serve more than seventeen million enrollees nationwide. Many enrollees are among the nation's poorest and sickest people who lack access to other health insurance. In contrast to many other insurers, ACAP member health plans primarily participate in the low-margin Medicaid market and rarely participate in the higher-margin large group employer market. As a consequence, ACAP insurers generally cannot offset large losses with profits from other markets. Further, as community-centric plans committed to serving vulnerable people, ACAP member plans are integral parts of their community's fragile "safety net." Non-payment of risk corridors, therefore, not only threatens the viability of some ACAP member plans, but also threatens damage to the safety net serving our nation's poorest and most vulnerable people.

For ACAP members, the availability of the risk corridors program was crucial in their decision to participate in the exchanges. This was exactly what Congress intended when it enacted the risk corridors as part of the ACA. As a result, the government's attempt to eliminate more than 90% of the scheduled risk corridors

[1] All parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part, and no person other than *amicus*, its members, and its counsel contributed money intended to fund preparing or submitting this brief.

payments would result in severe economic hardship for many ACAP members, and financial ruin or bankruptcy for some. That is not how the statute works. *Amicus* submits this brief to explain why.

SUMMARY OF ARGUMENT

When Congress wants people to take certain actions, it often enacts a statute offering payments in exchange for them. Congress did that in the Affordable Care Act (ACA). The ACA offered "risk corridors" funding to induce private health insurers to take a significant risk: offering coverage to new customers (many of whom were previously uninsured), under new policies, in a new government-sponsored marketplace, without actuarial experience to guide pricing. So the House and Senate passed, and the President signed, a bill stating with no qualifications that if insurers participate in the marketplace and suffer excessive losses in the first three years, the risk corridors program "shall pay" them specified amounts.

It worked. Insurers understood that some of the risk of insuring this new population would be mitigated by risk corridors payments, and accordingly offered health plans to customers who had not been able to access them before. But now, years later, the government wants to pull the rug out from under these insurers. It is offering only pennies on the dollar of the amount Congress said it "shall pay."

If the government is allowed to avoid its obligations in this way, the plight of *amicus*'s members will become a cautionary tale why market participants should not trust government promises of payment. ACAP members did just what Congress had

hoped when it said the government "shall pay" certain sums. They took significant actions and made massive investments to participate in the ACA's marketplace and become eligible for the payments. Under both the statutory command and their implied-in-fact contract, this qualified the insurers for risk corridors payments. But if the government gets its way, the insurers will not receive the promised payment—and instead will face severe financial hardship, or even ruin. That could cripple Congress's future ability to work with private partners by offering financial incentives, as even the clearest government promise of payment would be rendered unreliable.

Fortunately, the government's view is not the law. The government first argues that the risk corridors statute implicitly limited the payments to the amount *received* from other insurers under the program. But the government offers not a shred of evidence for this revisionist view. The plain text and structure of the statute, the pronouncements of HHS following its enactment, and indeed Congress's own later action all show everyone knew that "shall pay" means "shall pay." Second, the government contends that later appropriations bills implicitly repealed most of the obligation to make risk corridors payments. But that contravenes blackletter principles distinguishing payment obligations from appropriations, and also the strong presumption against implied repeals of obligations in appropriations bills.

In short, when the government has unequivocally promised payment in a statute, arguable implications from appropriations bills do not suffice to repeal it. That rule is necessary in this case to avoid devastating a large section of the health-

insurance industry that trusted Congress's promise. And it is necessary in future cases to ensure that Congress can again secure private-sector participation in programs through offers of future payments.

ARGUMENT

I. The Risk Corridors Legislation Created a Legal Obligation to Pay.

The plain text of ACA § 1342 mandates that the government "shall pay" specified risk corridors amounts to qualified insurers that suffer losses specified in the statute. The language is clear and unequivocal. Nothing in the statute suggests that the government can pay anything less than the amount prescribed by the statutory formula. And Congress, the executive branch, and the industry all showed by their actions that they understood the statute this way. Not until this litigation did the government try to revise history and claim that Section 1342 had always implicitly limited risk-sharing payments to the amount of profit-sharing revenues. The facts show otherwise.

A. Risk Corridors Can Inherently Involve Net Expenditures.

The story of the ACA's risk corridors program is well documented. Congress recognized that insurers would need time to figure out how to price coverage accurately for these new customers in the ACA's new marketplaces. That was in part because the ACA's individual subsidies allowed several million people to purchase coverage after previously being uninsured. It was also in part because of a change in the regulatory environment: insurers were now required to issue standardized

coverage to every applicant, when they previously had the right to adjust rates and benefits based on an applicant's risk profile. Because insurers had little or no information on how to accurately set premiums for these new markets, many of them would have been reluctant to participate for fear of taking large losses. Even insurers who did participate might charge higher premiums in response to the uncertainty, and the ACA's subsidies program would require the government to absorb some of those increased costs.

The risk corridors program was one aspect of Congress's response. The program created a transition period in which the impact of mispricing would be softened. Insurers who significantly underpriced—essentially, those who charged their customers less in aggregate premiums than they paid out in aggregate healthcare benefits—would have a portion of their losses reimbursed by the government. *See* ACA § 1342(b)(1). On the other hand, insurers who significantly overpriced—who charged more in aggregate premiums than they paid in benefits—would pay a portion of their profits to the government. *See* ACA § 1342(b)(2). There is no language in either Section 1342(b)(1) or (2) implying that the two are linked.

Likewise, the structure of Section 1342 does nothing to link payments out with payments in. The statutory formulas for calculating "payments out" and "payments in" to individual insurers are completely independent of each other. Under the terms of the statute, any change in profit-sharing payments received by the government—either from an individual insurer or in the aggregate—would have no effect on the

amounts of risk-sharing payments the government "shall pay" to insurers who underpriced. There is no suggestion that the Section 1342(b)(2) "payments out" formula was intended merely to redistribute "payments in."

In other words, nothing about the risk corridors system makes it inherently budget-neutral. There was no reason to think that underpricing by some insurers would be offset by other insurers overpricing by precisely the same amount. Indeed, the ACA's risk corridors were largely modeled on the Medicare Part D risk corridors established a decade earlier by the Medicare Modernization Act—which have never been legally required to be budget neutral. *See* ACA § 1342(a) ("Such program shall be based on the program for regional participating provider organizations under part D of" the Medicare statute.).

The government suggests that the statute implicitly requires artificially equalizing the risk-sharing payments ("payments out") with profit-sharing receipts ("payments in"). But the statutory text states only that the government "shall pay" the specified risk-sharing amounts. The language will not bear the reading the government now seeks—that the Secretary shall *not* pay risk-sharing amounts to the extent they exceed the government's profit-sharing income. If Congress had wanted to create that kind of scheme, it could easily have said so. It did not.

The government notes that no specific appropriation accompanied the statute when it was enacted, and so it contends that "even a freestanding directive to an agency to pay amounts calculated under a statutory formula would not" actually

require the United States to pay those amounts. (Gov't Br. at 28.) According to the government's argument, an unequivocal statutory promise to pay means nothing, and the government's payment obligation is only whatever amount Congress ultimately appropriates. That proposition, however, is "completely contrary to a mountain of controlling case law holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation." *Molina Healthcare of California, Inc. v. United States*, No. 17-97C, 2017 WL 3326842, at *19 (Fed. Cl. Aug. 4, 2017). It certainly does not follow from *Prairie County v. United States*. The statute at issue there explicitly provided that "[a]mounts are available only as provided in appropriation laws." 782 F.3d 685, 686 (Fed. Cir. 2015). That language, which the government's brief does not mention (*see* Gov't Br. at 28), makes the *Prairie County* case crucially distinct from this one. Of course *that* kind of statutory directive may not mandate payment independent of appropriations; the limitation is provided in the statutory language itself. But the risk corridors provision of the ACA includes no similar "as-provided-in-appropriations" qualifier. It therefore is not subject to the same interpretation.

B. HHS, Insurers, and Congress Acted on the Understanding that "Shall Pay" Requires Full Payment.

After the ACA's enactment, a controversy developed over the risk corridors program. Throughout, HHS consistently recognized a legal obligation to make risk corridors payments in full. And in the political debate even the ACA's opponents

understood that the risk corridors' "shall pay" requirement instructs HHS to make the specified payments, with no implied cap.

HHS delegated rulemaking authority for the risk corridors program to CMS. In March 2013, at the time CMS issued its final rule, it responded to a comment "ask[ing] for clarification on HHS's plans for funding risk corridors if payments exceed receipts," stating: "The Risk Corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, ***HHS will remit payments*** as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. 15409, 15473 (Mar. 11, 2013) (emphasis added). In the ensuing months of 2013, insurers—including ACAP members—committed to participation in the ACA exchanges for the year 2014. They did so with the understanding that risk-sharing payments would be made according to the statutory formula.

Even after Congress limited the available funding, HHS continued to regard itself as ultimately obligated to pay the entire amounts that Section 1342(b) says it "shall pay." Lacking appropriations in the full amount that it "shall pay," HHS pro-rated the 2014 risk-sharing payments. But HHS also was conscious that insurers would soon be deciding whether to participate in the exchange for 2016, and it feared that many of them would flee the marketplaces if the risk corridors were abandoned. HHS therefore took pains to reassure them that the ACA required full risk corridors payments. In late 2015, HHS sent letters to many insurers "reiterat[ing] that [HHS] recognizes that the Affordable Care Act requires the Secretary to make full payments

to issuers, and that HHS is recording those amounts that remain unpaid . . . as fiscal year 2015 obligations of the United States Government for which full payment is required." *See* Appx27 n.13; *Risk Corridors Payment and Charge Amounts for Benefit Year 2014*, Dept. of Health & Human Servs., Nov. 19, 2015.

HHS then acted according to this understanding. Although HHS pro-rated 2014 risk-sharing payments to match the amount of profit-sharing receipts, it never treated that as a completely discharged risk-sharing obligation. Instead, when 2015 profit-sharing revenues became available, HHS used them to pay another installment on its 2014 risk-sharing obligations. Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, Dept. of Health & Human Servs., Nov. 18, 2016 ("Today, we are confirming that all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments."). In other words, HHS has always recognized, and continues to recognize, that Section 1342 requires the government to pay the full risk-sharing amounts specified in the statute, even though Congress has not provided HHS with the money to do so.

Members of Congress shared the same understanding of Section 1342, and as a result some tried to repeal it. For example, in November 2013, Senator Rubio "introduc[ed] legislation that would eliminate the risk corridor provision," in his words to "ensur[e] that no taxpayer-funded bailout of the health insurance industry will ever occur under ObamaCare." Marco Rubio, *No Bailouts for ObamaCare*, Wall Street J. (Nov. 20, 2013). The legislation would have repealed Section 1342 in its

entirety. Congress did not pass that bill. S. 1726, 113th Cong. (2013). Numerous other "anti-bailout" bills introduced in 2013 and 2014 would have repealed the risk corridors program. *See, e.g., Amend the Affordable Care Act: Hearing on H.R. 3812*, 113th Cong. H137-06 (2014) (statement of Mr. Coffman) (noting that risk corridors "can provide for a massive taxpayer bailout to cover the insurance industry losses"). None of those bills were enacted.

II. The Shortfalls in Risk Corridors Appropriations Do Not Implicitly Repeal the Statutory "Shall Pay" Directive.

When Congress commits to making payments by statute, it should not lightly be held to have abandoned that promise. If private partners cannot trust Congress to make good on its promises of payments, then Congress will lose its ability to attract private parties into government-sponsored programs.[2]

A. Appropriations Bills Are Strongly Presumed Not to Affect Substantive Legislation.

Well-established law reflects this commonsense insight. Appropriations bills are strongly presumed ***not*** to repeal or amend substantive legislation such as Section 1342. For many decades, both Congress and the courts have distinguished appropriations legislation from "permanent" or "authorizing" legislation. *See, e.g.,*

[2] These principles explain why the government is wrong to treat the insurers' contract claims as merely duplicating their statutory claims. Both kinds of claims do depend on § 1342's promise of payment. But as the court below held, that promise was also an offer to contract with insurers, and the insurers accepted the offer through their conduct. Appx37-38. As a result, later changes through appropriations could not vitiate contractual obligations already incurred. Thus the contract claims persist.

Building & Constr. Trades Dep't v. Martin, 961 F.2d 269, 273 (D.C. Cir. 1992), *cert. denied*, 506 U.S. 915 (1992) (citing *Minis v. United States*, 40 U.S. (15 Pet.) 423 (1841)). On one hand, authorizing legislation tells government agencies what to do and what legal standards to follow; on the other, appropriations legislation provides them funds to carry out those instructions. *See generally* Cong. Res. Serv., *Authorization of Appropriations: Procedural and Legal Issues* (Nov. 30, 2016). Authorizing legislation is usually enacted only once and often becomes part of the U.S. Code; by contrast, appropriations generally are made yearly and not codified.

The law is well settled regarding how the two kinds of statutes interact. "While appropriation acts are 'Acts of Congress' which can substantively change existing [authorizing] law, there is a very strong presumption that they do not." *Calloway v. Dist. of Columbia*, 216 F.3d 1, 9 (D.C. Cir. 2000) (citation omitted). Moreover, if an appropriations bill does not expressly repeal preexisting law, "[t]he doctrine disfavoring repeals by implication" "applies with even *greater* force when the claimed repeal rests solely on an Appropriations Act." *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 189-90 (1978); *Robertson v. Seattle Audubon Society*, 503 U.S. 429, 440 (1992).

Congress's own rules reflect its reluctance to amend previous law through appropriations. In both the House and the Senate, amendments changing existing law are out of order in appropriations bills and subject to being stricken. *See* Clerk of the House of Representatives, 114th Cong., *Rules of the House of Representatives*, R. XXI(1)(b) (2015) ("A provision changing existing law may not be reported in a

general appropriation bill . . . ."); *Standing Rules of the Senate*, S. Res. 16, 113th Cong. (2013) (enacted) ("The Committee on Appropriations shall not report an appropriation bill containing amendments to such bill proposing new or general legislation . . . .").

There is good reason for these rules. Appropriations bills contain thousands of line items, most of which are effective for only a year. It would be enormously wasteful and chaotic if each of them had to be compared with the entire corpus of existing law to see if there might be any implicit inconsistencies. *See Williams v. United States*, 240 F.3d 1019, 1062 (Fed. Cir. 2001) (Plager, J., dissenting), *overruled by Beer v. United States*, 696 F.3d 1174 (Fed. Cir. 2012) ("[P]rovisions contained in an appropriations act are intended to apply during the term of that act, and not thereafter. This is a presumption not easily rebutted, as it reflects a salutary canon of legislative interpretation upon which members of Congress may rely, and is supported by affirmative rules of both Houses.").

These same principles apply when Congress tries to shape private behavior by offering payments to persons who take qualifying actions. Congress often passes authorizing legislation that instructs an agency to make such payments. Subsequent appropriations bills then provide money from which the agency does so. When an appropriations bill is alleged to have amended or repealed this kind of "statutory obligation [that] concerns an entitlement to funds," the same strong presumption against repeal or amendment applies. Cong. Res. Serv., *supra*, at 10. In that situation,

"[i]t has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute . . . . The failure to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims." *New York Airways, Inc. v. United States*, 369 F.2d 743, 747 (Ct. Cl. 1966).

When an authorizing statute specifies how much an agency must pay—either by dollar amount or by a formula for its calculation—the case law imposes a high standard for what a later appropriation measure must do to displace the previous payment obligation. As a threshold matter, the appropriation must expressly identify a different amount or formula to be paid. The cases relied upon by the government for repeals through appropriations, as well as many others, follow that pattern: authorizing legislation set a payment amount or formula; and an appropriations bill replaced it with an equally specific amount or formula. *United States v. Fisher*, 109 U.S. 143, 144 (1883) (statute setting dollar amount for a territorial judge's salary was amended by a later appropriation that set a lower amount and stated it was "full compensation" for the year in question); *Highland Falls-Ft. Montgomery Cent. Sch. Dist. v. United States*, 48 F.3d 1166 (1995) (statutory formulae for calculating amounts of various payments were supplanted by appropriations bill earmarking specific amounts for each kind of payment); *Am. Fed'n of Gov't Employees v. Campbell* , 659 F.2d 157, 158-

59 (D.C. Cir. 1980) (appropriation amended a statutory formula for federal-employee wage growth by specifically capping the formula at 5.5% raises for the year).

And even that alone is not enough. The court must inquire further into the statute's text to determine whether Congress really meant to replace the previous payment amount or formula. *United States v. Vulte*, 223 U.S. 509, 514-15 (1914) (The intent of Congress to permanently legislate by appropriation should not be presumed "unless it is expressed in the most clear and positive terms, and where the language admits of no other reasonable interpretation."); *Calloway*, 216 F.3d at 9 (appropriations restriction on payment of opposing parties' attorneys' fees did not implicitly amend the courts' statutory authority to award those fees). This is the legal standard against which the government's repeal-by-appropriation argument must be measured.

B. The Appropriations Bills Do Not Remotely Replace ACA § 1342's Payment Formula.

The appropriations measures on which the government relies do not come close to meeting this high standard. They do not even suggest that Congress wanted CMS to discard Section 1342's formula for calculating risk-sharing payments, or use some other formula or number in its place. As Judge Wheeler correctly recognized, "the limitation in this case singles out a specific use for a specific account. It does not . . . bar any appropriated funds from being used for a given purpose." Appx32.

The appropriation instruction the government relies on here states:

> None of the funds made available by this Act from [CMS trust funds], 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).

(Gov't. Br. at 23.) By its terms, this does not tell CMS to modify or toss out the Section 1342 formula for calculating risk-sharing payments. Nor does it specify any alternative amount or formula for CMS to use. Instead, it contemplates that CMS *will* calculate the risk-sharing payments according to Section 1342, and instructs CMS only not to pay them out of specified particular funding sources. It does not appear that any court has ever found this kind of vague source-of-funds instruction to work an implicit repeal of a specific statutory payment obligation.

The government points to factors outside the statutory text—specifically a GAO letter and a floor statement—to argue that Congress must have meant to allow only "user fees" as the source of funding for risk-sharing payments. (*See* Gov't Br. at 9-11.) But that is far from an overhaul of Section 1342's promise of payment itself. Congress did not change the method of calculating the obligation. It may have prevented the Secretary from making payments in excess of "user fees" in one fiscal year, but it did not impact the government's obligation to make the statutorily required payments. That obligation continues.

* * *

In the end, the legal rule governing this case converges with basic principles of fair dealing. If Congress wants to go back on a statutory promise of payment, it cannot do so by implication through the backdoor of an annual appropriations bill.

Instead, it must forthrightly say that it is repealing or amending the payment obligation. As Judge Wheeler put it, "[t]here can be no room for inference when dealing with whether the Government will honor its statutory commitments." *Molina*, 2017 WL 3326842, at * 24.

CONCLUSION

The Court should affirm the judgment below.

Dated: August 28, 2017

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned hereby certifies that this brief complies with the type-volume requirements in Federal Rule of Appellate Procedure 32 and Federal Circuit Rule 32. According to the word count function of the word-processing system used to prepare this brief, it contains 3,906 words, excluding the parts exempted by Federal Rule of Appellate Procedure 32(f) and Federal Circuit Rule 32(b). This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6). This brief has been prepared in proportionately spaced typeface using Microsoft Word 2010 in 14-point, Garamond.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 28th day of August, 2017, a copy of the foregoing was filed electronically with the Court's Electronic Case Filing ("ECF") system. I understand that notice of this filing will be sent to all parties by operation of the Court's ECF system.

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